West Sussex County Council

Marjorie Cobby House

Inspection report

St Peters Crescent
Selsey
West Sussex
PO20 0NA

Tel: 01243602632
Website: www.westsussex.gov.uk

Date of inspection visit:
28 June 2018
29 June 2018

Date of publication:
27 September 2018

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

Marjorie Cobby House is a residential care home for a maximum of 34 people. At the time of this inspection 14 people were staying at the home. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. This is a bespoke service model operated by West Sussex County Council [WSCC] that focused on the rehabilitation needs of people following their discharge from hospital. Marjorie Cobby House provides a short term service and people can stay there for up to 12 weeks, depending on the service criteria. Respite and emergency short term care can also be accommodated. The service works in partnership with the NHS, social workers, local GP surgery and intermediate care team to support people to meet their objectives.

The home was well maintained and spacious, with small lounges and a large communal dining area. Kitchen areas are available for people to use to support with daily living skills and rehabilitation. There are pleasant outdoor seating areas. A large assisted bathroom is also offered to community physiotherapists to support people who live in the local community to receive a bath safely and enable them to receive rehabilitation support.

The service accommodates up to 34 people on short-term basis for rehabilitation support. The 34 beds were divided to reflect people's different level of need and the level of support required by them to be able them to return to their home. There were 'discharge to assess' [D2A] beds, 'community transfer beds' [CTB] which were contracted by health commissioners and also standard 'interim' beds for those people with the lowest level of rehabilitation needs. People were admitted after an initial assessment was completed by a 'trusted assessor' who was a health professional based at the local hospital from where people would be discharged before moving to this service. We were told that the service had supported more than two hundred people to receive rehabilitation or to move onto more appropriate accommodation to meet their needs in the previous 12 months before this inspection.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of Good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service had not changed since our last inspection. Despite a safeguarding concern raised by the local social services safeguarding team, following a formal complaint that was raised, we found that the service responded to and managed risk to people appropriately. Following the safeguarding concern and after this inspection, the senior management team for this service had worked to change the structure of the service provided which meant that risks were further reduced. The 'trusted assessor' approach which had been used by the service to enable people to be discharged from hospital more quickly, had been stopped which enabled staff from the home to assess people's needs instead of health professionals based at the hospital. This ensured that staff felt more confident about meeting the

needs of people who were referred to stay at this rehabilitation service.

People were protected from abuse by trained staff who understood the reporting procedures when concerns may arise. Staff received appropriate training for their roles and were recruited safely which further protected people from the risks of abuse.

People had access to healthcare when they needed it. There was a regular presence of community health care professionals which included GP's, community matrons and a paramedic practitioner, at the home. Community physiotherapists and occupational therapists also visited people at the service to support with improving daily living skills and mobility to enable people to confidently return home following an operation, fall or illness which had resulted in them spending a period of time in hospital.

Risks to people were assessed and managed. Accidents and incidents were recorded and monitored. The management team reviewed accidents and incidents for any trends and appropriate preventative measures were taken to reduce risk and avoid reoccurrences. There was a complaints process. A large number of positive compliments were seen during this inspection.

People's medicines were managed safely and people were positively encouraged to maintain their independence with daily living skills which included self-administering their medication when safe to do so. People had a choice of food and dietary needs were maintained with healthy food and drink snacks which were always available.

The home was clean and well maintained and risks of infection were managed by appropriate use of protective equipment such as gloves and aprons when staff supported people with personal care or cleaning tasks.

During this inspection we were told that people at the service had the mental capacity to make decisions regarding their daily lives. The registered manager was aware of how to support people who may lack mental capacity and was able to describe previous occasions when they had provided appropriate support to people. People staying at Marjorie Cobby House 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 support this practice.

The service was well managed by an open and transparent management team. Daily handovers provided detailed information about people's changing needs and support required to enable them to return home. The registered manager engaged very professionally and positively with the recent safeguarding concerns and shared regularly updated action plans with the Care Quality Commission [CQC] and social services of the progress against the actions noted.

The service was previously inspected on 29 February 2016 at which time no concerns were identified. At this inspection we found the service remained Good.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remained Safe.	**Good**
Is the service effective? The service remained Effective.	**Good**
Is the service caring? The service remained Caring.	**Good**
Is the service responsive? The service remained Responsive.	**Good**
Is the service well-led? The service remained Well-led.	**Good**

Marjorie Cobby House

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 a comprehensive inspection. We inspected the service earlier than scheduled because we had been informed of safeguarding concerns regarding possible delays with the identification of a person's deteriorating health condition. This inspection took place on 28 and 29 June 2018. The first day if the inspection was unannounced and the second was announced. The service was previously inspected on the 29 February 2016 and was rated as 'Good' with no concerns identified.

The inspection was completed by one inspector and a specialist nurse advisor.

We used information the provider sent us in the Provider Information Return (PIR). 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. We also reviewed notifications sent to us by the provider. This is information that providers are required to send us in law.

We spoke to health and social care professionals and the police who attended the safeguarding adults meetings. We also spoke with a community matron, a community physiotherapist, two social workers, the registered manager, a deputy manager, three senior support workers, two carers, the admission and discharge officer based at the service and a paramedic practitioner who worked at the local GP surgery. We also spoke with six people who used the service and reviewed the records held for three people. Recruitment and training records were also reviewed for three members of staff.

We reviewed policies and procedures within the home, staff training, accidents and incidents, quality assurance audit outcomes and other daily records which included the staff handover report.

Good

Is the service safe?

Our findings

The service was safe. A recent safeguarding concern raised by the local social services department which noted concerns that staff at Marjorie Cobby House may not have responded quickly enough to a person's deteriorating health needs. These concerns and allegations were being investigated at the time of this inspection. We found that there were systems and processes to continually monitor the safety and wellbeing of people at the service. There were very detailed daily handover meetings between each shift change with supporting written reports which reviewed each person's needs and any changes to their health. Staff were informed and aware of people's health and other needs. The registered manager told us, "If someone is on blood thinners we have it on the handover and if they have a fall we call an ambulance." We reviewed a quality assurance survey completed by people who stayed at this service. Comments included, "I am very happy and feel very safe" and "I am always made to feel safe, somebody always supports me when I need it."

People were supported by daily on-site visits from community health professionals and weekly visits from a paramedic practitioner who worked with the local medical practice. Regular professional meetings took place between the service and the medical practice with any concerns regarding people's wellbeing and support required by the service discussed. We found that management staff at the service had asked for training and support from the medical practice regarding the identification of sepsis signs and symptoms in March 2018. This was requested by the service before a person had been identified as having sepsis in May 2018 which resulted in a safeguarding concern being raised. The service had not been given this training advice and support at the time of this inspection. Changes to systems at the home following the inspection continued to reduce risks to people who moved to the service.

People were protected from abuse by staff who understood the required processes to raise safeguarding concerns when they arose. We had received notifications from the service when concerns of a safeguarding nature had been reported to the local safeguarding adults social services team. Appropriate actions had been taken by the service to support people to stay safe. The provider told us in their Provider Information Return (PIR) that, "Safeguarding and CQC [Care Quality Commission] notifications are completed as required. Staff know how to recognise and respond to abuse/safeguarding issues. We have a 'person centred safeguarding champion'. The champion participated in compiling 'feeling safe cards' [for people]. The champion was also involved in the design of a feeling safe audit. Service specific training includes safeguarding, managing challenging behaviour through positive behaviour support."

Safeguarding was treated with an open approach with a safeguarding 'pledge tree' in the foyer area of the service. Staff had made individual pledges on each leaf of the tree, some of which included; "I will keep calm, listen carefully, do not interrupt and act upon my findings" and "I will continue to promote awareness in recognising signs and symptoms [of abuse] and our duty of care" and "safety is always at the foremost of my mind" and "I will make myself approachable for people to feel at ease and to talk." In addition to this, there was a selection of leaflets next to the pledge tree with a seating area, so that people could sit and read information about safeguarding and abuse and how to keep themselves safe or who they could report any concerns they may have to.

People received medicines safely. The specialist nurse reviewed the medicines at the service and found that medicines were stored safely and in line with legal requirements. Records were accurately maintained on people's Medication Administration Records (MAR). Due to the rehabilitation focus of the service, people were encouraged to manage their own medicines when it was safe for them to do so. We saw a 'self-administration risk assessment' completed appropriately for one person who had chosen to self-administer their medicines. People who may require medicines on an "as required" basis were asked at each medicines round if they required pain relief or other medicines as prescribed. Staff who gave medicines to people told us that "everyone can speak for themselves" and so they did not require detailed "as required" [also known as 'PRN'] protocols to be in place. A weekly 'self-administration' audit was completed to continually monitor the safely of any people who had chosen to administer their own medicines.

People were protected by a safe environment with appropriate safety checks completed which included fire safety. However, we found that the temperature records for one shower indicated that the water may become hotter than is safely recommended. We reported this to the registered manager who promptly acted upon this. Maintenance visited the service and fixed the concern immediately. No people had been scalded or had complained of the water being too hot for them. Other risks to people were appropriately assessed and monitored. Some of the risk assessments we viewed were for, falls, use of bed rails, walking aids, wheelchairs, eyesight, footwear and other equipment such as hoist slings.

There were enough staff on duty to support the needs of people fully. Safe recruitment practices were followed which ensured that staff who worked at the service were selected appropriately to support vulnerable people. Appropriate pre-employment checks were completed which included professional and character references from previous employment and Disclosure and Barring Service (DBS) checks which ensured that staff were of good character to work in a care home setting.

People were protected from the risks of infection with regular cleaning schedules, infection control audits completed by a 'lead' person with responsibility for this and dedicated housekeeping staff who maintained the cleanliness of the home. Housekeeping staff completed daily infection control checklists for each room within the home. Staff were observed to use personal protective equipment (PPE) such as gloves and aprons appropriately throughout the inspection. One staff member clearly explained the various PPE they would use for both personal care and in the kitchen. The home was clean and free from unpleasant odours.

Lessons were learned when things went wrong for people and systems and processes protected people from the reoccurrence of some accidents. Accidents and incidents were analysed thoroughly by the deputy manager with clear actions seen to avoid future occurrences. An example of this was for one person who had a history of falls. The staff reviewed when and where the falls happened and it was agreed with the person that they relocate to a different room where there would be more staff presence during the times that they fell. The person agreed to this and a reduction of falls was noted as a direct result.

Good

Is the service effective?

Our findings

The service was effective. Despite a recent safeguarding case that had happened at the service, we found that the service responded to people's changing needs promptly, with systems and processes that enabled access to healthcare support. For example, community matrons visited the service on a daily basis and staff were able to seek their professional views of people's wellbeing. Community physiotherapists and social workers also attended weekly meetings with Marjorie Cobby senior and management staff to review the wellbeing and rehabilitation needs of each person placed there. Lists of people that staff may have concerns about were given to the nurses when they arrived which ensured that clear records were maintained and that people were seen when they needed to be. A paramedic practitioner visited the service on a weekly basis. Staff were able to ask for their professional opinions of a person's healthcare needs should they have concerns. During the inspection we observed a 'handover' session between the admission and discharge officer at the service and the paramedic practitioner. Detailed actions were discussed in relation to the needs of people and some actions were referred back to the GP for follow up action.

People's needs were assessed before they moved into the service for rehabilitation. We discussed the current 'pre-admission' assessment process with the registered manager which was completed by a 'trusted assessor' who was a healthcare professional based at the local hospital. This process was established to avoid delays with discharges from the hospital to the service, but had not enabled staff based at the home to also fully assess a person's individual needs and how they may be suited to the home, before they moved to the service. Following this inspection this process was altered and the pre-admission assessments are now completed by staff from the service and a social worker. This meant that people's needs would be better understood before they were discharged to Marjorie Cobby House for rehabilitation.

People were supported by well trained staff who each completed the training that was expected of them in their roles to provide care to people. A member of staff said that "management were approachable, and training was available if wanted or required." New staff completed an induction period in line with national best practice which included them also shadowing more experienced staff. We reviewed staff training records and spoke to staff at the service. One member of staff described how they would tell if someone was becoming unwell and mentioned 'demeanour' and 'agitation', for example, and what action they would take. They described how they would support a person who had fallen were very clear and competent in their descriptions. Another staff member said when asked about how they would detect a person had become unwell, said things such as, "behaviour change, becoming immobile", or "agitated." They also said, 'If you know that person, you know they are not themselves.' If concerned, they would check with the 'duty officer', and check the person on a regular basis. This demonstrated that staff were confident to take appropriate action should a person become unwell. Staff received regular supervisions and detailed appraisals of their performance.

Healthy, varied meals were provided to suit people's individual choice and preferences, as well their specific needs. People who needed it had their foods fortified and allergies were clearly noted for people. We saw that one person had an allergy to fish. This information was clearly displayed in the kitchen. The kitchen staff knew people's individual dietary needs and these were documented. People's likes and dislikes were

sought when they moved into the home and copies of these were held in the kitchen. Checks were completed by the kitchen staff, which included fridge temperatures. This ensured that foods were prepared and served safely. A fridge that contained healthy snacks and drinks was placed in the communal dining room and people were able to access this when they chose to. People were able to choose the foods they wanted and built relationships with others at meal times. A recent survey completed by people who used the service included comments such as, "I choose what I want to eat, I write a list for the chef" and "I make friends at lunch."

The premises was adapted to meet people's needs and specifically provided people with opportunities to regain their independent living skills in line with the rehabilitation model of the service. On the first floor there were kitchen areas that could be used by people with or without support from community physiotherapists and occupational therapists, as well as staff at the home. This ensured that people did not lose their daily living skills while staying at the service and were enabled to regain skills and confidence that may have been reduced following a fall, operation or illness. This intervention directly supported people's ability to return to their homes when able to.

At the time of this inspection we were told by the registered and deputy manager that people who lived at the service had mental capacity to make decisions about their day to day activities and choices. 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). Staff were seen asking people for their consent before any support or intervention such as medication was given.

Good

Is the service caring?

Our findings

The service was caring and people's privacy and dignity were respected. The 'core values' of the service were that, 'the team at Marjorie Cobby House is committed to upholding the individuality of each person and to respecting their privacy and dignity within the centre.' We observed that this ethos was upheld by staff at the service. Staff were seen to knock on people's bedroom doors before they entered and people were spoken to in a respectful manner. People were supported by a dedicated and caring staff and management team who worked very well together and with external health and social care professionals which enabled people to regain as much independence as they were able following their discharge from hospital. Staff were seen to be very caring towards people at the service. Staff spoke kindly and calmly when they supported people with personal care and used a compassionate approach when they may have been unwell or experienced pain. People stated in a recent quality assurance survey that staff were kind. One person said, "everybody is so kind" and "staff are always helpful" and "I get excellent care here." Another person told us that the staff were, "very kind and helpful."

We observed a very friendly, happy and helpful staff team that consistently talked sensitively and with compassion about how they supported people. During weekly MDT meetings staff worked together with other health and social care professionals to discuss positive options for people to move on to when they were discharged from the service, given their individual circumstances and abilities. Staff knew people well and were passionate about people maintaining their independence in life.

People continued to be encouraged to be as independent as they were able. Staff were dedicated and determined to support people to return to their own homes or to move to more appropriate accommodation where their needs could be met safely. One staff member described their work routine and stressed that their role was to support "the residents in what they want" and to "encourage independence." Staff were seen taking people out to the shops or to local public houses to engage in the local wider community with confidence.

Confidentiality was respected and people felt their personal data was managed appropriately. One person said in a quality survey completed by the home that, "I feel very confident" [that personal information is confidential]. Records for people were held appropriately in accordance with legal requirements. Information about people was held securely. New legislation became effective from the 25 May 2018, namely the General Data Protection Regulations 2018 (GDPR). The GDPR is a legal framework that sets guidelines for the collection and processing of personal information of individuals. The registered manager had a good understanding of the new law and ensured the privacy of people and staff was maintained in relation to the data held about them. The organisational policies and procedures reflected this change to how people's and staff data is maintained. Staff had completed GDPR training and the registered manager told us how they were, "setting up an NHS email account so that GP health summaries can be sent securely."

Good

Is the service responsive?

Our findings

The service was caring and people's privacy and dignity were respected. The 'core values' of the service were that, 'the team at Marjorie Cobby House is committed to upholding the individuality of each person and to respecting their privacy and dignity within the centre.' We observed that this ethos was upheld by staff at the service. Staff were seen to knock on people's bedroom doors before they entered and people were spoken to in a respectful manner. People were supported by a dedicated and caring staff and management team who worked very well together and with external health and social care professionals which enabled people to regain as much independence as they were able following their discharge from hospital. Staff were seen to be very caring towards people at the service. Staff spoke kindly and calmly when they supported people with personal care and used a compassionate approach when they may have been unwell or experienced pain. People stated in a recent quality assurance survey that staff were kind. One person said, "everybody is so kind" and "staff are always helpful" and "I get excellent care here." Another person told us that the staff were, "very kind and helpful."

We observed a very friendly, happy and helpful staff team that consistently talked sensitively and with compassion about how they supported people. During weekly MDT meetings staff worked together with other health and social care professionals to discuss positive options for people to move on to when they were discharged from the service, given their individual circumstances and abilities. Staff knew people well and were passionate about people maintaining their independence in life.

People continued to be encouraged to be as independent as they were able. Staff were dedicated and determined to support people to return to their own homes or to move to more appropriate accommodation where their needs could be met safely. One staff member described their work routine and stressed that their role was to support "the residents in what they want" and to "encourage independence." Staff were seen taking people out to the shops or to local public houses to engage in the local wider community with confidence.

People received a service tailored to their individual needs and preferences which clearly and strongly focused upon the right levels of support required for people to regain as much independence as possible. In a person's bedroom we saw they had their own telephone to use to contact family, and their daily exercises were on an easy to follow colour printed sheet for staff to support with as appropriate. Daily notes demonstrated the person's progress from admission when they were unable to stand without staff support, to them now being able to walk with the help of a frame.

Confidentiality was respected and people felt their personal data was managed appropriately. One person said in a quality survey completed by the home that, "I feel very confident" [that personal information is confidential]. Records for people were held appropriately in accordance with legal requirements. Information about people was held securely. New legislation became effective from the 25 May 2018, namely the General Data Protection Regulations 2018 (GDPR). The GDPR is a legal framework that sets guidelines for the collection and processing of personal information of individuals. The registered manager had a good understanding of the new law and ensured the privacy of people and staff was maintained in

relation to the data held about them. The organisational policies and procedures reflected this change to how people's and staff data is maintained. Staff had completed GDPR training and the registered manager told us how they were, "setting up an NHS email account so that GP health summaries can be sent securely."

Good

Is the service well-led?

Our findings

The service was well-led. There was a strong management team with a clear leadership structure and vision for the service. The aims of the service were to provide a short-term rehabilitation service for people, for up to 12 weeks. This was achieved for those who used the service with very positive outcomes. We were told how some people liked to return for respite stays at the service each year. One person said, "I'm booking in for Christmas." During the 12 months previous to this inspection, we were told by the registered manager that the service had supported over two hundred people to rehabilitate through the service and to return to their own homes or on to another more appropriate setting for their individual needs. Staff were happy in their work at Marjorie Cobby House and told us that the management team were supportive and approachable. One staff member said, "I do think we're lucky to be working here. It's a happy place and there is teamwork."

There was new manager who had recently become registered with the Care Quality Commission [CQC] to manage services provided at Marjorie Cobby House. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager understood their responsibilities and had completed notifications to us as they are required to do so in law. The registered manager also understood the duty of candour regulation and had provided a written letter of apology appropriately as part of a safeguarding case. This regulation ensures providers are honest, open and transparent when things go wrong.

The registered manager worked openly, transparently and in partnership with local social services safeguarding teams and the CQC. Safeguarding and management plans were shared openly with us during and following the inspection process. The action and management plans demonstrated that the provider fully understood how to address any service concerns that had been raised as part of the safeguarding process and that measures were in place to reduce risks to people. Positive changes had been made to the service model as a result of the safeguarding which further protected people from reoccurrence of abuse.

Communication between the service and external professionals was positive. A paramedic practitioner told us that, "communication is good with the home." The paramedic practitioner used to attend the weekly MDT meetings at the service but due to effective and proactive communication with the admission and discharge officer, they no longer felt they needed to attend. The admission and discharge officer liaised directly with the paramedic practitioner to feed back any concerns that arose. They told us of an example when a person who was prescribed anticoagulant, blood thinning medication and had sustained a fall. Discussions between the service and paramedic practitioner had resulted in the service assessment form being changed to reflect the National Institute for Clinical Excellence (NICE) guidelines. The assessment form detailed appropriate action to take when a person sustained a fall if prescribed anticoagulant medicines. This change ensured that all staff knew that people had to be referred to external health professionals for a head scan, within 6 hours after all falls, when they were prescribed anticoagulant medication. The paramedic practitioner had used this example of good practice for their continual professional development

and reflective practice. The registered manager used this change to practice as a team meeting agenda item and also raised it at a senior staff meeting as "item of the month" to reflect on the organisational head injury policy. This demonstrated a service that adopted a learning culture to improve the service.

The views of people were captured using a "tell us what you think" survey. We reviewed the information contained within the outcomes of a recent quality assurance survey which 12 people had responded to. All people who completed the survey said they were 'happy with the support they received.' The registered manager invited people and their representatives to attend a meeting for 'tea and a chat' with them. We saw flyers around the service which made people aware of these opportunities to meet with the registered manager to share their views and discuss any matters as they wished.

Systems and process were used effectively to capture the quality and safety of the service provided to people. Quality assurance surveys were completed by people on a regular basis as they left the service and audits were completed to continually monitor and review other aspects of the service. These included, but were not limited to, infection control audits, accidents and incidents audits and analysis of any trends and medication audits.