Christchurch Court Limited

Christchurch Court - 4 Christchurch Road

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Good**

Summary of findings

Overall summary

This unannounced inspection took place on the 4 October 2016. This service provides accommodation and personal care for up to 17 people who require neurological rehabilitation resulting from injury, illness or disease. At the time of our inspection there were 10 people living at the home.

Following our inspection in July 2016 the service was rated as 'Inadequate' in one area and overall requires improvement due to concerns about the safety and well-being of the people who lived there. The Care Quality Commission placed a condition on the provider which meant that no more than 15 people could live at the home until improvements to quality and safety had been made. At the time of this inspection we found that there had been improvements in the way that the home operated and in relation to the way in which care was being provided.

The service did not have a registered manager in post. At the time of our inspection a manager had been appointed and was in the process of applying to the Care Quality Commission to become a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

There was a clear protocol in place to support new admissions into the home and to guide staff however we were unable at this inspection to assess its effectiveness because there had been no new admissions to the service since our last inspection. Rehabilitation programmes were not always reviewed in a timely manner and staff had not reported their uncertainty of care or the lack of rehabilitation to the senior management team or the multi-disciplinary team for prompt action to be taken. The provider took immediate action on our feedback.

People felt safe in the home. Staff understood the need to protect people from harm and knew what action they should take if they had any concerns. Staffing levels ensured that people received the support they required at the times they needed however this needed to be kept under close review as the provider begins to admit more people into the service. Recruitment procedures protected people from receiving unsafe care from care staff unsuited to the job.

Care records contained risk assessments and risk management plans to protect people from identified risks and helped to keep them safe. They gave information for staff on the identified risk and informed staff on the measures to take to minimise any risks. People were supported to take their medicines as prescribed and medicines were obtained, stored, administered and disposed of safely.

People received care from staff that were supported to carry out their roles to meet the assessed needs of people living at the home. Staff received training in areas that enabled them to understand and meet the care needs of each person and people were actively involved in decisions about their care and support

needs. There were formal systems in place to assess people's capacity for decision making under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). People were supported to maintain good health and had access to healthcare services when they were needed.

People received care from compassionate and supportive staff and people and staff had positive relationships with each other. Staff understood the needs of the people they supported and used the information they had about people to engage them in meaningful conversations. People were supported to make their own choices and when they needed additional support people's relatives were also consulted.

Care plans were up to date and reflected people's current assessed needs and focussed on giving people choices and opportunities to receive their care how they liked it to be. They detailed how people wished to be supported and people were fully involved in making decisions about their care. People were able to choose where they spent their time and what they did. People were able to raise complaints and they were investigated and resolved promptly.

People and staff were gaining confidence in the new management structure of the home and felt listened to and supported. People were able to provide feedback and this was acted on and improvements were made. The service had audits and quality monitoring systems in place And identified actions were taken in a timely manner. Policies and procedures were in place which reflected the care provided at the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was making improvements to be rated good in safe; the rating reflects that more time is required to evidence sustainability of the improvements made.

There were enough staff deployed to meet people's needs and keep them safe and administer medicine.

People felt safe and comfortable in the house and staff were clear on their roles and responsibilities to safeguard them.

Risk assessments were in place and were managed in a way which enabled people to be as independent as possible and receive safe support.

Is the service effective?

Good

This service was effective.

Staff received adequate support, supervision and direction to carry out their roles.

People were actively involved in decisions about their care and support needs and how they spent their day. Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People's physical and mental health needs were kept under regular review. People were supported to access relevant health and social care professionals to ensure they receive the care, support and treatment that they needed.

Is the service caring?

Good

This service was caring.

People were encouraged to make decisions about how their support was provided and their privacy and dignity were protected and promoted.

There were positive interactions between people living at the house and staff. People were happy with the support they

received from the staff.

Staff had a good understanding of people's needs and preferences and these were respected and accommodated by staff.

Is the service responsive?

Requires Improvement

This service was not always responsive.

The provider's assessment and admission process was not assessed.

Rehabilitation programmes were not always carried out or reviewed in a timely manner.

People were listened to, their views were acknowledged and acted upon and care and support was delivered in the way that people chose and preferred.

People living at the home and their relatives knew how to raise a concern or make a complaint. There was a transparent complaints system in place and concerns were responded to appropriately.

Is the service well-led?

Good

A manager was in post and was in the process of applying to the Care Quality Commission to become a registered manager.

The provider had taken immediate action since the last inspection and had made many positive changes within the service.

People, relatives and staff were encouraged to provide feedback about the service and it was used to drive improvement.

Quality assurance systems were in place to monitor and improve the quality of care people received.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We inspected the service on 4 October 2016. The inspection was unannounced. This full comprehensive inspection was undertaken to ascertain the improvements made by the provider following our findings from our previous full comprehensive inspection in July 2016.

This inspection was completed by one inspector. Before the inspection we reviewed the information we held about the service, including statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We also contacted health and social care commissioners who place and monitor the care of people living in the home.

During our inspection we spoke with four people who used the service and ten members of staff including four members of care staff, a therapy assistant, a team co-ordinator, a team leader, a member of catering staff, the deputy home manager and a visiting manager from another service.

We looked at care plan documentation relating to four people and medication administration documentation. We also looked at other information related to the running and quality of the service. This included quality assurance audits, maintenance schedules, training information for care staff, staff duty rotas and arrangements for managing complaints.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in July 2016 we found that staffing arrangements were not able to meet the needs of people living in the home and there was not always staff available in the home overnight to administer medicine if it was required. During this inspection we found that the provider had made improvements in these areas; however the rating reflects that it will take time to see these improvements embedded in practice and the areas of improvement sustained.

During our inspection we saw that the provider used a variety of tools to assess the dependency of people living in the home and to establish the level of staff required to support their needs. In addition to the care and managerial staff available, a team of therapists and specialist staff worked with people to support their specific rehabilitation pathway.

People living in the home felt that there was sufficient care and therapy staff available; they told us that they were happy with the staffing arrangements in place. We saw that there was still a high level use of agency staff working in the service which the provider was hoping to reduce when the recruitment was completed. Care staff consistently told us that with the current number of people using the service they felt there was enough staff to meet their needs. One care staff said "Right now we can meet people's needs; we have enough staff to support people and make sure people can go out in the community." However, care staff also expressed their concern that when the numbers of people living at the home increased, whether there would be enough staff to meet people's needs. We spoke with the deputy manager about care staff's concerns and we were informed that staffing levels would increase as people were admitted to the home to ensure people's needs were met. Staffing levels will required to be continually reviewed as new people move in to the home to ensure dependency levels are taken into account in relation to the numbers and competencies of staff deployed.

On the day of the inspection we saw that there were sufficient staffing levels to ensure that people who required supervision at meals times had their needs met; this was done in a calm and relaxed manner and the meal time experience for people was positive.

Since our last inspection in July 2016 the provider had proactively ensured that there were trained and competent staff available at the home 24 hours a day who were able to administer medicines to people. The staff rota indicated that a member of staff who was trained to administer medicines was allocated to each shift. The provider had developed a flow chart of action to be taken in the event of a short notice medicines trained staff absence; the chart clearly showed the action to be taken to ensure the service was able to continue to provide appropriate care and support 24 hours per day.

There were appropriate arrangements in place for the management of medicines. One person said, "We get our medicines at the same time each day, there's no concerns with that." We observed that people received their medication from staff in a professional and encouraging way. People were told what their medicines were for and were given reassurance when they needed it. We heard staff giving instructions to people who

required it about how to take their medicines safely. Staff had received training in the safe administration, storage and disposal of medicines and they were knowledgeable about how to safely administer medicines to people. People's medicines were stored securely and there were arrangements in place to dispose of unused medicines safely by the pharmacist.

At our last inspection in July 2016 we found people were not always supported by care staff who recognised and responded appropriately to their own concerns about neglect or omissions in people's care provision. During this inspection we found that the provider had made improvements in these areas.

All of the care staff we spoke with said that since our last inspection there had not been any situations where people were left to wait for care and support. One care staff said "At the moment it is good; we can support people when they ask us to; they don't have to wait." Another care staff said "It feels so much calmer at the moment, we are not rushing around and we can meet residents needs when they ask us to; we are using a lot of agency staff still so there are some days when it is more of a challenge." Staff told us they had learnt from their previous experiences and understood that reporting their concerns had made a difference. One care staff said "I won't ever put myself in that situation again where my concerns are not listened to; I would now go straight to [The director]." This area of staff practice requires to be monitored as part of the providers on-going oversight of the service to ensure that staffs renewed insights are translated into practice consistently.

People's needs were reviewed by staff so that risks were identified and acted upon as people's needs changed. The service used assistive technology to help reduce the risks for people; one person who was at risk of falls had a 'sensor beam' around their bed, if the person got out of bed the alarm sounded and staff were then able to support the person. Care staff said "The sensor beam is really good [the person] doesn't always wait for assistance so we're alerted straight away if they get out of bed." Staff understood the varying risks for each person and took appropriate action. For example staff offered people additional support to reduce the risk of falls such as ensuring they had secure footwear, access to walking equipment and additional staff support to stand and mobilise. Staff understood people's risk assessments and ensured people's care was in accordance with these. Staff also understood their responsibility to identify new risks, for example if people's behaviour or health changed, staff raised their concerns with senior staff and prompt action was taken to meet people's changing needs and keep people safe.

Since the last inspection in July 2016 the provider had taken the required action to ensure that the environment was fit for purpose and maintained accordingly. There had also been some renovation work completed; staff now have a larger space to prepare and administer medicines. One senior member of staff said "This room is so much better, we have room to have all of the medication records out, medication profiles and the medication; it's a big improvement." Some bedrooms had been renovated and included new soft furnishings which gave the appearance of bright spacious welcoming bedrooms. One person who was in the process of having their bedroom decorated was happy with the colour scheme they had chosen and observations showed that they were excited for the 'big reveal' when it was completed. The provider was in the process on changing the function of one room to enable it to become a staff room; the staff had been requesting a staff room for some time due to having nowhere to go when they take their scheduled breaks. All of the staff we spoke with were pleased about the changes that had been made and the future changes to include a staff room. One staff member said "In the summer it isn't too bad because we can go out of the building but in the winter it would be nice to be able to sit down and 'recharge our batteries' when we have our break."

There were appropriate recruitment practices in place. Staff employment histories were taken into account and staff backgrounds were checked with the Disclosure and Barring Service (DBS) for criminal convictions

before they were able to start work and provide care to people. This meant that people were safeguarded against the risk of being cared for by unsuitable staff. All staff confirmed that they were unable to begin working until they had received satisfactory references and background checks.

Good

Is the service effective?

Our findings

At our last inspection in July 2016 we found that not all staff received guidance, support and formal supervision they required to enable them to carry out their roles. During this inspection we found that the provider had made improvements in this area.

Staff had the guidance and support when they needed it. A senior member of staff had returned from planned leave and reinstated regular formal supervision. One member of staff told us "We have regular supervisions now, usually it's once a month. We talk about my progress and how people living here are getting on. I find it helpful." All staff also received informal support from a more cohesive management team who worked together to support the staff to carry out their roles to support people using the service with their rehabilitation programmes.

New staff received a thorough induction which included classroom based learning and shadowing experienced members of the staff team. The induction was comprehensive and was delivered in part by the multi-disciplinary team and included key topics on rehabilitation and an introduction to acquired brain injury and neurological conditions. At our last inspection in July 2016 there had been a recent dip in the level of staff training completed, however on this inspection we saw and records reconfirmed that this had taken a priority and staff had completed the required training. The deputy home manager told us that they planned to provide training to all staff in order that all staff could meet people's specific needs before new people moved in to the home. This included catheter care, epilepsy, diabetes and Percutaneous endoscopic gastrostomy (PEG) training and awareness.

People told us that staff always asked for their consent before providing any support and that they respected their personal needs and preferences. Relatives also said they had observed that staff sought consent before providing care. Staff provided examples of how they always sought consent before providing any personal care or support and this was confirmed during our observations. Individual plans of care also contained information about people's consent to care and treatment and details about their lasting power of attorney for a time when people may not have the mental capacity to make decisions themselves.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The deputy home manager and the staff team were knowledgeable and experienced in the requirements of the MCA and DoLS. Detailed assessments had been conducted to determine people's ability to make specific decisions and where appropriate DoLS authorisations had been obtained from the local authority. Senior staff had training in the MCA and DoLS and had a good understanding of people's rights regarding

choice; they carefully considered whether people had the capacity to make specific decisions in their daily lives and where they were unable, decisions were made in their best interests.

Catering staff ensured people were provided with meals that met their nutritional and cultural needs. We saw that they prepared meals to suit each person's individual needs, such as pureed food; they had access to information about people's dietary needs, their likes and dislikes. One person told us "The food is lovely, definitely no complaints from me." Pictorial menu's had been developed to assist people in making meal choices and where appropriate 'show plates' of the meals were used at meal times to support people with communication difficulties to have an informed choice.

Staff were aware of people who needed assistance and who needed prompting to eat; most people chose to eat together in the dining room which was set out so people could eat sociably. People were given the opportunity to choose from the daily menu and offered alternatives each morning. One member of catering staff said "We get to know what people like and we have a list of people's favourite food and any allergies." Records showed that people were encouraged to eat and drink regularly.

Staff assessed people's risk of not eating and drinking enough by using a Malnutrition Universal Screening Tool (MUST). Staff referred people to their GP and dietician for further guidance when they had been assessed as being at risk. Staff followed guidance from health professionals to ensure that people were able to have adequate food and drink safely. For example where people had difficulty in swallowing, staff followed the health professionals advice to provide food that had been pureed or thickened their drinks to help prevent choking. Where it was necessary, staff monitored the amount that people drank to ensure that they stayed hydrated. Appropriate equipment had been purchased to support people to eat independently. For example the 'Neater Eater' which provides support to people who have tremors while eating, this piece of equipment enables people to be independent while eating and helps to maintain their dignity.

People were supported to access appropriate healthcare services including hospital appointments, their GP, podiatrist, optician, and the provider's own team of consultants and therapists. Each person had a planned pathway of person centred rehabilitation which involved sessions with physiotherapists, occupational therapists and speech and language therapists. The provider had their own occupational therapy room on site and this was used on a daily basis. The team of specialists consisted of medicine consultants, neurologists and a range of therapists who assessed people continuously on the rehabilitation pathway and adapted people's therapy needs as people progressed.

Good

Is the service caring?

Our findings

At our last inspection in July 2016 we found that people had not been treated with dignity and respect as there was not always enough skilled and trained staff deployed in the home to meet people's needs in a timely manner. At this inspection we found that improvements had been made.

Staff told us that since the last inspection people's needs had been met in a timely manner. Staff of all grades told us that there had been no occasion when people were left waiting for their care and support. One care staff said "Everything has changed, it is calmer and we are not rushed when we are supporting people."

Staff demonstrated a good knowledge and understanding about the people they cared for. One person said "They know me pretty well and know when I'm pulling their leg – we have a nice bit of banter!" The staff showed a good understanding of people's needs and they were able to tell us about each person's individual choices and preferences. People had developed positive relationships with staff and they were able to have fun and share jokes together. We saw staff involving people in conversations about an upcoming charity event where people and staff were going to be wearing pyjamas for the day. People were encouraged to participate in conversations where they wished to.

People were involved in personalising their own bedrooms. For example, one person showed us their room which had their own personal items around that they treasured and had meaning to them including photographs and memorabilia from their lives. This person said "I love my room."

Staff understood the need to respect people's confidentiality; not to discuss issues in public or disclose information to people who did not need to know. Any information that needed to be passed on about people was placed in people's care plan or were discussed at staff handovers which were conducted in private. Staff respected people's privacy and ensured that all personal care was supported discreetly and with the doors closed. We saw that staff supported people to maintain their dignity and offered support to people to adjust their clothing when this had been compromised.

In order to help people build caring relationships with each other, each person had an identified key worker, a named member of staff. They were responsible for ensuring people had access to resources and support they required and we saw that people had good relationships not just with their keyworker but with all members of staff. One person said, "I get on well with all the staff here, I am going food shopping today with [staff member and another person living at the home], I go every week as part of my programme [rehabilitation programme]."

People were supported to access advocacy services when they required independent support. Staff understood when people would need the support of an advocate, for example if somebody had little or no family support outside of the home. Advocates regularly attended residents meetings and supported to facilitate conversations about any changes that people wanted or ideas and suggestions. We saw that people also had financial appointee's and the required documentation was in place.

Visitors, such as relatives and people's friends, were encouraged at the home and made to feel welcome. One person said, "My parents come and visit quite often, I can see them in my bedroom or I can use the flat area where I cook my meals if no-one else is in there; all the staff know them and talk with them."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in July 2016 we saw that new people were moving in to the service in quick succession and this did not give the care staff enough time to read people's care and support plans and to get to know how best to support people.

No new people have moved into the service since our last inspection so we were unable to assess the effectiveness of the admissions process. However the providers own procedure for new admissions detailed that the multi-disciplinary team (MDT) support people in the first 24 hours of admission into the home to enable a smooth transition and to undertake assessments such as moving and handling. When referrals to the service were received the MDT, consisting of consultants and therapists met with the person and carried out extensive assessments to ascertain whether the service could meet their needs. From the assessment the MDT would create a rehabilitation care pathway and detail the kind of interventions a person would require, for example, physiotherapy. We saw that there were clear documentation of this process within people's files. Senior staff complete care plans and risk assessments and the care staff are given enough time to read about peoples assessed needs and their preferred way of being supported. At this inspection we were unable to assess the effectiveness of this process because there had been no new admissions to the service.

Care plans were detailed about the risks people faced in relation to their physical and emotional circumstances. Each person's care plan was focussed on them and their individual circumstances and needs. Staff reviewed people's care plans regularly and adapted them to meet people's current needs. The service used recognised clinical outcome measures to monitor people's progress on the rehabilitation pathway.

However, at this inspection we found that not all people received all of the care that was planned for them. It was clear in one person's care plan that there were two rehabilitation exercises they required support with on a regular basis; we found that these were not happening on a regular basis. The shift leader and care staff we spoke with were unsure about one exercise and whether the person should still be completing this on a regular basis and the other daily exercise had not been completed for over a week; this was confirmed by other staff we spoke with. We gave feedback to the deputy home manager about our concerns and they took immediate action to ensure the MDT reviewed this person's rehabilitation programme and ensured all staff were clear of their responsibilities to support this person. However; we still remained concerned that there had been no oversight of this person's rehabilitation programme on a daily basis and staff at all grades had not highlighted their uncertainty or relayed their concerns about the exercises to the management.

People were involved in activities either through planned therapeutic programmes or personal choice. We saw that some people were able to go out independently and chose to visit friends or go shopping in the town centre. One person told us "I go and visit my friend often who lives nearby, it is really important to me that I can do that." On the day of our inspection a small group of people had been to the local park and other people went grocery shopping. Some people were supported to attend a day centre where they socialised with friends and learnt new skills. People told us about visits to local pubs, horse riding groups,

café's and The Rock Club; this club has been set up by four providers and provides activities for people with acquired brain injuries. There had been a recent coffee and cake morning where people who used the service were supported to bake cakes and sell them to visitors and staff with the proceeds going to charity. The amount collected on the day was proudly presented on the notice board. Activities were also based on rehabilitation, for example planning, shopping and cooking a meal and managing finances.

A complaints procedure was in place which explained what people or their relatives could do if they were unhappy about any aspect of the home. One person said, "I love it here, I've got no complaints but I'd just tell them if I did." Staff were responsive and aware of their responsibility to identify if people were unhappy with anything within the home and understood how they could support people to make a complaint. One member of staff said, "I'd support people to make a complaint, in whatever way they wanted to do it." Since our last inspection in July 2016 there had been no complaints received.

Good

Is the service well-led?

Our findings

At our last inspection in July 2016 we found that there was a lack of day leadership and support. At this inspection we saw that the provider had made improvements in this area. A new manager was in post and was applying to become the registered manager with the Care Quality Commission. The manager was not available on the day of our inspection; however there was another manager from another service visiting and offering support to the deputy home manager.

After the last inspection in July 2016 the provider took immediate action to address the lack of day to day leadership, guidance and support. The changes that took place were received positively from all the staff we spoke with. One care staff said "I feel like I am listened to now and I don't have that fear of coming to work like I used to have." Another member of staff said "They [The provider] made immediate changes for the better; I feel supported now and feel like I am getting my confidence back."

The provider had a governance structure in place, board meetings and meetings with the directors took place on a regular basis. The provider monitored on a monthly basis many quality assurance area's including medication errors, hospital admissions, notifiable events, complaints and other audits that were undertaken in each service and these were discussed at each board meeting.

The home had a programme of quality assurance in place to ensure people received good quality care. The service completed health and safety audits, medication audits and completed monthly monitoring of falls and accidents and incidents to ensure appropriate action was taken to prevent any unavoidable incidents.

The provider had a staff recognition in place which included 'Superstar Awards' which is focussed on recognising individual excellence across all of the providers services, there was also an employee of the month award which people using the service and other staff were able to vote for and the winner each month was displayed on the notice board in the hallway.

As a result from a staff survey the provider had created a 'you said, we did' poster which evidenced what suggestions or changes the staff team contributed on what the provider had actioned. An example was; staff requested a staff room so they could take their planned breaks in a comfortable relaxing area and the provider was in the process of changing the use of room to facilitate this.

Systems were in place to encourage people, visitors and staff to provide feedback about the home and the quality of care people received. In addition to the regular meetings people had about their care, people were encouraged to feedback about the quality of food after meals and comment cards had been developed for people to provide feedback at any time they wished to. The comment cards were new and at the time of the inspection there hadn't been any completed by people using the service. There had been a recent quality assurance survey which people using the service had completed and feedback was positive and people felt fully involved in planning their own care. Where people had comments about area's that required redecoration we saw that the provider had taken action.

The home had policies and procedures in place which covered all aspects relevant to operating a care home which included safeguarding and recruitment procedures. The policies and procedures were detailed and provided guidance for staff. Staff had access to the policies and procedures whenever they were required and staff were expected to read and understand them as part of their role. The registered manager had submitted appropriate notifications to the Care Quality Commission when required, for example, as a result of safeguarding concerns.