Sue Ryder

# Sue Ryder - The Chantry

**Inspection report**

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## Ratings

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|---|---|
| **Overall rating for this service** | **Requires improvement** |
| Is the service safe? | **Requires improvement** |
| Is the service effective? | **Good** |
| Is the service caring? | **Good** |
| Is the service responsive? | **Requires improvement** |
| Is the service well-led? | **Good** |

## Overall summary

This inspection took place on the 22nd, 23rd and 26 October 2015 and was unannounced.

Sue Ryder – The Chantry is a 30 bed service which supports people with complex neurological conditions and physical disabilities. During our inspection there were 26 people living at the service.

There was a registered manager. 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.

People felt included and listened to by staff. They told us they were involved in the planning of their care and that staff were responsive to their needs. People's decisions were respected and their dignity promoted.

The service wasn't completely safe as the provider did not operate safe systems in the audit of medicines and the recruitment of new staff to the service. Gaps in employment were not always identified and references

# Summary of findings

obtained from the previous employer. There were systems in place to ensure people received their medicines as prescribed, however audits were ineffective in identifying when checks of stock had not been carried out and stock carried forward from one month to the next.

Staff knew how to keep people safe from the risk of abuse as they had been trained and knew what to do if they had concerns. They could identify when people were at risk of abuse and what action to take to protect people from the risk of harm.

Staff were kind, caring and promoted people's privacy and their dignity was respected. People and their relatives were involved in the planning of their care and involved in making decisions about their everyday lives. People's choices and preferences were respected.

The service was responsive because people's care had been planned following an assessment of their needs. People were involved in the planning and review of their care and support. They were provided with opportunities to pursue their social interests in the local community and joined in activities provided from within the service.

The service routinely listened and learnt from people's experiences. Concerns and complaints were addressed. However, work was required to evidence the definition between a concern and a complaint and action taken to determine any emerging trends with planning for improvement.

The service had a positive culture that was person centred, open, inclusive and empowering. The manager said that the vision was to care and support people to live as full a life as possible in spite of their disabilities.

# Summary of findings

## 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 consistently safe as the provider did not operate a robust recruitment process to protect people who by virtue of their circumstances were vulnerable.

People received their medicines as prescribed and medicines were stored safely. However, medicines audits did not always identify when stocks of medicines had not been carried forward from one month to the next.

Staff knew how to keep people safe from abuse. They could identify when people were at risk of abuse and what action to take to protect people from the risk of harm.

There was not always enough staff to care and support people in meeting their needs in a timely manner. However, this was being addressed by the management team with creative ideas to attract new staff considered and implemented.

**Is the service effective?**

**Good**

The service was effective because staff were skilled, experienced and knowledgeable in their roles.

Staff received relevant training and support for the work they performed.

People's dietary needs were met.

**Is the service caring?**

**Good**

The service was caring because people's privacy and dignity was respected.

People and their relatives were involved in the decisions about their care.

People's choices and preferences were respected.

**Is the service responsive?**

**Requires improvement**

The service was responsive because people's care had been planned following an assessment of their needs.

People pursued their social interests in the local community and joined in activities provided within the service.

The service routinely listened and learnt from people's experiences. Concerns and complaints were addressed. However, work was required to evidence the definition between a concern and a complaint and action taken to determine any emerging trends with planning for improvement.

**Is the service well-led?**

**Good**

The service was well led because there was an open, inclusive culture where staff morale was good.

# Summary of findings

People were happy with the service they received and were confident in the management of the service the views of people were listened to and acted on.

Regular quality and safety audits were carried out to assess and monitor the service. Learning from incidents with action plans were produced in planning to improve the service.

# Sue Ryder - The Chantry

**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 the 22nd, 23rd and 26 October 2015 and was unannounced.

The inspection team consisted of two inspectors.

Prior to our inspection we reviewed the information we held about the service, this included all statutory notifications. A notification is information about important events which the provider is required to send us by law.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We spoke with three people who were able to verbally express their views about the service and three people's relatives. We observed how care and support was provided to people throughout our visit including the midday meal within the communal dining room. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We looked at records in relation to six people's care. We spoke with eight members of staff, including nurses, care assistant, the head of care and the registered manager. We looked at records relating to the management of medicines, staff training, recruitment records, and systems for monitoring the quality and safety of the service.

Requires improvement

# Is the service safe?

## Our findings

People told us that there was not always enough staff around to care and support them in meeting their needs in a timely manner. One person said, "There is not always enough staff around when you need them and they are run off their feet at times." A relative told us, "They have been short of staff lately and you can wait a long time for the call bell to be answered. We waited 20 minutes one time for someone to come. When you want staff they are not always visible." We observed during our inspection there was sufficient staff available. Staff supported people with their planned activities and spent time talking to them on a one to one basis. However, we also observed staff to be busy and rushed at times.

The registered manager confirmed that there had been recent shortages of nurses and 10 support staff vacancies. They also told us they had recently recruited nurses to their vacant posts They also told us they had created a band 4 practitioner post to support nursing staff with clinical duties such as medicines administration. There had been a high use of agency staff. The manager told us they used a pool of regular agency to ensure consistency of care for people from staff familiar to them. In an effort to recruit new staff ideas to attract the right calibre with incentives for new recruits was being considered. By the management team.

Staff told us that shortages of staff had resulted in a high use of agency which impacted on occasion's, people's ability to receive consistency of care. However, they also told us that staffing levels were flexible according to people's needs and where the need had been assessed people received one to one support. One member of staff told us, "I have worked in hospital and other places where the ratio of staff to people was not as good as here." Another told us, "Yes it is hard when we have agency staff but we try to make sure that we use the same staff who are familiar to us. This avoids people having to have their personal care from strangers." Staff told us in order to protect people with complex needs and who required two staff to support people, one of these staff allocated would always be a permanent member of staff familiar with people's needs alongside any agency workers.

The service did not always recruit staff in a way that protected people. A review of staff recruitment files showed us that the application forms were not always completed and Curriculum Vitae's (CV's) were accepted which did not always provide the information required to allow the provider to carry out necessary safety checks. For example, gaps in applicant's employment history were not always identified and not checked during the interview process. We saw examples of CV's that were not up to date, of poor quality and did not record the reasons people had left their last employment. We also found that for staff recently employed, references from their recent employer had not been obtained. This meant that the provider had not taken steps as required by law to determine that people were suitable to work with people who by virtue of their circumstances were vulnerable. We discussed this with the manager who took immediate action to rectify these shortfalls.

People told us that they received their medicines regularly and on time. One person said, "Staff give my medicines and sometimes I ask for them when I have pain and need my medicine and they provide this when I ask. They also ask me if I need pain relief medicines when they administer my other medicines."

People's medicines, including controlled medicines, were stored safely and there was a system for the ordering, receipt and disposal of medicines. Staff told us they received training in medicines management and also the use of specialist equipment. Their competency for administering medicines was assessed at two yearly intervals. Medicine errors were recorded on a monitoring system to ensure that lessons were learnt and people were protected. All the errors reported had been investigated and actions put in place to prevent them from re-occurring.

We looked at the medicines administration records on Alexandra unit. We carried out a check of stock against medicines administration records (MAR). However, we were unable to carry out an audit for several items of, as and when required medicines, as there was no record of stock received or carried forward from the previous month. This shortfall in the carry forward of stock had also been identified following an audit carried out by the supplying pharmacy in June 2015. This meant that the provider's audits did not pick up on these shortfalls.

Where people had been prescribed medicines on a when required basis, for example for pain relief, or when they were prescribed in variable doses, for example one or two

Requires improvement

# Is the service safe?

tablets, we found insufficient recording of the amounts administered for some variable does medicines we looked at. This meant that we were unable to balance the items of stock against the MAR records.

Everyone we spoke with told us they did not have any concerns about their safety. One person told us, “This is a good place. I definitely feel safe and would have no hesitation in telling someone if I did not feel safe.” One relative told us, “This place is amazing. You would not find better. We have absolute confidence that [relative] is safe here. We have no concerns.” When asked if they felt safe living at the service, people with capacity, but with limited verbal communication told us through their nonverbal communication that they were satisfied and felt safe.

Staff were aware and confident in how to escalate any concerns they might have in relation to protecting the safety of people and aware of how to identify those at risk of abuse. Staff had been provided with guidance in risk assessments and training in awareness of how to protect people from the possible risk of harm or abuse. Staff told us they were aware of their responsibilities to report any allegations or safeguarding concerns to the manager and local safeguarding protocols in place and aware of information to enable them to report to the local safeguarding authority for investigation.

We saw from a review of records and discussions with the registered manager that they had followed the local safeguarding authority protocols in reporting safeguarding concerns for investigation. The manager demonstrated learning and actions they had put in place following one recent safeguarding incident.

People told us that staff had discussed with them any identified risks to their health and safety. Where risks had been identified, a ‘what you need to do to keep me safe’ plan was put in place and provided staff with guidance on how to manage and mitigate these risks. For example, when using moving and handling equipment, the risk of developing pressure ulcers, dietary intake, accessing the community and responding to and monitoring epileptic episodes. Staff confirmed that risk assessments had been reviewed regularly and they would report any changes and act upon them to ensure that people were safe.

Where environmental risks to people’s safety had been identified, action had been taken to mitigate these risks. For example, where electrical cabling had been exposed as a result of mattress pumps running over wiring staff were informed of action they should take to mitigate the risks and regular checks were carried out on equipment to protect people from the risk of harm. Each person had a personal evacuation plan in place for use in emergencies such as in the event of a fire. Accidents and incidents were monitored, analysed and emerging trends identified and responded.

Good

# Is the service effective?

## Our findings

People received care and support from staff who were supported with adequate training, skilled, experienced and knowledgeable in the roles they were employed to perform. People and their relatives were complimentary of the staff. One person said, "The staff are efficient and well trained. They know what to do and when to do it." Another told us, "They know me well and know how to help me." One relative told us, "They are absolutely lovely. I have no concerns about their ability to support [relative] in a professional way."

Staff received a variety of training to support them in the roles. One nurse told us, "We get lots of training. We have opportunities to attend other external, specialist training as well." Another member of staff said, "We do lots of face to face training. I have trained as a trainer in safe moving and handling and train other staff. We incorporate good care practice into the practicalities of the training, like how to support people in a dignified way when using the hoist, like a reminder not to talk over people when hoisting them." Staff had received training relevant to their roles in supporting people with their nutrition through Percutaneous Endoscopic Gastrostomy (PEG) (a means of receiving nutrition through the stomach wall when people cannot take food).

Newly employed staff told us about their induction which included a period of shadowing more experienced member of staff. The staff training records confirmed that they had kept up to date with refresher courses where required.

Staff confirmed that they had received regular one to one supervision meetings and annual appraisals. This provided staff with the opportunity to discuss their performance and plan development opportunities. Nurses completed competency-based assessments around medicines every two years. One member of staff said, "There is always lots of training and we can request any additional training if we need." Nursing staff told us they were provided with opportunities to update their clinical practice and development. For example, in caring for people with complex medical health conditions.

Staff confirmed that they had received training in understanding their roles and responsibilities with regards to the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). Care records showed us that people who lacked mental capacity had an assessment carried out so that any decisions made regarding their health and welfare would be made in their best interests. Applications for authorisation with regards to the deprivation of liberty safeguards for some people had been made in relation to constant supervision and restrictions on people's movement to keep them safe. The service was waiting for authorisation from the local safeguarding authority with a request for best interest's assessments to be carried out by those qualified to do so.

People were supported to have enough to eat and drink and maintain a balanced, nutritious diet. People were complimentary about the food provided and said they enjoyed mealtimes and did not feel rushed. However, people also told us that they had provided feed back to the provider through resident committee meetings suggestions for further improvement. One person told us, "The food is good and I have no complaints." Another told us, "The food is good, and we have plenty of it but we would like to see more choice available. Although when I ask for omelette instead of what is on the menu I always get it."

Menus were developed following consultation and involvement of people who used the service. The cook attended meetings with people to ascertain their views. The registered manager told us that they were working to respond to people's views raised at resident committee meetings and following recent comments received review the current menus with the cook. Following feedback from people a recent initiative had been implemented to enable people to communicate their views at the end of each meal time by providing people with tokens with a happy and said face on them. This enabled people with limited verbal communication to express their views about the meals provided.

The provider had produced 'our mealtimes' guidelines following consultation with people. Under the section 'The dining room experience' people had stated they wanted, 'tables to be wheelchair friendly where appropriate', 'the choice of where to sit and who to sit with' and 'food plated or served at the table from serving dishes'. We observed the midday meal in the communal dining room. People who required assistance with their meals were supported in a quiet and discreet manner. Adaptations and equipment were available according to their assessed need. However, we noted that the dining room was sparsely decorated with one large rectangular table in the dining room. Very few

Good

# Is the service effective?

people were supported to sit at the table in their wheelchairs and the majority of people were sat around the edges of the room. The midday meal experience appeared regimented with each person waiting for their meal in turn as staff went from one person to the next to support them with their meal. We discussed this with the registered manager who said they would discuss and address these issues with staff and consult with people who used the service to look at ways of improving the meal time experience.

Care records showed that a nutritional assessment had been carried out for each person and their weight had been checked and monitored regularly. We noted from the care records we looked at that people's weight was stable with no current concerns.

The cook described to us how they would fortify foods to provide additional calories where people had been assessed as at risk of malnutrition. Staff told us how if they had any concerns about an individual's weight or lack of appetite, they would seek appropriate medical or dietetic advice.

We noted that appropriate referrals to the Speech and Language Therapy team had been made for people who had difficulty in swallowing and at risk of aspirating, choking on their food.

People had access to other health care services when required. One person told us, "If I need a doctor they are quick to respond." Another person said, "I have regular check-ups with the dentist."

People had access to the in house physiotherapists and occupational therapy when required.

People and staff told us there were good links with local GPs to ensure people's medical needs were met. People and family members told us they were supported to be in control of medical decisions that related to them.

Good

# Is the service caring?

## Our findings

Not many of the people who lived at the service were able to communicate with us verbally. We observed people by their non-verbal communication to be relaxed and comfortable in the presence of staff. People received care in a kind and compassionate way. One person who was able to verbally communicate with us said, "The care is good. Staff are all caring and helpful." Another person said, "Staff are pleasant, patient and kind." One relative told us, "Staff have always been kind, approachable and amenable. They always do their best to be helpful."

People were cared for and supported by staff who knew them well and understood their likes, dislikes, wishes and preferences. Support plans described people's needs and how they wished to be cared for in a personalised way. These contained specific guidance for staff in how best to deliver care in a respectful and dignified manner.

Staff were able to explain to us people's needs, their personal histories and their circumstances leading them to come and live within this care setting. We observed there was positive interaction between staff and people. People to be at ease and comfortable when staff were present. Throughout our visit we observed staff to support people in a kind, caring and dignified way. People when anxious were put at ease. People's privacy and dignity was maintained in supporting people with their personal care.

We noted that people and their relatives had provided information in discussion with them when planning their care. Staff told us that information they obtained to plan people's care had helped them to provide care and support in a way that was preferred by the person.

Relatives were complimentary of the care their family members received. People told us that the staff listened to them and talked with them about the care and support they provided. People and their relatives had been involved in the decisions about their care and support and care plans were reviewed with them on an annual basis. One person said, "My voice is heard. I insist on seeing everything that it is written about me and I know exactly what is in my care plan. I insist on a copy being made available to me in my room. They support this and understand."

Care and support plans showed us that people were involved and supported in how their care was planned and their opinions, decisions and informed their daily routines where possible.

People and their relative's told us that their views were listened to and staff supported them in accordance with what had been agreed with them when planning their care and support.

People told us that they were supported to maintain contact with their relatives and friends. One person said, "There are no restrictions here. You are treated as an adult not like a child. This is not a hospital but a home, my home. This is not a situation I would have chosen for my life but it is a good place."

People's privacy and dignity was respected. One person said, "The staff always treat you with respect." We observed staff treating people with dignity and respect and being discreet in relation to personal care needs. For example, we saw staff knocked on people's door and waited for a response before entering. Staff described how they would support people with their personal care in a dignified manner. They also told us how they supported people to maintain their independence and described how this promoted people's self-esteem. Care plans described how to support people by encouraging them to do as much as possible for themselves and how support would be provided to enable people to live fulfilling lives by respecting their autonomy and choice when planning activities. The registered manager told us, "We don't give up on people here despite their disabilities."

Staff told us they utilised the Gold Standards Framework around end of life care to ensure people received the support and care they wanted and needed. People's views about their end of life care were recorded. People's care records showed how people wanted to spend their final days and the people they wished to have involved in their care. For example, one person had stated they wished to stay at the service or in a hospice. Spiritual and religious needs at the end of life were recorded and acted upon. People were asked for their views on Do Not Attempt Cardiopulmonary Resuscitation orders (DNACPR). We saw everyone had been asked their views and these were reviewed on a regular basis to check and accommodate any changing views of people.

Requires improvement

# Is the service responsive?

## Our findings

People received care and support that was personalised and responsive to their needs. People and their relative's told us that a thorough assessment of their needs had been carried out before they came to stay at the service. Information obtained following the assessment of their needs, had been used to develop their care plan so that staff had the guidance they required to provide safe and appropriate care and support each person required. One person told us, "They started me on physio as soon as I got her and I have learnt to stand again. They have given me my life back." One person, who did not communicate verbally, responded positively when asked if the service met and supported them to live a good quality life by putting their thumbs up.

We saw evidence in people's care records that they and their relatives had been involved in the care planning process wherever possible. Information about people's individual preferences such as their likes and dislikes and preferences had been reflected in their care and support plans. One person said, "I choose what time I get up and go to bed. I am supported to be independent and despite the restrictions posed on me by my health I am supported to live my life how I choose to do so."

Care and support plans described how best to support people with little or no verbal communication and described how staff should look at their facial expressions for their response in promoting their rights to choice. For example, when choosing food and how people chose to spend their time. Following feedback from people about the need to improve the quality of the food a scheme was put in place to enable people to provide their feedback after each meal. This encouraged people to place a token with a happy or sad face in a bucket after their meal. This the cook told us helped them to gain a view as to people's preferences and helped them in planning menus.

Regular multi-disciplinary meetings took place where people's plan of care and support needs were reviewed. These meetings reviewed the holistic needs of people including their spirituality and diversity, sexuality and end of life care. Healthcare specialists such as, occupational therapists, physiotherapists and neurologists as well as people and their relatives were invited to be a part of this process and their views and opinions listened to. Following review, care plans were updated to reflect people's current care and support needs.

People were supported to pursue their leisure activities and hobbies according their personal wishes and preferences. One person was being supported by staff following a recent bereavement to organise a trip to London to scatter their loved one's ashes in a place special to them.

There was a variety of activities planned and organised for people to support their sense of well-being. These had been assessed on an individual's expressed needs basis. People living at the service had access to day services provided from within the premises. One person said, "There was always plenty going on." We observed people had joined in activities such as painting and crafts. People had access to community activities such as visits to a local gardening project, sailing, trips to the coast and local shops. One relative told us, "[our relative] goes sailing at Alton water. We are talking with the staff about providing opportunities for [our relative] to go swimming although I know this will require support from several staff to achieve this, but they listen and try their best to accommodate your suggestions."

People said that they were aware of the complaints procedure and information guiding people with regards to the provider's complaints procedure for logging a complaint was clearly displayed in the reception area. One person said, "I have made a complaint about the call bell not being answered and my laundry going missing." Other people told us that they did not have any complaints but were aware of the process for raising their concerns. It was evident from discussions with the manager that although people were aware of the complaints procedure there was no clear definition as to what constituted a concern as opposed to a complaint. For example, where people had complained about the call bell not being answered in a timely manner which people told us had impacted on their ability to access care and support when needed, this the manager told us would be considered to be a concern and not logged as a complaint. We considered that call bells not being answered in a timely manner could be serious enough to compromise people's safety and put them at risk of harm.

Requires improvement

# Is the service responsive?

We looked at the provider's complaints log. There was one formal complaint recorded for the last 12 months. We noted that not all the concerns and complaints people told us they had raised for example with regards to faulty call bells, the time taken to respond to call bells and missing laundry had been recorded within the provider's complaints logging system. The manager told us these concerns would be recorded within people's daily notes.

However, this meant that there was not a clear audit trail of how and when concerns and complaints had been responded to, outcomes recorded and identification of any emerging trends with planning for continuous improvement of the service. We discussed this with the manager who agreed with the shortfalls we identified and told us that this was an area they would immediately address.

Good

# Is the service well-led?

## Our findings

The service had a positive culture that was person centred, open, inclusive and empowering. The manager said that the vision was to care and support people to live as full a life as possible in spite of their disabilities.

People told us that they knew who the registered manager and the head of care was and that they were approachable if they needed to raise any concerns. They felt that their views were listened to and acted on. One person said, "The manager is approachable and I'm happy to talk with them." Another told us, "They empower me to be involved in decisions that are made about my care and I can speak up for other's who may not be able to do so." Staff told us that despite shortages of staff they worked well as a team and morale of the staff team was positive.

Staff were complimentary about the support they received. One staff member said, "The manager is supportive and will always stop what they are doing to listen to you." Staff told us that they attended regular staff meetings and were provided with opportunities for one to one supervision support meetings. Staff meeting minutes were available to staff who were unable to attend.

Staff had clearly defined roles and they understood their responsibilities in ensuring the service met the desired goals for people. The leadership structure was understood by staff and they told us the management was supportive and provided them with clear direction and a sense of value. Staff told us managers were visible, accessible and responsive to any concerns staff may have raised.

The service carried out a number of audits such as 'quality audits', medicines, infection control and environmental safety audits. We noted from the most recent quality improvement audit carried out the provider had identified a number of areas requiring improvement. We evidenced from the action plan that some of the issues had been addressed. There were also regular audits of health and safety, fire safety and the premises carried out so that people were cared for in a comfortable and safe environment.

The provider supported people to share their views collated through regular resident committee meetings with senior staff. This enabled people to discuss issues and feedback on the quality of the service they received. Minutes of these meetings evidenced actions taken in response to people's concerns and follow up on suggestions. For example, when planning for day care and community activities.

People were able to express their views about how they were cared for and what they needed to promote and protect their quality of life. The registered manager said that when people had any concerns or were not happy, they listened to them and tried to work with them to solve the problem. People and their relatives were provided with opportunities to communicate their views through satisfaction surveys.

Records from recent staff meetings and the quality improvement group meetings showed that staff had discussed incidents and clinical matters such as regular infection control audits, management of medicines, training for staff, safeguarding matters and ideas for development of the service. This demonstrated the provider had systems in place to assess and plan for continuous improvement of the service.