Chescombe Trust Limited

Chescombe

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

The inspection took place on 26 and 28 April 2016. This was an unannounced inspection. The service was last inspected in February 2015 and was in breach of the following:

Regulation 12 HSCA (RA) Regulations 2014 Safe care and Treatment: The registered person was not making appropriate arrangements for the recording of people's medicines.

Regulation 15 CQC (Registration) Regulations 2009 Notifications – notice of changes: The registered person was not notifying the Commission of all relevant changes affecting the running of the service as required under this regulation.

Regulation 17 HSCA (RA) Regulations 2014 Good Governance: The registered person was not operating an effective system for assessing and monitoring the quality of the service provided.

At the time of this inspection, there was evidence the provider had taken action to ensure it was complying with these regulations.

The service is registered to provide accommodation for up to 19 people and cares for people who predominantly have learning disabilities needs. The home is divided into three individual houses.

There was a registered manager in post. 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 service was safe. Risk assessments were implemented and reflected the current level of risk to people. There were sufficient staffing levels to ensure safe care and treatment.

People were receiving effective care and support. Staff received appropriate training which was relevant to their role. Staff received regular supervisions and appraisals. The service was adhering to the principles of the Mental Capacity Act 2005 (MCA) and where required the Deprivation of Liberty Safeguards (DoLS).

The service was caring. People and their relatives spoke positively about the staff at the home. Staff demonstrated a good understanding of respect and dignity and were observed providing care which promoted this.

The service was responsive. Care plans were person centred and provided sufficient detail to provide safe, high quality care to people. Care plans were reviewed and people were involved in the planning of their care. There was a robust complaints procedure in place and where complaints had been made, there was evidence these had been dealt with appropriately.

The service was well-led. Quality assurance checks and audits were occurring regularly and identified actions required to improve the service. Staff, people and their relatives spoke positively about the registered manager.

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.

Medicine administration, recording and storage were safe.

Risk assessments had been completed to reflect current risk to people.

People were protected from the risk of abuse. Staff had received safeguarding training and had a policy and procedure which advised them what to do if they had any concerns.

Staffing levels were sufficient.

Is the service effective?

Good

The service was effective

Staff received appropriate training and ongoing support through regular meetings on a one to one basis with a senior manager.

Staff had a good understanding of the Mental Capacity Act (MCA) 2005.

People and relevant professionals were involved in planning their nutritional needs.

Is the service caring?

Good

The service was caring.

People were treated with respect and dignity.

People were supported to maintain relationships with their families.

People had privacy when they wanted to be alone.

Is the service responsive?

Good

The service was responsive.

People and their families were involved in the planning of their care and support.

Each person had their own detailed care plan.

The staff worked with people, relatives and other services to recognise and respond to people's needs.

The service had a robust complaints procedure.

Is the service well-led?

Good

The service was well-led

Regular audits of the service were being undertaken.

The registered manager and senior staff were approachable.

Quality and safety monitoring systems were in place.

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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 was an unannounced inspection which was completed on 26 and 28 April 2016. The inspection was completed by one adult social care inspector. The previous inspection was completed in February 2015. At that time there were three breaches of regulations.

We contacted five health and social care professionals to obtain their views on the service and how it was being managed. This included professionals from the local authority and the GP practice.

During the inspection we looked at six people's records and those relating to the running of the home. This included staffing rotas, policies and procedures, quality checks that had been completed, supervision and training information for staff.
We spoke with six members of staff and the registered manager of the service. We spent time observing people and spoke with four people living at Chescombe. We spoke with six relatives to obtain their views about the service.

Good

Is the service safe?

Our findings

People told us they felt safe living at Chescombe. People used comments such as, "I feel safe", "All of the staff are friendly" and, "The staff care about me". We observed people were relaxed when in the company of staff. This demonstrated people felt secure in their surroundings and with the staff that supported them. We observed staff working at the pace of the people they were supporting and not rushing them to ensure safe care was being provided. Relatives told us they felt their relative was safe and comfortable in the home and had good relationships with the staff.

Medicines policies and procedures were available to ensure medicines were managed safely. Staff had been trained in the safe handling, administration and disposal of medicines. Staff who gave medicines to people had their competency checked annually to ensure they were aware of their responsibilities and understood their role. Clear records of medicines entering and leaving the home were maintained.

Risk assessments were present in the care files. These included risks associated with supporting people with personal care, assisting them when they are in the community, moving and handling and risks associated with specific medical conditions. For example, one person was at risk of cellulitis and their risk assessment clearly detailed symptoms for staff to look out for and instructions for staff to manage the condition. Another person had epilepsy and their risk assessment was detailed and provided clear instructions for staff to manage the condition.

There were sufficient numbers of staff supporting people. This was confirmed in conversations with staff and the rotas. The registered manager told us there was always a minimum of four staff in each house during the day and one staff for a waking night. Relatives stated they felt there were sufficient staffing levels employed at the home.

The registered manager understood their responsibility to ensure suitable staff were employed. We looked at the recruitment records of five staff employed at the home. Recruitment records contained the relevant checks including a Disclosure and Barring Service (DBS) check. A DBS check allows employers to check whether the applicant has any past convictions that may prevent them from working with vulnerable people. References were obtained from previous employers as part of the process to ensure staff were suitable and of good character. The service had a staff disciplinary procedure in place to help manage any issues whereby staff may have put people at risk from harm.

The provider had implemented a robust safeguarding procedure. For example, people's money was audited monthly by the finance manager and there was an additional audit every quarter from an independent external auditor. We were informed this was implemented to minimise any risk of financial abuse to the people living at the home.

Staff were aware of their roles and responsibilities when identifying and raising concerns. The staff felt confident to report concerns to the registered manager or team leaders. Procedures for staff to follow with contact information for the local authority safeguarding teams were available. All staff had received training

in safeguarding. Any issues had been managed appropriately and risk assessments and care plans were updated to minimise the risk of repeat events occurring.

Health and safety checks were carried out. We observed staff wearing gloves and aprons when supporting people with their care. Environmental risk assessments had been completed, so any hazards were identified and the risk to people either removed or reduced. Checks were completed on the environment by external contractors such as the fire system. Certificates of these checks were kept. Fire equipment had been checked at the appropriate intervals and staff had completed both fire training and fire evacuation drills. There were policies and procedures in the event of an emergency and fire evacuation. Each person had an individual evacuation plan to ensure their needs were recorded and could be met in emergencies.

There was a detailed maintenance plan which was completed at the start of the year. This identified any work required in the home, who was responsible for completing the work and when it was scheduled to be completed. Staff and relatives felt maintenance issues were identified promptly and the work required was completed in a timely manner.

The premises were clean and tidy and free from odour, cleaning was the responsibility of all staff during their shifts. Staff were observed washing their hands at frequent intervals. There was a sufficient stock of gloves, aprons and hand gel to reduce the risks of cross infection. Staff had completed training in this area. The staff we spoke with demonstrated a good understanding of infection control procedures. For example, different mops were used for different cleaning activities and all cleaning chemicals were kept in a locked room to minimise the risk of people coming into contact with them. The relatives we spoke with felt the home was clean.

Staff showed a good awareness in respect of food hygiene practices. For example, staff informed us different chopping boards were used for different foods to minimise the risk of cross contamination. Food was clearly dated when put into the fridge. We were shown records of the temperatures for the fridges and freezers which were taken daily.

Good

Is the service effective?

Our findings

Staff had been trained to meet people's care and support needs. The staff we spoke with felt they had received good levels of training to enable them to do their job effectively. Training records showed most staff had received training in core areas such as safeguarding adults, person centred care, health and safety, first aid, food hygiene and fire safety. People in administrative roles had also completed core training despite having limited contact with the people living at the home. For example, the finance manager informed us they had completed safeguarding training and felt this was beneficial as it meant they were well prepared if they ever came across any safeguarding concerns.

The home employed a coordinator to manage the training needs of staff. A matrix was used to identify staff training requirements which clearly detailed what training had been completed, what was outstanding and when this was due to be completed.

Staff had completed an induction when they first started working in the home. This was a mixture of shadowing more experienced staff and formal training. These shadow shifts allowed a new member of staff to work alongside more experienced staff so they felt more confident working with people. This also enabled them to get to know the person and the person to get to know them. The registered manager informed us each new member of staff had an induction pack which detailed core tasks and training they needed to complete. This was checked and signed off by the registered manager when a person completed their induction.

Staff had received regular supervision. These were recorded and kept in staff files. The staff we spoke with told us they felt well supported and they could discuss any issues with the registered manager who was always available. The registered manager also informed us supervision was used to discuss learning from any training staff had attended and to identify future learning needs. Staff we spoke with stated they found this to be useful as it allowed them to enhance their personal development. There was evidence staff received annual appraisals.

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 this is in their best interests and 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 service was working within the principles of the MCA. We saw from the training records that staff had received training on the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Everyone had assessments regarding their capacity to make decisions and where DoLS applications were required, these were made. The registered manager and staff demonstrated a clear understanding of the DoLS procedures.

It was evident from talking with staff, our observations and from care records that people were involved in day to day decisions such as what to wear, what they would like to eat and what activities they would like to participate in. We observed a staff member talking with one person about what they would like to do when they went out that afternoon. Staff respected the wishes of people using the service. For example, when showing us around the individual houses, staff sought permission from people who were in communal areas before entering their room. Staff provided us with detailed accounts of peoples' daily routines as well as their likes and dislikes.

The registered manager informed us that people and their representatives were provided with opportunities to discuss their care needs when they were planning their care. Relatives we spoke with informed us that they were always consulted in relation to the care planning of people using the service. We were given an account of a person who was scheduled to move into the home shortly after the inspection. We were informed of how this person was enabled to visit the home and discuss their preferences for decorating and furnishing their room and, the home's plans for completing this work before the person moved.

The registered manager informed us they used evidence from health and social care professionals involved in people's care to plan care effectively. This was evidenced in the care files. For example, one person could present with behaviours which may challenge. There was evidence management had involved relevant professionals when planning this person's care to ensure staff were well informed to support this person.

Care records included information about any special arrangements for meal times and dietary needs. Menus seen showed people were offered a varied and nutritious diet. People informed us they were asked what they would like to eat and menus were planned according to their preferences. One person required a soft diet and their individual dietary needs were documented clearly in their care file.

Meals were flexible and if people wanted something different to what was on the menu they could choose this. This was confirmed to us by the staff and the registered manager. People we spoke with stated the food was good. One relative told us, "The food is of good quality and there is always enough to eat". Individual records were maintained in relation to food intake so that people could be monitored appropriately. These were also shared with relevant health professionals where required.

People had access to a GP, dentist and other health professionals. The outcomes following appointments were recorded and were also reflected within care files. A senior member of staff in each house was appointed as a health champion to oversee the health and nutritional needs of people to ensure there were prompt responses to changes in people's health. These staff were responsible for monitoring peoples needs and when required arranging appointments with the relevant health professional. For example arranging GP visits or appointments with a nutritionist if a person had specific dietary needs.

The property was suitable for the people that were accommodated and where adaptations were required these were made. Needs of people had been taken into account when decorating the hallways and communal areas. Each bedroom was decorated to individual preferences and the registered manager informed us people had choice as to how they wanted to decorate their room. For example, one person liked trees and woods so one wall in their room had been painted with trees and fields. There was parking available to visitors and staff and, there was sufficient secure garden space at all of the properties which people could access if they wanted to.

Good

Is the service caring?

Our findings

We observed positive staff interactions and people were engaged. We saw examples of this throughout the inspection, where staff were present in communal areas and engaging with people. For example, we observed one member of staff playing cards with a person whilst they were waiting for lunch. Another person was encouraged by staff to complete their weekly shopping online with support from a member of staff.

Staff were knowledgeable and supportive in assisting people to communicate with them. People were confident in the presence of staff and staff were able to communicate well with people. Staff evidently knew people well and had built positive relationships. Family members we spoke with felt the staff knew their relative's needs well and were able to respond accordingly.

Care records contained the information staff needed about people's significant relationships including maintaining contact with family. Relatives told us they were able to visit when they wanted to.

Staff treated people with understanding, kindness, respect and dignity. Staff were observed providing personal care behind closed bedroom or bathroom doors. One staff member described a person who did not like to close their bathroom door when using the toilet or showering. Due to the layout of their room, people from outside could see through the window directly into the bathroom. To maintain this person's dignity, staff worked with them and their family to identify another room where the person's dignity could be maintained. Staff were observed knocking and waiting for permission before entering a person's bedroom.

There was a genuine sense of fondness and respect between the staff and people. People were laughing and joking with staff. People told us they felt staff were caring. Relatives we spoke to informed us the staff showed a high level of commitment and compassion towards the people they supported. Staff were positive about the people they supported. One member of staff stated, "I really like my job and enjoy working with the people at the home".

At mealtimes we saw that people who required assistance to eat their lunch were supported appropriately. Staff appeared caring and attentive and helped people at their own pace, ensuring they were not rushed. People were given the information and explanations they need, at the time they needed them. We heard staff clearly explaining and asking permission before they assisted people.

People looked well cared for and their preferences in relation to support with personal care was clearly recorded. Relatives provided positive feedback about the staff team and their ability to care and support people using words such as "Excellent" and "Caring" to describe the staff.

Good

Is the service responsive?

Our findings

The service was responsive to people's needs. Each person had a care plan and a structure to record and review information. The support plans detailed individual needs and how staff were to support people. Each care file also had a page detailing people's likes and dislikes so it was easy for staff to identify individual preferences.

Staff confirmed any changes to people's care was discussed regularly through the shift handover process to ensure they were responding to people's care and support needs. The daily notes contained information such as what activities people had engaged in, their nutritional intake and also any behaviour which may challenge so that the staff working the next shift were well prepared.

Changes to people's needs were identified promptly and were reviewed with the person, their relatives and the involvement of other health and social care professionals where required. The home had a robust process for ensuring changes were recorded in people's files. Each care file had a monthly report from their keyworker. This included a summary of the past month and also identified if any changes were required to their care plan. For example, one person indicated they wanted to become more independent with showering but were unable to do this due to access issues with the bath in their room. This was identified in a monthly keyworker report which was followed up by management who involved the relevant professionals to install a level access shower and maximise this person's independence.

We observed staff supporting and responding to people's needs throughout the day. People were observed spending time with staff. The people we spoke with indicated that they were happy living in the home and with the staff that supported them. People we spoke with stated they liked living at the home. Staff were observed spending time with people, engaging in conversations and ensuring people were comfortable.

The registered manager informed us that people and their representatives were provided with opportunities to discuss their care needs during their assessment prior to moving to the home. The provider also stated they used evidence from health and social care professionals involved in the person's care. Examples of the involvement of family and professionals were found throughout people's care files in relation to their day to day care needs.

Reports and guidance had been produced to ensure that unforeseen incidents affecting people would be well responded to. For example, if a person required an emergency admission to hospital, each care file contained a hospital passport. This contained basic contact details, medication and daily needs. Staff were clear as to what documents and information needed to be shared with hospital staff.

People were supported on a regular basis to participate in meaningful activities. Each person had their own activities timetable detailing what they were doing during the week. In addition to activities outside of the home, we observed staff sitting with people and engaging with them when they were back at the home. One person stated, "I have lots to do". Relatives said activities were suitable for people and there were sufficient activities taking place. Relatives felt people had choices of activities and were able to do the things they

enjoyed.

End of life care planning had been established in one of the houses due to the older age group of the people living there. These plans were detailed and involved the person and their family where relevant. The registered manager stated this would be established across the other two houses in the coming months.

Complaints were managed well. There was a complaints policy in place which detailed a robust procedure for managing complaints. When looking at the records, it was evident complaints had been dealt with appropriately and there had been learning taken from complaints.

Good

Is the service well-led?

Our findings

There was a registered manager working at the home who was responsible for the overall management of the service as well as one of the houses. The registered manager had been in post for five years. In addition to the registered manager, the other two houses had their own manager responsible for the day to day running of the house. Staff spoke positively about management. Staff told us they felt they could discuss any concerns they had with the managers. Staff used words such as "Dedicated", "Approachable" and "Hard working" to describe the managers. Staff informed us there had been many positive changes since the registered manager came into post. Staff stated the organisation was now more transparent and there was better communication between staff and people using the service.

The staff described the managers as being "Hands on". We observed this during the inspection when the managers attended to matters of care throughout the day. Staff told us if there were any staffing issues, the managers would support the care staff in their daily tasks. Staff we spoke with told us they felt morale amongst staff was good and this was down to good leadership from the management team.

Staff informed us there was an open culture within the home and the registered manager listened to them. Staff informed us they used monthly "Thinking meetings" to raise suggestions to improve the service. Staff informed us they had requested a Netflix subscription so people could have a cinema night. This was noted and put forward to the directors at a board meeting and was subsequently agreed. The registered manager was making arrangements to set up a cinema room for people living at the home at the time of the inspection. The registered manager and house managers stated they felt these meetings were important as they allowed the staff team to identify good practice as well as areas for improvement.

Regular audits of the service were taking place. This included audits by the registered manager and an external audit for 'Investors in People' as part of their accreditation process. There were separate monthly audits of company finances and finances of people living in the home by the finance manager and also external audits every quarter of the finances. Once audits were completed, issues identified during the audit process were incorporated into the annual business plan. For example, the last audit had identified significant refurbishment work was required in one of the houses. This was incorporated into the business plan and the work had been completed.

There was evidence people were involved in making decisions relating to improving the service. A resident's forum took place every six weeks to enable people to voice their opinions about the service. For example, these forums were used to discuss the menus for the next six weeks. Annual surveys were sent out to relatives and the feedback from these was positive. The home had also implemented a monthly newsletter for relatives to inform them of what was happening at the home. People had provided positive feedback stating they found these to be informative.

We discussed the value base of the service with the registered manager and staff. It was clear there was a strong value base around providing person centred care to people using the service. The registered manager and staff told us they involved relatives where relevant. Staff were clear that Chescombe was the home of

the people living there.

The registered manager had a clear contingency plan to manage the home in her absence. This was robust and the plans in place ensured a continuation of the service with minimal disruption to the care of people. In addition to planned absences, the registered manager was able to outline plans for short and long term unexpected absences. For example, the provider had implemented an on call system to cover for unexpected staff absences. The registered manager also detailed how the team leader would cover for them in their absence.

From looking at the accident and incident reports, we found the registered manager was reporting to us appropriately. The provider has a legal duty to report certain events that affect the well-being of the person or affects the whole service.