

Community Integrated Care

Charlotte Grange Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 1 November 2017 and was unannounced. A second day of inspection took place on 2 November 2017 and was announced.

Charlotte Grange 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. Charlotte Grange provides personal care for up to 46 people. At the time of our inspection there were 45 people living at the home, some of whom were living with dementia.

A registered manager was in place at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

We last inspected this service on 7 and 9 March 2017 when it was rated 'Requires Improvement' overall. We asked the provider to take action to make improvements because we found the service was in breach of a number of regulations. At that time we found people were not protected from the risk of cross infection due to poor infection control management, medicines were not managed in a safe way, people's personal evacuation plans were not always up to date, staff had not received appropriate training to meet the needs of the service, and the provider's quality assurance system was ineffective.

During this inspection we found the action plan to address the areas which previously required improvement had worked well, and positive outcomes had been achieved in most areas. We found the requirements of the law were now being met although some improvement was still required.

The registered manager told us how they had worked closely with the local Infection Prevention and Control nurse to address the issues we found at the last inspection. Although we noted significant improvements since the last inspection in relation to infection prevention and control, communal bathrooms did not contain foot operated bins. The registered manager informed us this was rectified shortly after our inspection.

Medicines were managed safely and effectively. Staff who administered medicines had received the appropriate training.

People we spoke with told us they felt safe living at Charlotte Grange Care Home. Relatives told us they felt their family members were safe.

Staff had received training in safeguarding and knew how to respond to any concerns. Safeguarding referrals had been made to the local authority appropriately, in line with set protocols. Lessons had been

learnt and practice changed following safeguarding incidents.

A thorough recruitment and selection process was in place which ensured staff had the right skills and experience to support people who used the service. Identity and background checks had been completed which included references from previous employers and a Disclosure and Barring Service (DBS) check.

Each person had an up to date personal emergency evacuation plan (PEEP) which provided staff with information about how to support them to evacuate the building in an emergency situation such as a fire or flood.

Risk assessments about people's individual care needs were in place, for example in relation to falls, pressure damage and nutrition. Control measures to minimise the risks identified were set out in people's care plans for staff to refer to.

There were enough staff on duty to meet people's needs. Essential staff training was up to date. Staff received regular supervisions and appraisals.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People's nutritional needs were met and they enjoyed the food and drink they received. Menu information was confusing and was not available in an accessible format appropriate to everyone's needs. Food and fluid charts were completed accurately. People's day to day health needs were met.

Care plans were specific about people's individual care needs and were written in a person-centred way. Person-centred care is about ensuring the person is at the centre of any care or support plans and their individual wishes, needs and choices are taken into account.

People were supported by a care staff team who were kind and caring towards them. People were given choices about their care and how they chose to spend their time. People's dignity was upheld and independence promoted.

People had access to important information about the service, including how to complain and how to access independent advice and assistance such as an advocate.

Staff said the registered manager was approachable and supportive, and that they had plenty of opportunities to provide feedback about the service. People and relatives spoke positively about the registered manager and their approach to managing the service.

The quality monitoring of the service had led to improvements, although a few areas of improvement remained in relation to bins in communal bathrooms, menu information and best interest documentation. Whilst we noted improvements in quality monitoring this needed to be embedded and sustained over a period of time.

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.

Although infection prevention measures had improved since the last inspection communal bathrooms did not contain foot operated bins.

Planned and preventative maintenance checks were up to date.

Staff had completed safeguarding training and understood their responsibilities to report any concerns.

Thorough background checks had been carried out before staff began their employment.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Menu information was confusing and was not available in an accessible format appropriate to everyone's needs.

People received support to eat in a timely manner.

Staff training had improved since the last inspection.

Food and fluid charts were completed accurately.

Is the service caring?

Good ●

The service was caring.

People told us staff were kind and caring.

People were treated with respect

People looked relaxed and happy in the presence of staff.

People were given information about the service.

Is the service responsive?

Good ●

The service was responsive.

Care plans contained details about how people wished and needed to be cared for in line with their individual preferences.

People told us the range of activities available had improved.

People and relatives told us they knew how to make a complaint.

There had been no complaints since the last inspection.

Is the service well-led?

The service was not always well-led.

The quality monitoring of the service had led to improvements, although a few areas of improvement remained in relation to bins in communal bathrooms, menu information best interest documentation.

People and relatives spoke positively about the registered manager.

Staff said they felt supported and had plenty of opportunities to provide feedback.

The Commission had been notified of important events that happened in the service in the form of a 'notification.'

Requires Improvement 

Charlotte Grange 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 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 1 and 2 November 2017. Day one of the inspection was unannounced which meant the provider did not know we would be visiting. The second day of inspection was announced so the provider knew we would be returning.

The inspection team was made up of one adult social care inspector, a specialist nurse advisor with expertise in clinical governance (that is continuous improvement in care practice) and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We also contacted the local authority commissioners for the service, the local authority safeguarding team, the clinical commissioning group (CCG) and the local Healthwatch to gain their views of the service provided. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also spoke with a specialist infection prevention and control (IPC) nurse who had provided advice and support to the service since our last inspection. We used the feedback we received to inform the planning of our inspection.

During the inspection we spent time with people living at the service. We spoke with 14 people and nine relatives. We also spoke with the registered manager, the deputy manager, two senior support workers, seven support workers, one administrator, one maintenance staff member, one kitchen staff member and

two domestic staff members. We also spoke with a community matron who visited the service during our inspection.

We reviewed eight people's care records and three staff recruitment files. We reviewed medicine administration records for eight people as well as records relating to staff training, supervisions and the management of the service. We also checked the building to ensure it was clean, hygienic and a safe place for people to live.

Is the service safe?

Our findings

When we last inspected this service in March 2017 we found infection control procedures were not being followed regarding the laundering of soiled items. Sluice rooms had contained items that were at risk of contamination from bodily fluids. The registered manager told us how they had worked closely with the local infection prevention and control nurse to address the issues we found at the last inspection. During this inspection we found significant improvements had been made in this area, although some areas for improvement remained. Improvements to infection prevention and control measures needed to be consistently monitored and sustained.

We found sponges were no longer reused and laundered for personal care. Since our last inspection all of the sluice rooms were in the process of being refurbished, and they were no longer used to store items which were at risk of contamination from bodily fluids.

We found work had been carried out in the laundry to remove a sink and rusting pipes which could not be cleaned effectively. Laundry was segregated appropriately in order to facilitate safe laundering in line with infection control guidelines. The laundry was clean and tidy and there was no dust or fluff behind the washing machines or tumble driers.

A room near the laundry had been turned into a clean linen store. Plastic drawers and boxes were used for storage which meant clean items could be stored appropriately until they were needed.

Although we noted significant improvements since the last inspection in relation to infection prevention and control, we found communal bathrooms did not contain foot operated bins. Foot operated bins prevent recontamination of hands by lifting the lid of the bin by pressing the pedal with your foot. When we discussed this with the registered manager they said they would address this immediately. Shortly after the inspection the manager notified us that foot operated bins had been purchased and were in use.

Staff were provided with a range of equipment to help reduce the spread of infection such as gloves and aprons. We observed staff used personal protective equipment effectively and followed good infection control practices. Gloves and aprons were stored appropriately where staff could access them easily.

The premises were clean and tidy. Checks and tests of the premises had been carried out to ensure they were safe and well maintained.

At the last inspection we found medicines were not managed safely. At this inspection we found significant improvements had been made in this area and medicines were now managed safely. Some people took medicines 'when required', such as painkillers. There were detailed guidelines for staff to follow which explained when a person may require these medicines. Where some people could not always communicate their needs, guidance was now in place for staff regarding signs to look for which would indicate that people may need to be offered their 'when required' medicines, for example when they displayed signs of being in pain. This meant staff had appropriate information to refer to.

Prescribed creams were recorded as administered on topical medicines application records and body maps highlighting where staff should apply the creams and ointments were in place. This demonstrated that processes were in place to ensure people received their prescribed creams in line with instructions.

Medicines records we viewed had been completed accurately. Medicines were stored securely and checks were in place to ensure they were stored at the correct temperature. Medicines that are liable to misuse, called controlled drugs, were recorded and stored appropriately. Records relating to controlled drugs had been completed correctly and stock balances tallied with these records.

Staff understood how to protect people from abuse. They had received training about safeguarding people and knew the provider's safeguarding policy and procedure. Staff understood their safeguarding responsibilities and told us they would have no hesitation in reporting any concerns about the safety or care of people who lived there. They also understood the whistleblowing procedure if senior staff did not act on the information they had provided.

Lessons were learnt from safeguarding incidents which were shared with all staff. For example, the arrangements for the storage of one person's domestic item was changed after an incident. This meant the provider was responsive when new risks arose.

Staff had a good understanding of their roles and responsibilities. Senior staff allocated tasks and duties to support staff on a shift by shift basis to ensure staff kept people safe and met their needs.

We looked at recruitment records for three staff members who had started working at the service since the last inspection. Adequate checks were in place to ensure staff were suitable to work with vulnerable people. The recruitment practices for new staff members were robust and included an application form and interview, references from previous employers, identification checks and checks with the Disclosure and Barring Service (DBS) before they started to work at the home. DBS checks help employers make safer recruitment decisions by reducing the risk of unsuitable people from working with vulnerable people.

Accidents and incidents were recorded, dealt with appropriately and analysed monthly. Action following an incident or accident was evident, for example measures were put in place such as increased observations for people who chose to stay in their rooms who had a history of falls, and referrals to the falls team where appropriate.

Risks to each person's safety and health were assessed, managed and reviewed. These included risks associated with medicines, nutrition, mobility and skin care. Appropriate action was taken to reduce the risk of harm to people. For example, people who were at high risk of pressure damage had pressure relieving mattresses in place which were set correctly.

Since the last inspection each person's personal emergency evacuation plan (PEEP) had been updated to reflect their current needs. These contained details about their individual needs, should they need to be evacuated from the building in an emergency. They contained clear step by step guidance for staff about how to communicate and support people in the event of an emergency evacuation.

We viewed staff rotas and the dependency tool the registered manager used to establish staffing levels. The provider employed 64 staff at this service. The registered manager told us each of the four units had two support workers during the day and two senior support workers covered all four units. Four support workers worked during the night. Night staff had access to an on-call staff member if an emergency situation arose or further advice was needed. Staff were also expected to deliver recreational activities as part of their

duties. People did not raise any concerns with us about staffing levels. There were sufficient numbers of staff deployed to meet people's needs. Staff carried out their duties in a relaxed and unhurried manner. We saw that they had time to chat with people in between their tasks, which people told us they liked.

We asked people and their relatives whether they felt Charlotte Grange was a safe place. One person told us, "I definitely feel safe." A relative said, "This is a great place with great staff. I can't speak highly enough of it. There are plenty of staff, I have peace of mind."

Is the service effective?

Our findings

At the last inspection we found staff training in some areas was not up to date. At this inspection we found this had improved. The majority of staff had completed training relevant to their job role in a number of key areas. For example, staff had completed up to date training in moving and assisting, emergency first aid, safeguarding vulnerable adults, dementia awareness and fire safety. Some staff had yet to receive updated training on the Mental Capacity Act and dementia care but these were in the minority and we saw evidence this was arranged for the coming months. Improvements in staff training needed to be sustained.

People we spoke with told us staff were well trained. Relatives we spoke with said they felt staff were trained to meet their family member's needs. Staff told us training had improved since the last inspection and they felt supported.

Staff told us, and records confirmed, staff received regular supervisions or one to one meetings with their line managers. Supervisions are important to ensure staff have structured opportunities to discuss training needs and future development and to promote best practice. Supervision records contained a good level of detail regarding the topics discussed and any resulting actions.

We observed lunch time in the dining room. There were enough staff to support people to eat and drink. Tables were nicely set with placemats, cutlery and condiments. Lunch was a choice of chicken or pork with mash or roast potatoes and vegetables. Other options were available if people preferred sandwiches or something else. The lunch time meal was followed by toasted teacakes with jam. Staff told us a hot pudding was served after the evening meal, as most people enjoyed it better then, and people confirmed this. Hot and cold drinks were readily available depending on people's preferences.

Meals looked appetising and nutritious and people spoke positively about the quality and choice of meals. One person said, "The food is good here you have a choice." Another person told us, "No complaints about the food at all, we can have anything we want." A relative commented, "[Family member] has started putting on weight again since she came here." Another relative told us, "My [family member] is well looked after here. Their only complaint is that there's too much food."

The menu advertised in dining rooms on white boards did not match what was available on the days of our inspection, and menus were not available in picture format. Picture menus support people's decision-making and communication needs. This may have caused confusion for some people who used the service. When we spoke to the registered manager about this they said they would ensure white boards were up to date. The registered manager showed us evidence that they had requested picture menus from the provider, which were in the process of being developed.

If people were identified as being at risk of poor nutrition or dehydration, staff monitored and recorded their daily food and fluid intake. The food and fluid charts we reviewed had been completed accurately and in a timely manner. People were weighed when necessary and their BMI (body mass index) was calculated accordingly. This meant people were supported to meet their nutrition and hydration needs.

Care plans evidenced that where appropriate people had been supported to access external healthcare from professionals such as dieticians, community nurses, tissue viability nurses and GPs. We spoke with an external healthcare professional who was visiting during our inspection. They told us, "The staff here are really good at referring appropriately. They're good at assessing people's conditions and changes and they always follow our instructions."

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 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.

People can only be deprived of their liberty to receive care and treatment when it is in their best interests to do so and when it is legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the provider worked within the principles of the MCA. Care records showed, and the registered manager confirmed that 27 people were subject to a DoLS. We reviewed the records regarding the applications to the local authority and outcomes of these decisions. We found evidence of mental capacity assessments and best interest decisions in people's care plans, although best interest decisions had not been recorded on the appropriate documentation. We discussed this with the registered manager who acknowledged that the wrong documentation had been used. They said they would rectify this immediately.

People who lack mental capacity to understand some aspects of their lives, may still have the ability to consent to some aspects of their care and support, such as choosing what to eat and wear. Records showed that people had been included in decision making processes as far as reasonably possible. Records showed that people had given their consent to receive the planned care and support. Where people had not been able to give their consent to care, decisions had been made in people's best interest. We heard staff gain people's consent before assisting people with tasks.

Is the service caring?

Our findings

People spoke positively about the care they received. One person said, "Staff are very good and very nice. They are very helpful." A second person commented, "The staff are really caring and nothing's too much trouble." A relative said, "The staff are great here. They're caring and they take the time to talk to people. They help them to be as independent as possible and treat people with dignity." Another relative told us, "It's excellent here, we couldn't be more pleased."

We saw staff showed people kindness, patience and respect and offered people lots of praise and gentle encouragement. We heard one staff member say to a person, "Come on take my arm and I'll help you get a nice spot for the Zumba." Staff respected people's preferences and gave them choices how to spend their time.

An external healthcare professional told us, "The staff here are really caring and friendly. They always ensure people are clean and dressed appropriately. They know people's needs really well."

Some people who used the service were unable to tell us about the care they received, but throughout our visit staff addressed people in a respectful and considerate manner and communicated with people as individuals. For example, by giving people time to respond to questions and keeping sentences short. There were good interactions between staff and people who used the service, particularly those living with dementia. For example, we saw one staff member comforting and reassuring a person who was anxious by holding their hand and speaking to them softly.

Throughout our visit the atmosphere in the communal areas was good natured and people looked relaxed and happy in the company of the staff who, when needed, provided comfort and reassurance to people. For example, holding their hands and stroking their arms. Staff spoke fondly about the people they supported and it was clear they had developed a good relationship with each person and their families.

We saw positive relationships between people and staff. People's facial expressions and body language showed they were comfortable in the presence of staff and enjoyed a laugh and a joke with them. One staff member commented, "I really like working here and wouldn't have my family anywhere else. Several of my family members have lived here and they were well looked after."

The service had received several written compliments from relatives since the last inspection. Comments included, 'Thanks everyone – you truly are carers,' 'Thank you for your support and care of [family member]' and 'Thank you for all the care and support you have given. We really appreciate it.'

Each person who used the service was given a residents' guide (an information booklet that people received on admission) which contained information about the service. This included the service's statement of purpose and how to make a complaint.

Information about advocacy support from external agencies was available. An advocate is someone who

represents and acts on a person's behalf, and helps them make decisions. One person who used the service had an advocate to support them as and when needed.

Is the service responsive?

Our findings

At the last inspection we recommended that the provider considered current guidance and best practice regarding activities for people living with dementia. We noted that activities for people living with dementia had improved as themed memory boxes and twiddle mats were in place. Visual and tactile items can help engage people living with dementia and help reduce their anxiety levels.

The provider did not employ an activities co-ordinator as support staff were expected to facilitate activities as part of their duties. We noted that since the last inspection a senior support worker had been tasked with leading on activities. People told us this had resulted in improvements to the activities on offer and an activities timetable was now produced as a result of people's feedback.

People's care plans contained information about their hobbies and interests. For example, one person's care plan stated, 'I like listening to Abba, Susan Boyle and Matt Munro.' Staff we spoke with knew how people liked to spend their time and encouraged them to try new things. Numerous photographs of people enjoying activities had been taken so people and their relatives could look at them at any time.

During our inspection people told us how much they had enjoyed a Halloween party the previous day. People told us there had been a coffee morning followed by a party on the afternoon which included pumpkin carving, staff in fancy dress, people wearing witches' hats, a trick or treat table and bobbing apples. People's comments included, "The party was brilliant," "We had great fun" and "The staff were dressed up really well."

Other day to day activities included games afternoons, jigsaw puzzles, arts and crafts and afternoon tea. Staff told us a puppet show, carol service and Christmas party were planned for the Christmas period. One person told us they liked singing so were going to sing on Christmas Day to entertain everybody.

One person told us how much they had enjoyed a 'lads' night in'. They said, "I enjoyed the lads night in very much. I had a shandy and watched the football." Another person told us they liked it when the hairdresser came in as they loved having their hair done. We noted the hairdresser was engaged with people and spoke to them in a compassionate way appropriate to their needs.

During our inspection a Zumba singalong took place. This was attended by most people who used the service, some relatives and staff. Everyone enjoyed themselves singing and clapping to the music.

Care records showed people's needs were assessed and determined before the service was provided. A pre-admission assessment was carried out to ensure staff could meet the needs of the individual concerned. This was usually done by the manager or deputy manager and information about people's general health needs and care preferences were recorded. This information was used to inform people's care plans.

People had a range of care plans in place to meet their needs including personal care, eating and drinking,

medicines, skin care, continence and mobility. Care plans were personalised and included people's choices, preferences, likes and dislikes. Care plans contained relevant detail and clear directions to inform staff how to meet the specific needs of each individual. The registered manager told us the provider was introducing a new format for care plans. Care plans we viewed in the new format contained all relevant information and remained person-centred.

Care plans were reviewed on a regular basis, as well as when people's needs changed. All care plans we viewed were up to date and reflected the current needs of each individual person. People and relatives told us they were involved in reviewing care plans.

The staff we spoke with had a good understanding of people's preferences and wishes and we observed staff using this information in their day to day role when supporting people.

The provider had a complaints policy in place. There had been no complaints received since the last inspection. People and relatives told us if they had any concerns they would speak to staff members or the manager straight away. One person told us, "I've never needed to complain." A relative commented, "I've never needed to complain about anything here. If I did I would speak to the staff or [registered manager]. The staff are always on the ball with everything. If ever [family member] is under the weather they're onto it straight away and always keep me informed."

Is the service well-led?

Our findings

At the last inspection in March 2017 we found the provider's quality monitoring or audit systems had been ineffective in protecting people from the risk of cross infection due to poor infection control management. We also found that medicines were not managed in a safe way, people's personal evacuation plans were not up to date and staff had not received appropriate training to meet the needs of people using the service.

During this inspection we found significant improvements had been made in relation to all of these areas, although a few areas for improvement remained. The registered manager told us, "We've done an awful lot of work on our improvement plan since the last inspection. We've had lots more quality excellence visits from the provider and more support since the last inspection which has helped a lot."

We found that a monthly quality assurance cycle was in place which consisted of the registered manager auditing areas such as staffing, health and safety, accidents and incidents, care plans and medicines. These audits had been effective in generating improvements. For example, weekly medicines checks had been introduced since the last inspection and improvements were noted in the completion of medicines records. Provider visits happened more regularly, the most recent of which was 14 September 2017. Provider visits led to action plans with target dates for completion and a responsible person identified.

However, not all audits had been effective as we found communal bathrooms did not contain foot operated bins, menu information was confusing and best interest decisions had been recorded on incorrect documentation. When we spoke to the registered manager about these issues they said they would rectify them immediately. Information about menus was not available in picture format but this had already been identified as an area for improvement and was being addressed. Whilst improvements in quality monitoring were noted, this needed to be embedded and sustained over a period of time.

Services that provide health and social care to people are required to inform the Commission of important events that happen in the service in the form of a 'notification'. The provider had made timely notifications to the Commission when required in relation to significant events that had occurred in the home.

Staff meetings were held regularly. Minutes of staff meetings were available to all staff so staff who could not attend could read them at a later date. Staff told us they had enough opportunities to provide feedback about the service. A staff member said, "We have regular staff meetings and we can give feedback at any time."

Staff said the manager was supportive and approachable. One staff member told us, "Their door is always open and they're very approachable. We get plenty of support."

Residents' meetings were held regularly and were reasonably attended. Minutes of these meetings were available for those unable to attend. The agenda for a recent meeting included menus and activities. The registered manager told us they used these meetings to gather people's views of the service informally. At a recent meeting it was decided there would be a Halloween coffee morning and party, and cakes and poems

for dementia awareness day. People said they would like to see an activities calendar on display. We saw this during our visit which meant people's feedback was acted upon. Feedback from people and relatives was also sought via an annual questionnaire each January.

The registered manager advertised a weekly 'open door surgery' but relatives told us they were happy approaching a staff member or the registered manager as and when things came up. People and relatives spoke positively about the registered manager. One person said, "They're a lovely person and will help you." A relative told us, "I just speak to [registered manager] if there's something I want sorting. They do it straight away."