HC-One Limited

Chorlton Place Nursing Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

Chorlton Place is a purpose built nursing and residential home for up to 48 older people, many of whom were living with dementia. The residential unit on the ground floor had 24 bedrooms, with a further 24 bedrooms in the nursing unit on the first floor. At the time of our inspection 47 people were living at Chorlton Place.

Rating at last inspection.

At the last inspection in January 2015, the service was rated as Good.

Rating at this inspection

At this inspection we found the service remained Good, with the safe domain rated as Requires Improvement.

Why the service is rated Good.

People said they felt safe living at Chorlton Place. Staff received training and information to meet people's health and social care needs. Risks assessments were in place to guide staff to provide safe support. However we found the scores for one person's risk assessments had not been calculated accurately, however appropriate support plans were in place to mitigate the risks and a referral was being made to the Speech and Language Team (SALT) with regard to the person's risk of choking. Care plans were in place for each individual detailing people's health and social care needs. The care plans were regularly reviewed.

A system was in place to recruit staff who were suitable to work with vulnerable people. A reference from one staff member's last employer had not been obtained. This was requested during our inspection.

The home had recruited a new handyman who was due to start work the week after our inspection. Since December 2016 a handyman from another service had worked at the home whenever possible. However they had not been able to complete all the weekly fire and safety checks, which had been done monthly instead.

Medicines were administered as prescribed. Body maps for where creams were to be applied were completed for the first floor during our inspection. Health professionals were positive about the service, with the GP visiting the home twice each week.

Infection control procedures were in place. These enabled the staff team to safely support one person who had Methicillin-resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (CDif).

People and relatives we spoke with were positive about the home and the staff team. There were sufficient

staff on duty to meet people's needs, although staff were busy, especially in the morning. Staff knew people's needs and how to support them.

Staff were supported by the registered manager through regular supervisions and team meetings. Staff said they enjoyed working at the service and that the registered manager, deputy manager and residential unit manager were very approachable.

Where applicable capacity assessments were completed and the service was working within the principles of the Mental Capacity Act (2005).

People's health and nutritional needs were met by the service. Referrals to medical professionals were appropriately made and any guidance provided was followed. People and relatives told us the food was good and they had a choice of meals.

Staff encouraged people to maintain their independence, with some people able to access the local community on their own. Staff explained how they maintained people's privacy and dignity when supporting them.

People were supported to make decisions about their wishes at the end of their lives. Support was provided for people who wanted to stay at Chorlton House at the end of their lives.

People and relatives were able to provide feedback on the service provided through regular residents and relatives meetings and annual surveys.

Two part time activities officers had been appointed and a programme of activities was in place, which people said they enjoyed.

The registered manager had a comprehensive system of quality assurance and audits in place. A monthly report was used to monitor any trends in key indicators for the service. The provider's area manager completed a monthly audit of the service. Any actions identified were recorded and noted when completed.

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?

Requires Improvement

The service was not always safe.

Care records included information about the risks people may face and guidelines for staff in how to minimise or eliminate the risks. However some risk assessment scores had not been calculated or added up correctly.

Weekly checks of the fire alarm and exit door sensors had only been completed on a monthly basis since the handyman had left the service in December 2016. A new handyman was due to start work the week after our inspection.

Medication was administered as prescribed. Body maps for creams were put in place during our inspection on the first floor.

A system of staff recruitment was in place. However, one of the four files we looked at did not contain a reference from the staff members last employer.

Staff had received training in safeguarding vulnerable adults and knew the correct action to take if they witness or suspect abuse.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The service remains Good.

Chorlton Place Nursing Home

Detailed findings

Background to this inspection

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

This inspection took place on 16, 17 and 18 May 2017 and was unannounced. The inspection team consisted of one adult social care inspector and an expert-by-experience on the first day of the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of services for older people. The inspector returned for the second and third days of the inspection.

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. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.
We contacted the local authority commissioning and safeguarding teams as well as the local Healthwatch board. No one raised any concerns about Chorlton Place.

During the inspection we observed interactions between staff and people who used the service. As some people were not able to tell us about their experiences, we used the Short Observational Framework for Inspection (SOFI) during the lunch period in the lounge areas of the home. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with six people, three relatives, the registered manager, the deputy manager, the ground floor unit

manager and seven care staff. We observed the way people were supported in communal areas and looked at records relating to the service. This included four care records, four staff recruitment files, daily record notes, medication administration records (MAR), maintenance records, audits on health and safety, accidents and incidents, policies and procedures and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

People we spoke with said they felt safe living at Chorlton Place. Comments we received included, "I feel safe because there is always someone around; you are never left on your own completely" and "Yes, I feel safe here." Relatives we spoke with also thought their loved ones were safe living at the service.

We saw that suitable arrangements were in place to help safeguard people who used the service from abuse. The training records we saw showed that staff had undertaken training in safeguarding vulnerable adults. The staff members we spoke with confirmed this and were able to explain the correct action they would take if they witnessed or suspected any abuse taking place. They told us that they would inform the senior care staff member or nurse on duty, the unit manager, deputy manager or the registered manager. We saw the service had appropriate safeguarding and whistleblowing policies in place to support the staff in providing safe care.

We looked at the way the service identified and managed any risks for the people living at the home. We saw risk assessments were in place for each person, for example for falls, nutrition using the Malnutrition Universal Screening Tool (MUST) and pressure area care. Where appropriate there was a manual handling risk assessment. The risk assessments gave staff guidance to manage potential risks.

The risk assessments used by the service calculated the overall risk by multiplying the likelihood an event will occur with the severity of any potential harm if the event does occur. We found that this calculation for one person's risk assessment for oxygen therapy had not been calculated correctly. The choking risk assessment in use at the home has scores for different criteria. The total score of all the criteria indicated the overall risk of choking. The scores for the same person as above had not been added up correctly resulting in a lower total than there should have been. The risk assessment did state a referral to the Speech and Language Team (SALT) was to be made even though the score had not been added up correctly. This meant the actual risks to the person were underplayed by the risk assessment score. The calculations and scores we saw in the other care files we looked had been calculated correctly.

We discussed this with the registered manager who asked the deputy manager and unit manager to check all the care files to ensure the risk assessment scores had been correctly calculated.

We looked at the recruitment files for four members of staff. We found they contained application forms with employment histories and the reasons for any gaps in employment were explained. Appropriate checks had been made with the disclosure and barring service (DBS). The DBS checks to ensure that the person is suitable to work with vulnerable people. We saw checks were made with the Nursing and Midwifery Council to ensure any nurses employed were appropriately registered. Each file contained two references. However one staff member's references were not from their last employer but were from other previous employers. The service's policy states one reference will be obtained from the last employer. We spoke with the registered manager about this and they immediately requested a reference from the staff member's last employer. The other three staff files contained a reference from their last employer.

This meant the service had a recruitment system in place to protect people from unsuitable staff being recruited, however it had not been fully followed for one of the staff members we checked.

The registered manager showed us that disciplinary procedures had been recently followed for one member of the night staff which resulted in their dismissal as they had been found to be asleep when on duty. This meant systems were in place when staff did not meet the standards of care and behaviour expected by the service.

We were told that the home had not had a handyman since December 2016. A handyman from another of the providers' homes had visited the service when they were able to. We saw that the home was in a good state of repair. However fire alarm tests, fire extinguisher checks and exit door sensor checks had been completed on a monthly basis rather than weekly as required. Daily checks made by the handyman had also been completed monthly. Other checks, for example monthly emergency lighting and laundry equipment checks had been completed as planned. This meant that not all the safety checks had been carried out as planned whilst the home did not have a handyman in place. The registered manager had arranged for some cover from another home but had not delegated the weekly checks to another staff member when the handyman was not available. This potentially put people at risk as regular checks of the safety equipment had not been made. A new handyman was due to start working at the service the week following our inspection. This would mean the regular weekly safety checks would be completed in the future.

A fire risk assessment had been completed in July 2016 by an external contractor. All actions noted in the report had been implemented. Records showed the equipment within the home had been serviced and maintained in accordance with the manufacturer's instructions. This should help to ensure that people were kept safe.

We checked the systems that were in place to protect people in the event of an emergency. We found personal emergency evacuation plans (PEEPs) had been written for people who used the service. These contained details of the support a person would need to leave the building in the event of an emergency. Contact information and guidance was seen for staff to deal with any emergency situations such as a gas or water leak, however this was dated 2015. We recommend that this document is reviewed to ensure that all contact telephone numbers are still correct.

We looked at how medicines were managed at the service. On the ground floor a senior carer administered the medicines. On the first floor a registered nurse administered them. We saw the medicines administration records were fully completed. Details were recorded of how people preferred to take their medicines, for example one person wanted all the tablets to be put in their hand with water.

We saw that a stock check of five medicines was completed every day on both the ground and first floor. There were no discrepancies noted during May 2017. The quantity of medicines we checked corresponded with the amount recorded on the MAR. We were told if the quantity of tablets was found to be different to that indicated by the MAR an incident form would be completed and the GP contacted for advice.

We saw guidelines were in place for any 'as required' (PRN) or variable dose medicines. This included how the person would indicate if they required the PRN medication, either verbally or the signs staff needed to be aware of through the person's body language.

Care staff applied any topical (non-medicated) creams prescribed and signed the MAR when they had completed this. On the ground floor a clear body map indicated where the creams needed to be applied. However body maps were not in place on the first floor. We were told that a previous area director had told

the home to remove the body maps. They had been re-introduced on the ground floor and the deputy manager had the body maps ready to complete for the first floor. They had been completed by the last day of our inspection.

This meant people received their medicines as prescribed.

Medicines classed as controlled drugs were appropriately stored and recorded. A stock check was completed at every handover. This minimised the risk of errors or misuse.

We saw one person had Methicillin-resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (CDif). Information for the staff was contained within the person's care file. This included what MRSA and CDif are and how staff should support people safely so they did not contract the conditions or spread them to other people living at the service. Staff we spoke with, including the domestic staff, were fully aware of the procedures in place. These were to always use personal protective equipment (PPE) such as gloves and aprons. All the person's laundry was bagged, kept separate from other laundry and washed on its own. The bedroom was thoroughly cleaned each day. This meant staff and other people were living at the service were kept safe from contracting MRSA or CDif.

From the rotas we saw on the ground floor there were one senior care staff and two care staff on duty throughout the day and one senior and one care staff at night. On the first floor there were one nurse and four care staff during the day and one nurse and two care staff at night. People and relatives told us they thought there were enough staff on duty, although they were very busy. We saw the staff were busy first thing in the morning when people were getting up and having breakfast. On four days a week the activities officers assisted people with breakfast which allowed the care staff to support people to get up. We noted during our inspection that call bells were responded to quickly, although two people told us they sometimes had to wait longer for staff to respond at night or when agency staff were working. When agency staff were required to cover the rota the service requested the same agency staff wherever possible so they had some knowledge of the home and the people living there. The registered manager told us that a dependency tool was used to determine how many staff were required, however they did have some flexibility to alter the staff levels to reflect any changes in people's needs, for example if someone required additional end of life care. This meant there were enough staff on duty to meet people's needs.

Incidents and accidents were recorded and 48 hour monitoring following an incident or fall was completed. All incidents and accidents were reviewed by the manager. We saw the incident forms contained full details of what had occurred and what action had been taken by the staff. A monthly summary of all incidents was produced, including any actions taken, for example referrals to the falls team, so the manager could monitor any patterns or repeated issues. Risk assessments were reviewed following an incident or fall. This meant the staff had an overview of accidents and incidents and steps were put in place to reduce the likelihood of them re-occurring.

We saw that the home was clean and tidy throughout, with no mal-odour present. Our observations during the inspection showed that staff used personal protective equipment (PPE) such as gloves and aprons appropriately when carrying out tasks. The service completed an internal infection control audit every three months. We saw that any actions identified in the audits had been addressed.

Good

Is the service effective?

Our findings

All the people and staff we spoke with said the staff knew their needs well. One relative said, "They (the staff) are great with mum." Staff were able to tell us about different people's needs and the support they required, for example people who required thickeners in their drinks to reduce the risk of choking.

Staff received regular training and were up to date with their on-line refresher courses. A 'Hearts and Minds' course had been introduced. This was four separate on line courses covering dementia, dignity, choice and person centred care. This was followed by a face to face session to re-enforce what the staff had learnt. An additional taught course on falls had also been arranged to augment the on line training staff had completed.

New staff undertook an induction, including completing the training courses and shadowing an experienced member of staff so they could get to know people and their support needs. If the new staff member had not worked in care before they were enrolled on the care certificate, which is a nationally recognised set of standards that health and social care workers adhere to in their daily working life.

The registered manager completed quarterly supervisions with all staff. Staff told us they were able to make suggestions and raise any issues they wanted to during their supervisions.

Staff received a handover at the start of each shift. They were provided with verbal and written information about the support needs of people who were moving to the service. Each person had a one page profile in their care files with key points on their likes / dislikes and needs. This meant staff had the skills, support and information to meet people's needs effectively.

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 Mental Capacity Act (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We found Chorlton Place was working within the principles of the MCA. A capacity assessment was completed for people who were thought to lack capacity and DoLS applications were made when appropriate.

People told us they enjoyed the food at the home. People's weights were monitored and appropriate action taken if people were losing weight. Referrals were made to the Speech and Language Team (SALT) or dietician when required. The chef was aware of people's dietary needs. Halal meals were provided to meet people's cultural needs. The latest environmental health inspection in July 2016 had awarded the service a 5 (Very Good) rating.

A GP from the local surgery had scheduled visits to the home twice a week. All the health professionals we spoke with were very positive about the home and the support people received to maintain their health. One said, "The staff always have the information we need available and know the residents well" and another told us, "They always follow any guidance they are given."

Good

Is the service caring?

Our findings

All the people, relatives and health professionals we spoke with were positive about the staff working at the service. People said, "The staff are lovely and friendly. I'm very happy" and, "The staff know what I like." A relative told us, "The staff are fantastic."

Staff knew people and their needs well. We saw people, or their relatives where applicable, had been involved in agreeing the care plans. One relative said, "I helped devise [name's] care plans and the manager visited us at home before they moved in."

A 'Your Life' booklet was used to establish details of each person's life, for example their family, jobs they had done, hobbies and holidays they had enjoyed. This meant staff were able to form meaningful relationships with people. We also saw that one person had not wanted to tell staff about their life history and this decision was respected.

We saw some people were able to access the local community on their own when they wanted to. Staff explained how they encouraged and prompted people to complete some tasks, or parts of tasks, such as personal care, themselves where they were able to do so. This meant people were prompted to maintain their independence and skills where possible.

We observed and heard staff talking and re-assuring people when they were providing them with support. Staff were able to describe how they ensured people's privacy and dignity were maintained when they were supporting them.

People's confidential information was securely stored in the staff office on each floor. We saw the hand over on the first floor was held in an area outside the lounge so staff could observe if anyone got up and needed support. However this meant personal information was discussed in a communal area. We noted that on the day of our inspection no people who used the service could hear the handover.

Some people had advanced decisions in place for their wishes at the end of their lives. The local GP was involved in these discussions. People made their wishes known about where they wanted to be cared for at the end of their lives and whether they wanted any medical interventions to be made. The deputy manager had completed the Six Steps end of life training programme. The Six Steps is a recognised programme to improve end of life care within care homes. They were the lead person for writing the end of life care plans when they were required and supporting the staff team to care for people at the end of their lives.

Good

Is the service responsive?

Our findings

Each person had care plans in place which detailed their social care and health support needs. The care plans were regularly reviewed to ensure they were current.

For new people moving to the service an initial assessment was completed by the registered manager. This was made available for staff before they moved in and a verbal handover was also provided. The detailed care plans were then written as staff got to know the person better. This meant the staff had the information they required to meet people's needs.

We saw that both floors had a 'resident of the day' each day. This meant the person's care plans and risk assessments were reviewed and staff spent time with them asking them about the service, for example the food they liked. This meant the service sought feedback from people about the support they received.

Records were kept of the support provided, for example personal care, food and fluid charts and daily logs.

Two part time activities officers had recently been appointed. They had developed a programme of activities throughout the week. This included some external entertainers, such as singers and a session for chair exercises. They also described how they spent time on a 1:1 basis with people who were nursed in bed and were not able to join in the communal activities.

The service had a complaints policy in place. We saw not many complaints had been made. Those that had been raised were recorded and any investigation and the outcome noted. The registered manager said they encouraged people who used the service and their relatives to raise any issues they had with them straight away so they could be dealt with. People and relatives we spoke with said they would raise any issues they had with the staff or registered manager and they were then dealt with.

Annual surveys for the people living at Chorlton Place and their relatives were conducted. We saw the vast majority of returns from the July 2016 survey were positive. A food survey was also completed each year. Professionals were also asked for their feedback annually. Separate residents and relatives meetings were held, although the relatives' meeting was not very well attended. This meant the service sought the views of people and their relatives about the service.

Good

Is the service well-led?

Our findings

The service had a registered manager in post as required by their registration with the Care Quality Commission (CQC). 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 was supported by a deputy manager and a unit manager for the ground floor residential unit. The deputy manager only had six hours per week supernumerary to the rota.

We saw there was a system of audits and quality checks made by the registered manager, deputy manager and senior care staff. These included medication, care plan, health and safety and mattress audits. Daily walk rounds of the home were completed by the senior member of staff on duty.

The provider's area director completed a monthly audit of the service. Any issues identified were addressed through a written action plan. We noted that six months ago the area manager had identified that not all audits were up to date. We saw that they were all now being completed.

A monthly report was available for 'Key Clinical Indicators' for the home. This summarised any falls, bed rails, incidents, pressure ulcers, infections and hospital admissions by person and overall for the home. The registered manager said this enabled them to monitor any trends and ensure care plans were updated and appropriate referrals had been made.

This meant the registered manager had a system in place to monitor and improve the service.

Staff we spoke with were positive about working at Chorlton Place and their roles. They said the management team were open and approachable and they were able to raise any issues or concerns with them. Regular staff meetings were held; staff said they were able to raise any issues they wanted to during the meetings.

Services providing regulated activities have a statutory duty to report certain incidents and accident to the Care Quality Commission (CQC). We checked our records and looked at records during the inspection and found that all events had been notified to us as required.