Northumberland County Council

Chibburn Court

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

This inspection took place on 18 December 2017 and was announced. We gave the provider 48 hours' notice of the inspection. This was to ensure someone would be available to speak with and show us records.

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

Chibburn Court accommodates three people with learning disabilities in one adapted building. The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen. On the day of our inspection there were three people using the service.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We last inspected the service in October 2015 and rated the service as 'Good.' At this inspection we found the service remained 'Good' and met all the fundamental standards we inspected against.

Accidents and incidents were appropriately recorded and risk assessments were in place. The registered manager understood their responsibilities with regard to safeguarding and staff had been trained in safeguarding vulnerable adults.

Appropriate arrangements were in place for the safe administration and storage of medicines.

The home was clean, spacious and suitable for the people who used the service, and appropriate health and safety checks had been carried out.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant checks before they employed staff. Staff were suitably trained and received regular supervisions and appraisals.

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

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs. However, support plans required updating to reflect people were no longer at risk of malnutrition.

Care records showed that people's needs were assessed before they started using the service and contained evidence of people being supported during visits to and from external health care specialists.

People who used the service and family members were extremely complimentary about the standard of care at Chibburn Court.

Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible. Care plans were in place that recorded people's plans and wishes for their end of life care.

Care records were person-centred. Person-centred means ensuring the person is at the centre of any care or support plans and their individual wishes, needs and choices are taken into account.

People were actively encouraged to make choices and these were clearly documented in the care records.

People were protected from social isolation and activities were arranged for people who used the service based on their likes and interests, and to help meet their social needs.

The provider had an effective complaints procedure in place and people who used the service and family members were aware of how to make a complaint.

The provider had an effective quality assurance process in place. Staff said they felt supported by the registered manager. People who used the service, family members and staff were regularly consulted about the quality of the service via meetings and surveys.

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 remained Good.

Is the service effective?

Good

The service remained Good.

Is the service caring?

Good

The service remained Good.

Is the service responsive?

Good

The service deteriorated to Good.

People received personalised care that was responsive to their needs.

People were protected from social isolation and a wide range of activities were available.

The provider had a complaints policy and procedure in place, and people and family members were encouraged to voice their opinions.

Is the service well-led?

Good

The service remained Good.

Chibburn Court

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 18 December 2017 and was announced. One adult social care inspector carried out this inspection.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, statutory notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We contacted professionals involved in caring for people who used the service, including commissioners, safeguarding staff, and health and social care professionals. Information provided by these professionals was used to inform the inspection and some of their comments are included in this report.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Some of the people who used the service had complex needs which limited their verbal communication. This meant they could not always tell us their views of the service so we carried out observations and spoke with three of their family members. We also spoke with the registered manager, three members of staff and received feedback from three health and social care professionals.

We looked at the care records of the three people who used the service and observed how people were being cared for. We also looked at the personnel files for three members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

Good

Is the service safe?

Our findings

Family members we spoke with told us their relatives were safe at Chibburn Court. One family member told us, "Oh yes, definitely." Another told us, "Very safe."

There were sufficient numbers of staff on duty to keep people safe. Staffing levels varied depending on the needs of the people who used the service. The registered manager told us agency staff were not used at the home. The home's permanent staff covered any absences but where there were still gaps, bank staff were used. The registered manager told us they always used the same bank staff who were familiar with the people who used the service. Staff and family members did not raise any concerns regarding staffing levels at the home.

The provider had an effective recruitment and selection procedure in place and carried out relevant security and identification checks when they employed new staff to ensure they were suitable to work with vulnerable people. These included checks with the Disclosure and Barring Service (DBS), two written references and proof of identification. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults.

Accidents and incidents were appropriately recorded on the provider's electronic system. These were allocated to the registered manager for action and to the operations manager for information and any additional action. Updates were recorded on the system and described what action had been taken and whether there were any lessons learned. For example, a recent medication error, that had not resulted in any side-effects, was recorded on the system. Lessons learned included the consequences of not following protocol and this was highlighted to staff.

Behaviour support plans provided information on potential triggers for behaviour and what action staff should take to prevent or reduce the risk. For example, "Allow time to calm down" and "Respect [name]'s personal space." Appropriate guidance was used to identify triggers and staff had been trained in non-abusive psychological and physical intervention (NAPPI).

Appropriate health and safety checks had been carried out, and risk assessments were in place for people who used the service. These described potential risks and the safeguards in place to reduce the risk. Risk assessments included negative communication, verbal aggression, accessing the vehicle safely, reducing risks within the home environment and providing appropriate observations. This meant the provider had taken seriously any risks to people and put in place actions to prevent accidents and incidents from occurring.

The home was clean. An annual infection control audit took place and regular hand hygiene audits were carried out. The most recent infection control audit was in April 2017 where the service scored 97.7% and the four actions as a result of the audit had been completed within two days.

Hot water temperature checks had been carried out and were within recommended guidelines. Equipment was in place to meet people's needs including hoists, shower chairs and wheelchairs. Where required we saw evidence that equipment had been serviced in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). Electrical testing and portable appliance testing (PAT) records were all up to date.

Risks to people's safety in the event of a fire had been identified and managed, for example, fire alarm and fire equipment service checks were up to date, and fire drills took place regularly. People who used the service had Personal Emergency Evacuation Plans (PEEPs), which meant appropriate information was available to staff or emergency personnel, should there be a need to evacuate people from the building in an emergency situation.

The service's safeguarding file included a copy of the provider's safeguarding policy, procedure and guidelines, as well as a safeguarding adults at risk flow chart. There was also an easy to read 'Keep safe' guide. There had not been any safeguarding related incidents at the service in the previous 12 months. We found the registered manager and staff understood safeguarding procedures, staff had been trained in how to protect vulnerable people and safeguarding was a standing agenda item at staff supervision sessions.

Appropriate arrangements were in place for the safe administration and storage of medicines. The provider's administration of medicines procedure had been written in conjunction with the community pharmacy team. Medicines were stored in a secure cabinet in the office.

Each person had a medication care plan and profile in place. Medication administration records (MAR) we saw were accurate and up to date. A MAR is a document showing the medicines a person has been prescribed and records whether they have been administered or not, and if not, the reasons for non-administration. Staff were appropriately trained in the administration of medicines and annual competency checks were carried out.

Good

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. A family member told us, "[Name] is doing really well", "The staff know [name] as well as I do" and "It's just like home from home here." Another family member told us, "I'm delighted with the care. It is like home from home." Another told us, "They [staff] look after him. Nothing's a bother."

Staff were supported in their role and received regular supervisions and an annual appraisal. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. Staff mandatory training was up to date and where refresher training was due, we saw it was planned. New staff completed an induction and were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care.

People's needs were assessed before they started using the service and continually evaluated in order to develop care plans.

People were supported with their dietary needs and were able to make choices regarding their meals by contributing to meal planning. Each person had a nutrition and weight support plan in place and nutritional screening tools were used to identify people at risk of malnutrition or obesity. We saw one person's support plan describe the person as being at risk of weight gain and their weight should be monitored weekly initially and then monthly if no great fluctuation. However, the person's nutritional screening tool dated 9 November 2017 described them as being at low risk and did not need to be weighed regularly. Another person had a monitoring and maintaining weight support plan in place that stated, "[Name]'s weight should be monitored and recorded monthly." However, the person's most recent nutritional screening tool described them as being at low risk. We discussed this with the registered manager who told us both people were now low risk and did not need to be weighed monthly. They agreed to update the care plans to reflect this.

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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity to make decisions MCA assessments and best interest decision meeting records were available.

DoLS applications had been submitted appropriately and CQC had been notified of any authorisations. Staff

had been trained in mental capacity and DoLS, and mental capacity assessments and best interest decisions had been made and recorded. For example, access to information, duty to care, using a lapbelt on the wheelchair and the locked door policy of the home.

People who used the service had 'Hospital passports' in place, had access to healthcare services and received ongoing healthcare support. The aim of the hospital passport is to assist people with learning disabilities to provide hospital staff with important information about them and their health if they are admitted to hospital. Care records contained evidence of visits to and from external specialists including GPs, care managers, hospital outpatients appointments and eye clinics. A healthcare professional told us, "The service is proactive in supporting people to have their health needs met."

The premises was appropriately designed for the people who used the service. All the accommodation was on one floor, and corridors and communal areas were wide and free from obstruction to allow people to mobilise with support around the home.

Good

Is the service caring?

Our findings

Family members told us staff were very caring. One family member told us, "I'm delighted with the care there." Another family member told us, "You've no idea how happy we are [with the care]." Another told us, "They [staff] are always laughing and carrying on." A healthcare professional told us, "There is a homely atmosphere when you visit this service and clients are always well presented and have been supported to a high standard with regard to their personal hygiene needs."

People we saw were well presented and looked comfortable in the presence of staff. There was always a member of staff present for people to interact with and we saw staff speaking with people in a polite and respectful manner. People enjoyed this interaction and laughed and smiled with staff. We saw and heard how people had a good rapport with staff. For example, we heard a person singing Christmas songs and staff were joking with them regarding the Christmas headwear they were wearing.

People's care records described how staff were to promote dignity and respect people's privacy. For example, "Staff will speak to [name] at all times with respect and dignity" and "Staff to leave [name] safely in the bathroom." We saw staff knocking on bedroom doors and asking permission before entering people's rooms. Staff also knocked on bathroom and toilet doors to ensure the rooms were empty before entering. Our observations confirmed staff treated people with dignity and respect and care records demonstrated the provider promoted dignified and respectful care practices to staff.

Supporting people to maintain their independence where possible was an important aspect of the service. Care records described how staff were to support people with this. For example, "I am able to fully dress myself but will help others in assisting me by lifting my arms and legs", "I can assist staff during my bath and getting dressed" and "I can undress myself but will need a little support." We observed a staff member interacting with a person who used the service in an attempt to get them to help with the laundry by taking the laundry basket to the room where the washing machine was. Although the person declined, the interaction was positive and the staff member respected the person's decision. This demonstrated that staff supported people to be independent and people were encouraged to care for themselves where possible.

People's preferences were clearly documented in their care records. For example, people's preferred name was recorded, as well as preferences for bed time, clothing, diet and social activities.

Communication support plans described people's communication abilities and preferences, and what they required support with. For example, one person could vocalise their preferences and choices but needed time to communicate these. A healthcare professional told us. "Staff have built up good relationships with [name] and their family, and have the ability to change how they communicate information so that it is understood."

People's religious needs were recorded where appropriate. If the person did not have any needs in this area, it was clearly recorded that staff would provide support if the person did express any needs.

We saw that records were kept securely and could be located when needed. This meant only care and management staff had access to them, ensuring the confidentiality of people's personal information as it could only be viewed by those who were authorised to look at records.

Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. We discussed advocacy with the registered manager who told us none of the people using the service at the time of our inspection had independent advocates as they all had family members involved in their care.

Good

Is the service responsive?

Our findings

The service provided care that was responsive to people's needs. A family member told us, "[Name] has come on leaps and bounds, and that is due to the excellent care [name] gets there. [Name] never used to speak at all, now [name] says 'hello' and 'goodbye'." Another family member told us their relative had a serious condition when they moved into the home but no longer had the condition due to the care and support received from staff.

People's care records were person centred, which means the person was at the centre of any care or support plans and their individual wishes, needs and choices were taken into account. Each person's care record included important information about the person, such as next of kin, medical history, diagnosis and details of their personal background, family and friends, and interests, and contained evidence of family involvement. A healthcare professional told us, "I have found the staff to be very person centred and caring." Another healthcare professional told us, "[Name] is supported in a person centred way to purchase and decorate their bedroom in a way in which they want to."

Choice was embedded in the ethos of the service. People were encouraged to make choices and these were clearly documented in the care records. For example, "I am able to vocalise all of my preferences and choices", "I require staff to respect my choices and preferences, and listen to me" and "[Name] has the ability to make choices and [name]'s choices should be recognised. This includes choices in clothing, activity, daily living and life skills." A family member told us, "[Name] loves clothes. [Name] can choose, it's up to [name]. Where people were at risk of making unwise or appropriate choices, staff were provided with guidance and advice to reduce any risks to the person.

The service actively involved family members in reviewing their relatives' care and support plans. Family members were invited to attend regular meetings. Discussions also took place with family members when they visited their relatives. Outcomes from these meetings and discussions assisted in reviewing their relatives' needs. One family member told us, "I get a profile on [name] twice per year, what [name]'s done, achievements etc. I look at [name]'s care plan and know exactly what [name] likes." Another told us, "They consult with me all the time. I am very involved."

Support plans were in place and included communication, death and dying, work and leisure, religious needs, mental health and well-being, sleeping, eating and drinking, personal care, pain, medicines management, maintaining a safe environment, mobilising, and where I live. These included evidence of involvement from family members and described what the person could do for themselves, what they needed support with and how the service would meet their needs. Records were regularly reviewed and included guidance from relevant healthcare professionals. A social care professional told us the care records were, "Excellent and up to date."

Staff were responsive to people's changing needs and worked together to develop support plans. A healthcare professional told us, "[Staff] demonstrated the ability to reflect on difficult situations and to learn from each other, and to work together to seek solutions to challenging situations."

The service enabled people to engage with their religious beliefs and support plans described their individual needs in this area. Support plans were also in place that described people's needs and wishes for their end of life care and funeral arrangements. These recorded whether the person was aware of death and what it meant, whether they wanted to discuss it, and the emotional and psychological support they required. Where appropriate, funeral plans were also documented in the records.

Daily diaries were maintained for each person who used the service. These included information on bathing, including a record of the water temperature, continence recording, diet and fluid intake, timetabled activities and any additional diary entries such as one to one time and bed time. Staff daily handover sheets also recorded any important information about the person such as activities and outings, any behavioural incidents, and medical appointments.

A wide range of activities were available for people and included events where people could be involved in the local community. People had work and leisure support plans in place detailing activities the person enjoyed doing. For example, one person enjoyed dog walking, action and horror films, going to the market and army stalls. Another person enjoyed going out in the car, visiting a local coastal town, going to the theatre and shopping trips. They also attended a local tea dance where they could meet and engage with other people.

People had been Christmas shopping and had helped to decorate the home and garden with Christmas decorations, some of which they had made themselves. One of the people enjoyed singing and had a diverse knowledge of music. They particularly enjoyed karaoke sessions and music quizzes, where staff made up the teams alongside the people who used the service and encouraged them to be involved.

People enjoyed playing 'Play your cards right' with giant cards, bingo and flower arranging. One person enjoyed drawing and painting, particularly after having eye surgery. The same person had helped to paint a beach hut picture that was on the dining room wall. Family members were included in activities. For example, a family member told us, "[Name]'s always out and about. Sometimes they pick me up as well and I go with them" and "I get invited to attend events. Families are always involved."

The provider had a complaints policy and procedure in place, and people and family members were encouraged to voice their opinions. 'Have your say' information was available to people who used the service, which described how to make a complaint, comment or compliment, who to complain to and how long it would take for a response to a complaint. There had not been any formal complaints recorded at the service in the previous 12 months. A family member told us, "In 10 years, I've never had a complaint at all." Another told us, "I've never had any issues."

The compliments book included a number or recent compliments from visitors to the service. These included, "Always a joy to come to Chibburn Court. Lovely staff, always a warm welcome" and "Friendly staff and a nice atmosphere in the house." The registered manager showed us a recent Christmas card from a family member that stated, "Just to say a big thank you for everything that you do to make [name] happy at Chibburn Court. [Name] is always happy and content and it makes me happy too."

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. They had been registered since October 2010, when the location had registered with CQC and were supported in their role by a nurse employed by the service.

We spoke with the registered manager about what was good about their service and any improvements they intended to make in the next 12 months. They told us a new vehicle had been ordered, which was larger and would be able to accommodate all three people who used the service at the same time. Plans were in place to redecorate the communal areas, including a new carpet for the living room.

The registered manager told us what was important to them and the people who used the service in the future. They told us they wanted to ensure people continued to be cared for and supported to a high standard. This included meeting their social, spiritual, psychological and physical needs and responding to these in a safe, person centred way. They also told us of plans to introduce a timeline of medical history for ambulance drivers. This had been requested by an ambulance driver in the past for one person, and the manager and staff thought it would be good practice to have this in place for all the people who used the service.

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.

The service was an important part of the local community. Coffee mornings had been held at the home to raise money for charity and staff told us how they were involved in the fundraising. At one recent event, people from the local community, family members, and staff and their family members had been invited, where they had enjoyed afternoon tea whilst being entertained by singers. Two of the people who used the service had attended a similar event at a neighbour's property.

The service had a positive culture that was person centred and inclusive. Staff were regularly consulted and kept up to date with information about the home and the provider. Regular staff 'house' meetings took place and an agenda was prepared in advance. These included people's needs, equality and diversity, supervisions, compliments and complaints, ideas and developments, operational issues, review of care plans or new care plans/protocols, health and safety, training and any other business.

Staff we spoke with felt supported by the management team. They told us, "I cannot complain at all about [registered manager]. I think she goes above and beyond", "We get plenty of support. We have a good team", "You can go to [registered manager] with anything" and "She's always been very supportive." A healthcare professional told us, "[Registered manager and nurse] provide strong and responsive management." Another told us, "My assessment is that the service performs very well." Another told us, "The staff are lovely."

Family members told us they were kept up to date with anything that was happening with their relative and communication was good. A family member told us, "They just phone us up" and "I cannot say enough for this place. They really do look after her." Another family member told us, "From [registered manager] right down, I can't say just how good it is." Another told us, "They put you in the picture straight away" and "They keep you informed. You are the first to know."

We looked at what the provider did to check the quality of the service, and to seek people's views about it. The provider had a robust quality assurance process in place.

This registered manager completed a quarterly quality performance review that included a review of occupancy, staffing, training, documentation, complaints, accidents and incidents, any additional comments, and an action plan. A performance meeting took place after each quarterly review had been submitted where the provider's operations manager discussed the review with the managers of each service and identified any additional actions.

The operations manager carried out regular visits to the home and completed their own audits of the service. An annual quality monitoring visit also took place and we saw action plans were developed based on any issues identified from these visits.

The registered manager completed a monthly feedback form to measure compliance with the CQC five key questions. The form was submitted to the provider's 'CQC assurance group', who met monthly with managers of each service to discuss the form with them.

The provider sent an annual survey to family members and professionals involved with the service to obtain feedback on the quality of the service. Family members told us they felt involved with the service and their opinions were taken into consideration. People who used the service were involved in 'Core team' meetings, where they and staff sat down to discuss any issues, concerns or new ideas and activities.

This demonstrated that the provider gathered information about the quality of their service from a variety of sources and acted to address shortfalls where they were identified.