Mr & Mrs A Knight

Chamber Mount

Inspection report

197 Chamber Road
Werneth
Oldham
Greater Manchester
OL8 4DJ

Tel: 01616653185

Date of inspection visit:
04 February 2016
05 February 2016

Date of publication:
18 April 2016

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 inspection was carried out over two days on the 4 and 5 February 2016. Our visit on 4 February was unannounced.

We last inspected Chamber Mount in May 2014. At that inspection we found that the service was meeting the regulations we assessed.

Chamber Mount is a converted detached property situated in a residential area of Oldham, approximately one mile from Oldham Town centre. The service is registered to provide care and accommodation for up to 23 older people, some of whom may have dementia. At the time of our inspection there were 21 people living at Chamber Mount. There are three lounges, two dining rooms and a large conservatory. All bedrooms have vanity units and are fitted with a call system and have access to bathroom and toileting facilities. The property is surrounded by a small garden and there is an area containing garden furniture at the rear of the property. Chamber Mount is privately owned and the owners are both actively involved with supporting the registered manager in the day to day management of the home.

The home had a manager registered with the Care Quality Commission (CQC) who was present for both days 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 registered manager had been in post for nearly thirteen years and was highly regarded by the owners, staff and residents. She had a positive and proactive approach to managing the home and maintaining high standards of care.

Staff had a good understanding of safeguarding procedures, how to identify signs of abuse and what action they would take to protect people. People were kept safe, and risk assessments had been completed to show how people were supported with everyday risks. The building was well-maintained and environmental checks were up-to-date. There were sufficient numbers of staff on duty to care for residents and recruitment checks had been carried out on all staff to ensure they were suitable to work in a care setting. Medication was administered in a safe manner.

Staff had undertaken a variety of training to ensure that they had the skills and knowledge required for their role and received regular supervision from senior staff. All staff had undertaken training in the Mental Capacity Act (MCA): The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to 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 interest and as least restrictive as possible. Staff we spoke to understood how to encourage people to make choices where they had the capacity to do so, and to seek consent before undertaking any care. People were supported to eat and drink sufficient amounts to meet their needs and they told us the food was good.

People told us the staff were kind and caring and that their dignity and privacy were respected. Care plans were person-centred, reflecting the needs of each individual and were reviewed on a regular basis. The home had taken part in the 'six steps end of life training programme' in order to improve knowledge and understanding in this area.

People were supported to maintain good health and referrals to healthcare professionals, for example to District Nurses, or General Practitioners (GP) were made promptly. Families were kept informed of any changes to their relatives' health and were invited to give feedback on the service through meetings and surveys. The service had a complaints procedure in place and people we spoke with knew how to raise a complaint if they needed to.

Staff received regular supervision and quality assurance processes were in place to ensure that the service delivered high quality care.

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.

The administration and management of medication was carried out safely.

There were recruitment procedures and checks in place to ensure that staff were suitable to care for vulnerable adults.

Staffing levels were sufficient to meet the needs of the people using the service

Arrangements were in place to safeguard people from harm and abuse.

Prevention and control of infection was well managed.

Is the service effective?

Good

The service was effective.

Staff received training and supervision to help them care for people appropriately.

People who used the service received the appropriate support to ensure their health and nutritional needs were met.

People's rights were protected because the Mental Capacity Act (MCA) 2005 Code of Practice was followed when decisions were made on their behalf.

Is the service caring?

Good

The service was caring.

People spoke positively about the staff and said they were kind and caring.

People were treated with dignity and respect.

Staff encouraged people to make choices about their daily life style.

Care staff on duty demonstrated that they knew and understood the needs of the people they were supporting and caring for.

Is the service responsive?

Good

The service was responsive.

People had care plans that were detailed and personalised to their particular needs and they and their families were involved in the review process.

Care plans, risk assessments and associated care documentation were regularly reviewed and updated where necessary.

People were given information about how to make a complaint and systems were in place to record and address any complaints about the service.

Meaningful activities were supported to take place on a day to day basis, according to the wishes of the people using the service.

Is the service well-led?

Good

The service was well-led.

The home had a registered manager who was supported by senior carers.

People who used the service and staff spoke positively about the registered manager and the home.

There were systems in place to monitor the quality of care provided by staff.

We observed a culture of openness and a friendly and warm atmosphere amongst the people who lived at Chamber Mount.

Chamber Mount

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.

The inspection was unannounced and took place on 4 and 5 February 2016. On the first day the inspection team consisted of two adult social care inspectors. On the second day the inspection was carried out by one adult social care inspector. Prior to the inspection we reviewed information we held about the service, including the notifications the CQC had received from the provider. Notifications are changes, events or incidents that the provider is legally obliged to send us within a required timescale. We also reviewed the inspection report from the previous inspection and contacted the local authority to ask them if they had any concerns about the service, which they did not.

During our inspection we spoke with three people who used the service, four visitors, the registered manager and owners of the service and three members of the care staff. We also spoke with one visiting health care professional.

We observed how staff interacted with people using the service in the communal areas and dining rooms, reviewed records and looked at other information which helped us assess how people's care needs were met. We spent time observing the lunchtime meal, and watched the administration of medication to check that this was done safely.

As part of the inspection we reviewed four people's care records, including their care plans and risk assessments. We looked at the four staff files, which included their recruitment checks, induction and supervision information. We also reviewed other information about the service, such as its quality assurance records, staff rotas, complaint and compliment records and policies.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe. One person said ''I definitely feel safe'' and a relative, commenting about the staff, said ''no one has been harsh with her''. The service had a 'Safeguarding Vulnerable Adults' policy and a 'Whistleblowing' policy and all staff had undertaken mandatory safeguarding vulnerable adults training. Staff had a good understanding of what was meant by the term 'safeguarding' and could describe different types of abuse, such as physical, emotional and financial. Staff were aware of what was meant by 'whistleblowing' and could explain who they would speak to if they had any concerns about the treatment of a person using the service by a staff member.

Risks to people's health and safety, such as poor nutrition, manual handling and the potential to develop pressure sores had been assessed and information to support staff in managing the identified risks was written in the care plans. We saw that these were reviewed monthly.

We undertook a tour of the premises to check that the building and equipment were safe. The home was well maintained and decorated and was free from any unpleasant odour. Health and safety risk assessments and checks for the building, for example for gas safety and emergency lighting had been completed and equipment, such as hoists and the call bell system had been regularly maintained and serviced.

We saw that the home protected people and visitors from the risk of fire. The fire alarm was tested weekly and the fire extinguishers' servicing history was up-to-date. In addition, there was a visitors' signing-in book in the entrance hall to enable the evacuation of the correct number of people from the premises in the event of an emergency. There was a personal evacuation escape plan (PEEP) in place for each person using the service. These plans explain how a person is to be evacuated from the building in the event of an emergency and take into consideration a person's individual mobility and support needs. We saw that these plans were available in each resident's room and also in the entrance hall.

We checked the systems the service had in place to protect people and staff from cross infection. The home had an infection control policy and all staff had received training in infection prevention and control. Staff we spoke with understood the importance of infection control measures, such as the use of personal protective equipment, including disposable vinyl gloves and disposable plastic aprons and we observed them using these appropriately. We saw that the toilets and bathrooms had posters detailing safe handwashing techniques and that soap, paper towels, aprons and alcohol hand gel were available, all of which helped to minimise the risk of the spread of infection between staff and people using the service.

We saw that the home looked clean and furnishings were well maintained. We spoke with the housekeeper and she described her thorough daily and monthly cleaning rotas and her use of national colour coding for cleaning equipment, which prevents materials and equipment from being used in multiple areas, thus reducing the risk of cross infection. An audit of infection control procedures had been undertaken by Oldham Council in May 2013 and this showed the home to be one hundred percent compliant.

We checked the kitchen and saw that it was clean and that the fridge temperatures were being monitored and recorded regularly and food stored safely. This minimised the risk of food contamination and food poisoning. A Food Standards Agency 'Food Hygiene' rating had been awarded in September 2015, which showed the rating of 5.

In the laundry we saw that soiled items were appropriately washed separately from other items of clothing, preventing the risk of cross contamination. Handwashing facilities were provided for staff to use after handling contaminated laundry.

Staff employed at the service had been through a thorough recruitment process. We reviewed four staff personnel files and found that they contained all the relevant documentation including, reference checks, confirmation of identification and application form. All staff had Disclosure and Barring (DBS) criminal record checks in place. These help the provider to make an informed decision about the person's suitability to work with vulnerable people, as they identify if a person has had any criminal convictions or cautions. Although DBS checks have no official expiry dates, any information included will only be accurate at the time the check is carried out. The registered manager informed us she would consider renewing the DBS checks for those staff who had been working at the home for some time and had not had a recent DBS check, to ensure that the information was still correct.

The home had a range of policies in place relating to the safe management of medication, including receipt and disposal, missing medication and safe administration. Only staff who had undergone specific medication administration training and supervision were allowed to administer medication to people using the service. All medication was supplied to the home by a local pharmacy and they had carried out a medication audit during 2015. The audit identified that the medication policy should contain information for Muslim service users and that some medication might contain gelatine or alcohol or be derived from pork and therefore would not be appropriate for them. The registered manager subsequently added 'cultural and moral beliefs of service user be considered when administering medication' to the medication policy, which encouraged staff to be aware that some medication may be unsuitable to people of certain faiths.

Observation of the medicine round showed that it was carried out safely and people were not rushed by staff. We looked at five Medication Administration Record sheets (MAR) and saw that these contained a photograph of each person, which minimised the risk of medication being given to the wrong person. The MARs sheets had been neatly and legibly completed and reflected the dosage of medication given. All medication was stored safely in a locked cupboard, which also contained the locked controlled drugs cabinet. Medication that was not dispensed from the dosage system was stored in individual plastic containers with the appropriate person's name and photograph displayed. Medications such as eye drops, which needed to be disposed of after they had been opened for four weeks, had the date of opening displayed on them. We saw that a list of common drugs and their uses was displayed in the medication cupboard. This helped staff understand the reason for the administration of particular medicines.

No medication was being administered covertly – this means giving it in a disguised form, for example in food or drink, when a person refuses the treatment necessary for their physical or mental health. The registered manager understood the legal process to be followed if medication was required to be given in this way.

People we spoke with felt there were enough staff to meet the needs of people living there and our observations confirmed this. One relative said ''there are plenty of staff''. On the days of our inspection we observed people being supported promptly by staff. There were sufficient staff available to support those people who required some assistance at meal times and we saw that people using the service were not left

unsupervised for any length of time. The registered manager said there was senior staff cover seven days a week and that she used a dependency tool, based on the level of need for each resident, to help plan the staff rota. She explained that the tool, along with her knowledge and many years of experience enabled her to ensure there were sufficient staff to care properly for people.

The service had a disciplinary procedure in place, which could be used when there were concerns around inappropriate staff practice. The registered manager explained that she promoted an open and transparent culture within the home that enabled staff to be honest about reporting errors, for example in medication administration.

Good

Is the service effective?

Our findings

Newly recruited staff had completed an induction to the service which included information about the running of the home, policies and procedures, and mandatory training, such as infection control, manual handling, food hygiene, mental capacity act and safeguarding vulnerable adults. Following the induction staff undertook three days of 'shadowing', where they worked alongside more senior staff, gaining experience and being observed caring for people using the service. This process ensured staff were suitably trained to support people, and those staff we spoke with said the induction training provided them with the knowledge they required.

The registered manager had identified the importance of pressure sore prevention and all staff received a copy of the local National Health Service (NHS) tissue viability service pressure sore prevention booklet. This information was reinforced during staff meetings, where staff were reminded to check residents' skin for signs of pressure damage and to notify the registered manager if they identified any problems. This helped to promote best practice for pressure sore prevention within the home.

We saw records showing that carers received supervision from senior staff at least every six months and also an annual appraisal. This enabled the registered manager to monitor the quality of care staff provided and identify any problems they might be experiencing.

People told us that they liked the meals provided and we saw that the food looked appetising and hot and was in sufficient quantities. One person commented ''the food is lovely'', and another person said ''there are no problems with the food''.

The home operated a four-weekly menu plan, offering people a variety of freshly prepared food. The main meal of the day was at lunchtime, with a lighter meal being served at teatime, followed by a late supper of sandwiches and hot drinks. Drinks and biscuits were offered between meals, and the registered manager explained that they provided residents with extra juice or water during warm weather, in order to prevent dehydration. We observed the lunchtime meal being served and saw that the menu was on display and that the tables were appropriately laid with wipeable table clothes and condiments. Although there was no choice of meal, staff stated that if a person did not like the meal offered they would offer them an alternative. People we spoke to confirmed this. One relative said '' if she says she doesn't like something they will try something else'' and ''they keep on going until they find something for her to eat''.

Those people who needed assistance with feeding were served their meal first. We saw that staff were patient with the people they were supporting and did not rush them, and that they talked with them, making comments such as '' is that nice?''. Information sheets detailing special diets were kept in the kitchen so that the cook had an accurate record of which people required, for example, pureed food, or thickened fluids.

People's nutritional requirements had been assessed and were reviewed monthly and people were weighed and a malnutrition universal screening tool (MUST) score recorded. The MUST tool helps to identify adults

who are malnourished, at risk of malnutrition or obese. It also includes management guidelines which can be used to develop nutrition care plans. Where a nutritional risk had been identified the appropriate action had been taken, for example referring to a dietician or for a swallowing assessment. One visitor commented that prior to admission her relative had not been eating well, but since living at the home he had put on weight. She said ''they have a cracking cook''.

We saw that staff sought people's consent before care and support were provided and that where possible they were offered choices, for example in what they would like to do and what they would to drink. We saw evidence that the need for consent and choice were incorporated into care plans: for example' 'talk to (the person), explain what you are doing to gain consent, include them in everything you do'' and ''carers to ask (the person) what they would like to wear. Show them their clothes'.

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. The registered manager had a good understanding of the MCA and we saw that mental capacity assessments had been appropriately undertaken by the Care home Liaison Nurse from the local NHS trust.

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 Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. None of the people using the service at the time of our inspection had been assessed as needing a DoLs. The registered manager, in conjunction with the Care Home Liaison nurse reviewed the potential need for any DoLS applications regularly and understood the procedure for applying for DoLs if required.

We saw evidence that people's health needs were monitored and any changes acted upon promptly. Care files contained documentation which detailed contact made with healthcare professionals, such as General Practitioners (GPs) and the outcome of any discussions and visits, and this information was communicated between staff at 'handovers'. One visiting healthcare professional we spoke with said that any referrals to their service were made quickly and a relative commented ''if (their relative) is not well then the GP comes here immediately''. Another person explained how, when her relative was admitted to hospital, the home rang her several times to keep her up-to-date with her progress.

There were several lounges and two dining areas, which provided a variety of communal living spaces for people. In addition there was a conservatory in which people could sit during warmer weather. A stair and a passenger lift provided access to the upper floor and enabled those who were mobile to get upstairs independently. Some attempt had been made to make the décor 'dementia friendly' by the use of large coloured signs on doors.

At the front of the home there was a small, well-kept garden, containing shrubs and trees and to the rear of the property there was a paved area containing garden furniture, where people could sit out. This was accessible for wheelchairs. The registered manager explained that this area was normally decorated with tubs and pots of flowers during the summer months, to make it more attractive.

Good

Is the service caring?

Our findings

People we spoke with said they were very happy with the care and support they received. One person said '' I would recommend it (the home) to anyone'' and another said ''I couldn't wish for anything better''. Visitors and people using the service were complimentary about the staff and spoke of their kindness and their caring attitude. One person said ''the carers are lovely'' and another person commented '' nothing is too much for them to do''.

We saw that people looked cared for: their clothes and appearance were clean. One relative commented ''she has always got fresh clothes on'', and another said '' we are very pleased with how they are looking after her''.

The home had received numerous 'Thank you' cards and compliments and these included ''the love, compassion and empathy that you show are remarkable'' and ''I just wanted to say a heartfelt thank you for looking after (the relative) so wonderfully''.

Staff spoke kindly and politely to people and treated them with dignity and respect. They described how they would protect people's privacy, for example when carrying out personal care and we saw that screens were provided in the twin-bedded rooms to ensure that personal care could be carried out privately. The importance of treating people with dignity was expressed in the persons' care plans, for example '' keeping (the person's) body covered as much as possible, make sure the windows, curtains and door are closed, explain what you are doing to gain consent, include her in everything you do''.

Staff understood the importance of confidentiality – one carer described how during the medication round they would ask a person quietly if they required a laxative, so as not to embarrass them or divulge personal information to other people. We saw that there was a sign displayed in the dining room requesting that staff refrain from using their mobile phones, in order to protect the privacy of people using the service.

We saw that staff responded promptly to peoples' needs and they were kind and caring in their approach. The call bell was answered quickly and people did not have to wait long for assistance when they asked for help. One relative commented ''they don't leave them waiting (for care)'', and another said ''there's always someone around''. We observed staff interactions with people and saw that staff were patient and used touch in a gentle and appropriate manner. For example, we watched a member of staff walking slowly with a person while holding their hand and offering them encouragement.

The staff at the home had completed the 'Six steps to success – Northwest end of life care programme for care homes', which aims to provide staff with the knowledge to offer high quality end of life care to people using the service. Information about the course was displayed in the entrance hall and the registered manager and staff felt that they had benefited from the knowledge gained through the course. The registered manager explained how she would involve a person and their family in 'advance care planning' when that person was moving towards the end of their life. This meant that the person's choices and wishes for their end of life care could be carefully planned. The registered manager told us that there was an area

available for relatives to stay at the home, if they wished, when their relative was approaching the end of their life.

People using the service and their families received a written invitation to attend an annual review of their care plan and of the service the home provided. The registered manager explained that this helped to ensure that the care was tailored to people's individual needs.

People were free to visit at any time and we observed friendly interaction between visitors and staff. One relative commented that if she wanted to speak to her relative privately, staff would always find them a quiet area in which to sit. Another person commented that if she was unable to visit she would 'phone, and staff would take the phone to her relative so that they could talk together.

The atmosphere in the home was calm and relaxed and we saw that people looked happy, as they were chatting and smiling to each other and to staff. One visiting healthcare professional described the home as being ''one of the best homes I go in''.

Good

Is the service responsive?

Our findings

Prior to moving in, a pre-admission assessment was carried out by a senior staff member, which enabled people to make an informed choice as to whether or not the service could meet their needs. People were invited to make an introductory visit to the home, and following the start of their stay they were allowed a period of four weeks in which to decide if they wished to make their stay permanent.

We reviewed four care files and saw that they were very 'person-centred' and contained detailed descriptions of each individual person's care needs and how they should be managed by staff. Documentation included a full physical assessment, risk assessments such as nutrition, manual handling and skin integrity and other completed charts, such as MUST, waterlow score and weight. The waterlow score gives an estimated risk for the development of a pressure sore and is used as part of a prevention strategy. Files also contained the 'All About Me' documentation where details about a person's past history, likes and dislikes were recorded and the information used to contribute to their care plan.

Care plans were detailed and very personal. For example, one care plan said 'likes a wet shave and likes his aftershave on', and another said 'for (the person) to be of a smart appearance, preferably in clothes of her choice'. Other examples of person-centred care plans included 'remind (the person) when the football is on' and 'likes to go to bed between 8.00 and 8.30pm'. We saw that care plans were reviewed monthly by the registered manager and that annually, people using the service and their families, were invited by letter for a full review of their care plans to ensure that they were continuing to meet their needs and expectations. People were encouraged to bring in personal effects, such as photographs and pictures and their own bedding, in order to help them feel at home.

We saw that there were a range of activities on offer to people and that there was a large collection of DVDs, games and puzzles available. On the first day of our inspection one of the people using the service played records while other people sang along to the music, looking happy and relaxed. In the afternoon one of the carers held a game of bingo, while others watched television in another lounge. All activities were recorded in an activities book, along with details of who had participated.

Those people with religious needs were invited to take part in a monthly communion service held in the home by a local priest, and at Christmas ten people had attended the local church for a special service and lunch.

The home had a complaints procedure which was displayed in the 'Service Users Guide' and in the hallway, along with a complaints form. The procedure stated that all complaints would be dealt with within fifteen working days, but as the service had not received any complaints it was not possible to check if this was adhered to. People we spoke to said they had never had cause to complain about the service, but knew how to if they needed to. One relative commented about the service '' there is not a thing wrong with it''.

Good

Is the service well-led?

Our findings

At the time of this inspection visit there was a registered manager in post. The manager was registered with the Care Quality Commission (CQC) on 13/07/2012. The home is privately owned and the owners are actively involved in the day-to-day running of the service, along with the registered manager. All were present during our inspection. The registered manager had been in post for nearly thirteen years and was committed to running a service which provided good quality care. One staff member commented '' I couldn't ask for a better manager'' and a relative said ''the manager is always on the ball''. People we spoke with commented that they appreciated the way the registered manager and owners were 'visible' and staff we spoke with said they felt supported. A healthcare professional we spoke with commented '' the staff are brilliant, really helpful'' and added'' ''they work well as a team, they help each other out''.

People who used the service were given a 'Service Users Guide' which contained a variety of useful information about the home, such as its organisational structure, welcome letter, facilities, complaints procedure and philosophy of care, which included the '10 Dignity Do's' described by the National Dignity Council. This booklet provided people using the service and families with the necessary information to help them settle into their new environment. The registered manager said the booklet could be provided in a large print format if required.

We saw evidence that quality assurance processes, such as audits of documentation were carried out and feedback given during staff meetings, which were held every few months. This ensured that the safety of people using the service and staff was maintained and high standards promoted. The registered manager was in regular contact with the local NHS Trust 'Care Home Liaison Nurse', who provided support and advice on all issues relating to the provision of care. In addition, the District Nursing Service, podiatrists and opticians visited the home regularly. Notifications of incidents occurring at the home had been made to the CQC as required.

People who used the service and their families were provided with regular opportunities to comment on the quality of care and to raise any matters of concern with the management, through relatives meetings. These were held every six months. Feedback about the service was also obtained through an annual staff questionnaire, an annual 'visiting professionals' questionnaire and the annual service user survey. In the February 2015 service user survey, one person commented they 'would occasionally enjoy a glass of sherry or whisky'. As a result, the manager arranged for afternoon drinks and snacks to be provided.

One of the 'thank you' cards we saw said ''I really appreciated the special care, love and attention you have her, making her last few difficult years as comfortable and enjoyable as possible. I have always felt confident that she was getting cared for in a compassionate and thoughtful way, You work so hard and are shining examples to anyone working in the care services profession''.