Cherre Residential Care Limited

Cherre Residential Care

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 3 August 2016 and was unannounced.

Cherre Residential Care is a care home for people with learning disabilities, autism spectrum disorder and mental health needs. A maximum of 14 people can use the service. At the time of our visit, nine people lived in the home.

The service had 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.

Staff and people understood safeguarding policies and procedures. Staff followed people's individual risk assessments to ensure they minimised any identified risks to people's health and social care. Checks were carried out prior to staff starting work at the service to reduce the risk of employing unsuitable staff. People who lived at the home had complex needs. There were good levels of staff on duty to keep people safe, and they had received training to help them meet people's needs effectively.

The provider understood the requirements of the Mental Capacity Act and Deprivation of Liberty safeguards and the service complied with these requirements. Medicines were administered safely to people, and people had good access to health care professionals when required.

People enjoyed activities within the home, and were supported to take part in hobbies or activities that interested them such as going out to the pub, shopping, swimming and going for walks.

People received care and support which was tailored to their individual needs. They enjoyed the food provided, and helped with meal planning, preparation and cooking.

Staff were motivated to work with people who lived at Cherre Residential Care. People and staff enjoyed good relationships with each other which were supportive, friendly, and caring.

The registered manager was open and accessible to both people and staff. There were sufficient informal and formal monitoring systems in place to ensure quality of service was maintained. People and their relatives knew how to complain and both formal and informal complaints were investigated fully.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were good staffing levels to meet people's needs. Recruitment practice reduced the risks of employing unsuitable staff. The risks related to people's health and social care were identified and managed well. People received their medicines as prescribed.

Is the service effective?

Good

The service was effective.

Staff had been trained well to support the complex physical and social needs of people who lived at Cherre Residential Care. They understood and worked with the principles of the Mental Capacity Act. Where possible, people were involved with planning and cooking their meals, and told us they enjoyed their meals. People's healthcare needs were met.

Is the service caring?

Good

The service was caring.

Staff had a good understanding of people's needs, and had positive, supportive relationships with people who lived at the home. People's dignity, privacy and human rights were respected by staff. Visitors were welcomed at times agreed with people who lived at the home.

Is the service responsive?

Good

The service was responsive.

People were supported to take part in activities which reflected their preferences and interests. People had good opportunities to give feedback about the service, and people and relatives felt able to raise concerns.

Is the service well-led?

Good

The service was well-led.

The provider made regular visits to the home, and there were systems in place to check the quality of care and support met the required standards. Management were seen as open and supportive of people and staff.	

Cherre Residential Care

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.

The inspection took place on 3 August 2016 and was unannounced. One inspector undertook the inspection.

We looked at information received from statutory notifications the provider had sent to us. A statutory notification is information about important events which the provider is required to send to us by law. We also contacted the local authority commissioners. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority. The commissioners had no concerns about the service.

Before the inspection, the provider completed 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. Our visit reflected what we found in the PIR.

We sent out letters requesting feedback from other professionals involved with the home. We received feedback from a consultant psychiatrist about the support given to people's mental health conditions. This was positive.

On the day of our visit we spoke with six people who lived at the home, and four staff on duty. We also spoke with the registered manager and the area manager. After our visit, we spoke with the provider.

We reviewed three people's care plans to see how their care and support was planned and delivered and looked at the medicine administration records of people. We looked at other supplementary records related to people's care and how the service operated. This included checks management took to assure themselves that people received a good quality service.

Good

Is the service safe?

Our findings

There were enough staff on duty to care for people safely during the day and night. Nine people lived at the home at the time of our visit, most of whom had complex and high dependency needs. Some people who lived at Cherre Residential Care, had been assessed as needing support from a member of staff at all times during the day to keep them safe, and other people, had been assessed as needing two members of staff to support them. Staffing numbers reflected their assessed needs. The manager and area manager were not included in the staffing numbers and could provide additional support if this was required.

Staff received 24 hour support from management to keep people safe. There was an on-call support system staffed by team leaders and the management team. We were told this had only needed to be used once in the last three years.

People were protected by the provider's recruitment practices. Staff told us the registered manager checked they were of good character before they started working at the home. The provider obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions. It was previously known as the Criminal Records Bureau (CRB). The registered manager and staff confirmed staff were not able to work alone until the recruitment checks had been completed.

The administration of medicines was managed safely and people received the medicines prescribed to them. We looked at the storage of medicines. Not all medicines were stored in accordance with the legislation. The registered manager informed us this was because one of the locks on the medication cupboard was faulty. They had sought advice from their pharmacist who said their temporary arrangement was suitable. The registered manager told us they would ensure the lock was fixed straight away.

We looked at the medicine administration records (MAR). These had been completed correctly. There were systems to check whether medicines had been administered as prescribed. We looked at medicines given on an 'as required' basis. There was clear and comprehensive guidance given to staff to inform them why these medicines had been prescribed. For example, a medication used to reduce the symptoms of anxiety was given as required. Records showed when staff should consider giving people these medicines and the signs and symptoms which indicated the person might require them. This reduced the risks of staff having an inconsistent approach when administering these medicines to people. The provider information return told us the registered manager was assured that staff continued to administer medicines safely because they undertook checks on staff competency.

People were safe and protected from the risks of abuse. This was because they had all undertaken a 'safeguarding' workshop and received certificates of attendance. The workshop supported people to understand what safeguarding meant and what they should do if they did not feel safe.

Staff also understood their responsibilities and the actions they should take if they had any concerns about people's safety. We gave staff different scenarios which meant people were not being safeguarded from

harm. Staff understood their roles and responsibilities in each of the scenarios, and the importance of informing their manager and external authorities if they had concerns a person was unsafe. For example, one member of staff told us, "I would go and speak with the manager. If the manager didn't do anything about it I would complain to the CQC." Another said, "My responsibility is to go to management. If they don't do anything I would go above, or call the CQC or a social worker or the police." The registered manager was aware of their responsibility to notify us when there had been concerns raised about the safety of people.

The service had good financial safeguards to protect people from the risk of financial abuse. This included procedures where two staff booked money in and out of the home, and checked the remaining balance against receipts.

Accidents and incidents were always logged and appropriate action was taken at the time to support the individual and to check for trends or patterns in incidents which took place.

The registered manager had assessed risks to people's individual health and wellbeing. The risk assessments explained to staff what the risks were to each person and the action they should take to minimise the risks. For example, if the person's behaviour was a potential risk to themselves and to others, the assessment determined what the risk was, and how staff could minimise the risk of the behaviour occurring.

The premises and equipment were safe for people to use. For example, electrical appliances had been PAT tested (PAT tests ensure electrical appliances are safe to use). A person told us they were not able to buy second hand electrical appliances because it was not safe to do so. Instead they bought battery operated appliances. There were weekly audits for checking fire equipment and emergency lighting, and both staff and people who used the service knew the evacuation procedure and where to assemble. Staff were not aware of where they should take people if they could not go back into the building after evacuation. The registered manager was aware of this, and said they would ensure that all staff were knowledgeable of any contingency measures.

Good

Is the service effective?

Our findings

Staff had received training to meet people's needs and people told us they felt staff knew how to support them. On the day of our visit, a person had experienced a seizure. Staff were aware of their responsibilities and understood what they needed to do.

We checked how staff were supported in their roles when they first started work at the home. We were told new staff had an induction to familiarise them with the home, the people who lived there, and their role. This included being informed of the policies and procedures of the home, and working alongside more experienced people.

New staff had undertaken the Care Certificate. This replaced the previous common induction standards framework for new staff. The Care Certificate is expected to help new members of staff develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care.

The registered manager told us staff had received all the training considered mandatory to meet people's health and social care needs. Staff confirmed this and explained they had undertaken training such as health and safety, and food hygiene. They also told us they had been trained to become more knowledgeable about supporting people with learning disabilities, epilepsy (a number of people in the home lived with epilepsy), managing challenging behaviour, and autism.

Staff had undertaken further training such as National Vocational Qualifications in health and social care to further develop their practice as social care workers. Staff had completed levels 2 and 3. These were in line with the expectations of their roles and responsibilities.

Staff received on going help and support from their seniors and manager. Monthly individual meetings gave staff the opportunity to discuss their role and responsibilities and to receive feedback about their work performance (supervision). The registered manager also undertook observation of the interactions between staff and people. The registered manager met with staff to discuss their observations and offered positive and constructive feedback. These discussions were recorded and used to support the staff member's development.

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

The registered manager understood their responsibilities under the Act. They and staff had a working

knowledge of the MCA and where there were concerns that people did not have the capacity to make specific decisions, there had been assessments with relevant professionals to determine whether this was the case. For example, one person wanted to buy a particular item each week. If they had done this without any restrictions, there would have been problems with space in their bedroom. It had been agreed that the least restrictive practice was for them to buy the item, and at the same time give one of the existing items they had previously bought to a charity shop. This meant they still had the pleasure of buying something new and their desire to shop for it was not restricted.

We saw people were asked for their consent before any care act or support was given. For example, people had activities planned into their schedules. Staff checked with them that they were still happy to go to their activities.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Appropriate applications had been made to the local authority responsible for the approval of the DoLS. Some of the DoLS were expired. The registered manager told us they had put in a request to extend the DoLS and were waiting for the local authority's response.

People received food and drink which met their needs. One person told us, "I like the food, I like curries, I eat a lot of curries". People were involved in menu planning so meals reflected their wishes and preferences. The PIR told us the home worked with the 'Eat well plate'. This is a guide published by Public Health England to support people in having nutritionally balanced meals. The home had a four week menu with choices available for each meal.

During our visit we saw one person support a member of staff in making lunch for people. Lunch was either a corned beef salad, or sausage rolls and beans. The person told us they enjoyed helping make the meals. People had a range of hot and cold drinks available to them.

People were assessed to check whether they were at risk of weight gain or weight loss. At the time of our visit there was no one who lived at the home who had specific dietary needs.

People received support to maintain their health and wellbeing. People saw other health and social care professionals when necessary to meet their physical and mental health needs. One person told us, "I see the doctor if I feel sick." A consultant psychiatrist responded to our request for information about the home. They told us staff followed the management plans advised by them and the multidisciplinary team, and staff gave them up to date information about people's mental health and wellbeing which helped them make appropriate clinical decisions.

Good

Is the service caring?

Our findings

During our visit we saw a good rapport between people who lived in the home and the staff who supported them. All the people we spoke with were happy living at Cherre Residential Care. One person told us, "It's nice living here – the staff are alright." Another person answered "Yes" when asked if the staff were kind. A member of staff told us, "If you look at the service users [people's] faces you will see they are happy. If I can make them smile it makes me smile."

Whilst a number of people at the home required at least one member of staff to be with them at all times for safety, staff were as unobtrusive as possible, and respected the person's need for personal space. They engaged well with the people they provided support to.

Staff demonstrated a good understanding of the people they supported. We looked at three care records. These provided detailed information, written from the person's perspective, about the person's care and support needs and the outcomes people wanted to achieve. For example, one person's care file told us, "I can make everyday decisions, what meals I prefer to eat, the clothes I want to wear, and who I wish to spend time with."

One person had a severe form of epilepsy which was known as a difficult to manage condition. There was detailed information in their care record about the condition and how staff should support the person to live safely and well. Through discussion with staff, we found they had a good working knowledge of people and had read the care plans to help them with their knowledge of people's needs. A member of staff told us that all staff, including agency staff, sit and read through the care plans before they started to work with people.

Each person who lived at the home had a key worker (known in the home as a 'link worker). This person was responsible for recording and, along with a senior manager, updating the person's care files to ensure care plans reflected the person's current needs. People who lived at the home knew who their key workers were. One person told us, "[Name of worker] is my key worker. He writes down what you've been doing."

We were present at the staff 'handover' meeting, where the outgoing morning workers, handed over information to the incoming afternoon shift. This meeting provided comprehensive information to staff about the activities and support needs of people during the morning, and what, if necessary, they needed to follow up during their forthcoming shift. At the handover meeting, staff were allocated to people who required individual, or two members of staff for support. A member of staff confirmed that allocation was based on the experience and knowledge of the staff member to ensure they could respond to people well.

People were involved in planning their care and support. They told us they were involved in making day to day decisions, and when possible, decisions for activities such as trips out of the home. People who lived in the home also took part in monthly 'residents' meetings, the minutes of which demonstrated that people had an active say in how they wanted to live their lives. Meetings included discussions about activities people wanted to take part in, concerns or complaints they had, a reminder of what safeguarding meant, health and safety, and discussion about key workers.

During our inspection we saw people treated with respect. Staff listened to what people had to say, and responded to them respectfully. We asked staff how they supported people with personal care to ensure people's dignity was maintained. One member of staff told us they joked with a person whilst personal care was provided as the person found it less embarrassing if they had a laugh and a joke at the same time. They also told us the person maintained their dignity by doing as much of their personal care as they could for themselves.

The Provider Information Return informed us that some staff were 'Dignity Champions' and all staff were trained in the dignity charter. It told us that staff discussed examples of good practice during team hand-overs and staff meetings. Staff were also provided with training on human rights, and equality and diversity policies which were discussed and re-capped during staff meetings and supervisions. Women who lived at the home were provided with personal support from female staff to protect their privacy and dignity.

People were supported and encouraged to maintain relationships with people who were important to them; and visitors were welcomed at the home. Visiting times had been decided by people who lived at the home. They had decided they would not normally want visitors before 10am and after 9.30pm.

Good

Is the service responsive?

Our findings

People were encouraged to tell staff what their support needs were through monthly key (link) worker meetings. A person gave us permission to attend their meeting. The meeting discussed how they were feeling, what they had achieved and any goals or aspirations they had. A written record was kept of the meeting so both the person and the member of staff could look back at the month and see whether the goals were achieved. The meeting was a two way process, where the person fully contributed to the process.

We also saw some building work had been undertaken to 'future proof' one person's living accommodation. The person's mobility was changing, and their accommodation had been redesigned in response to their changing needs and to provide more space if, or when, the person required additional aids to support them.

People were supported to follow their interests, take part in social activities and in educational opportunities. People had activity diaries. One person told us they went shopping on a Thursday and liked to go to the pub on Tuesdays to have a drink of beer, a packet of crisps and a game of pool. Another person told us they liked to go the resource centre (owned by the provider). They told us they had recently made a chicken wrap in a cooking skills class. On the day of our visit, one person had been to the resource centre and learned IT skills. One person told us they enjoyed going out on long walks. Staff supported this person to do so safely.

Within the home, there were other activities available. One person enjoyed playing the guitar and listening to other people who played the guitar. Staff who could play, supported this enjoyment by playing the guitar when they were on duty. Staff helped people with cooking skills, and played board games, undertook arts and crafts with people, and supported people to do aerobics in the home and played badminton in the garden when the weather was fine. One person showed us their book of crosswords, an activity they liked to do in the home.

The Provider Information Return told us that as a consequence of the link working, they had identified with a person that they wanted to go swimming. They had put positive risk management plans in place and the person was now able to swim. The person had been swimming on the day of our visit.

Both staff and people told us they used to enjoy going on holidays. One person told us they had been to Spain. They told us they would like to go again, but there was not enough money for them to do this now. Staff told us they would like people to have the opportunity to go away on holiday but the funding was not there.

People were encouraged to be open about concerns or complaints. They were invited to share concerns at link meetings and in resident meetings. There was also information on the notice board in the home's hallway to inform people of how they could complain. This was in a format which made it easier for people to read and understand.

We saw three complaints had been logged. One was a formal complaint from a relative, and two were

informal concerns raised by people who lived at the home. All had been taken seriously, investigated and responded to appropriately. None were substantiated; however measures were put in place to reduce people's concerns. For example, one part of the formal complaint was that a relative thought the person's room was too cold. A thermometer had been placed in the room to check that the room temperature was maintained at 20C, the temperature the person wanted.

Good

Is the service well-led?

Our findings

Cherre Residential Care had a registered manager. The registered manager had been in post for three years. The registered manager had started work in the company as an apprentice and had worked their way up to the role of registered manager. They felt this was important because they could understand how to support staff effectively having worked in the same positions as them. A person told us the registered manager was a "Good person."

The registered manager was provided with good support from the provider and area manager. The provider was also a registered manager of another service nearby, and they worked closely to ensure both services were well supported. All three managers we spoke with during the visit had a high level of understanding of the needs of people who lived in the home, and a desire to provide a good service and quality of life for people in their care.

During our visit we saw the shift managers ran their shifts well. They knew what was expected of them, and their roles and responsibilities. One of the shift managers told us, "We do a walk through to ensure everything is in place…. We check food is labelled and wrapped, and we check medication to make sure there are no missing signatures."

The registered manager encouraged open communication with people, staff and visitors. We saw people felt able to talk directly with the manager and talk to them about their concerns. Staff we spoke with felt supported by the registered manager. One staff member told us the registered manager was, "Really good. If we every have any problems she'll support you the best way she can. She treats everyone fairly." Another said, "We get support from management. There is an open door policy. It works. We always get feedback."

We saw the registered manager demonstrate their management skills during our visit. At handover they noted that a member of staff had wrongly completed some hand over information. The member of staff was new to the organisation. Later in the day, the manager discussed the issue with the staff member in a short individual meeting. This meant the staff member learned quickly what the expectations were, but learned this discreetly.

All staff we spoke with told us they enjoyed working at the home and felt they worked well as a team. There were regular team meetings. Staff told us they felt able to contribute to the agenda and to discuss issues at the meetings. One member of staff told us if they were not able to make the meeting because they were not on shift, they could put their opinions in writing so they could be expressed at the meeting.

We saw from the Provider Information Return, and from speaking with staff that, whilst there was a core group of staff, there had been a lot of staff changes in the previous 12 months. The registered manager told us there was no trend as to why staff had left. We had been told that staff only received their work rota for the following week, two days before they started the rota. We asked if this had impacted on staff leaving or on staff sickness. The registered manager told us they had tried having fixed rotas but this had led to other difficulties, and they were satisfied that the current rota planning was sufficient.

The provider had a number of checks in place to ensure the quality of service and safety of people who lived at the home. These included regular checks of people's finances, staff training, medication, maintenance, and fire safety. Each month senior management visited the home and as part of their audits, they spoke with people who lived at the home to check people were satisfied with the care and support they received.