Nottinghamshire County Council

Church Street Care Home

Inspection report

84 Church Street
Eastwood
Nottinghamshire
NG16 3HS

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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

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

Church Street Care Home is in Eastwood, Nottinghamshire and is registered for eight places. It provides care for people with a learning disability and/or autism. There were six people living there at the time of our inspection. Accommodation is provided on two floors and there is access to a small outside space. The care service has been developed and designed in line with the values that underpin the Registering the Right Support and other best practice guidance. These values include choice, promotion of independence and inclusion. People with learning disabilities and autism using the service can live as ordinary a life as any citizen.

At our last inspection in August 2016, we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Processes were in place to protect people from abuse and avoidable harm. Staff completed risk assessments and reviewed them regularly to ensure risks to people's health and safety were identified and managed, while avoiding unnecessary restrictions to people's freedom. Incidents and accidents were reported, investigated and action was taken to minimise the risk of similar incidents occurring in the future.

Staffing levels were planned to ensure the required care and support could be provided and staff were organised and deployed effectively. Medicines were managed and administered safely.

The premises and environment were well maintained and the required safety checks were completed. Infection prevention and control was effectively managed.

People's care and support needs were assessed and care was effective; resulting in positive outcomes for people. Staff had good access to training and development, supervision and appraisal. Staff worked well with other professionals to ensure people had access to healthcare support as needed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. Staff gained people's consent to care and support and when people lacked capacity to make a decision, the principles of the Mental Capacity Act (2005) were followed.

People participated in a range of activities according to their individual choices and preferences within the home and in the community. They were encouraged to develop independent living skills and live life to the full. Staff understood the importance of this for people and provided the structured support people

required. This enabled people to achieve positive outcomes and promoted a good quality of life.

Relatives praised staff for their kind and caring approach. Although people were unable to fully express themselves verbally, they showed by their actions they were relaxed and happy with staff. People were treated with dignity and respect by staff, who provided positive support and encouragement.

Staff provided person centred care and had an in-depth knowledge of the people they cared for. They engaged in a wide range of activities based on their personal choices. People were treated equally, without discrimination and information was presented to them in a way they could understand.

The service continued to be well led. The registered manager demonstrated excellent leadership skills and was committed to continuous quality improvement. The service was person centred and focused on providing as many opportunities for people as possible. People were involved in the development of the service. Quality audits were undertaken to monitor and improve the quality of the service provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good	**Good**
Is the service effective? The service remains Good	**Good**
Is the service caring? The service remains Good	**Good**
Is the service responsive? The service remains Good	**Good**
Is the service well-led? The service remains Good	**Good**

Church Street Care 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 was a comprehensive inspection. The inspection took place on 11 January 2019 and was unannounced.

The inspection team consisted of one inspector. Before the inspection, we reviewed information the provider sent us in the Provider Information Return. This is information we require providers to send to us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we held about the home including notifications they had sent us. These are events that happen in the service that the provider is required to tell us about. We considered the last inspection report and information that had been sent to us by other agencies.

During the inspection, we spoke with two people who used the service and two relatives, to obtain their views about the service they or their family member received. We spoke with the registered manager, the assistant manager and three care staff. We also spoke with a visiting community healthcare professional.

We observed staff providing support to people in the communal areas of the service. This was so we could understand people's experiences. By observing the care received, we could determine whether or not they were comfortable with the support they were provided with.

We reviewed a range of records about people's care and how the service was managed. This included looking at two people's care records and associated documents. We reviewed records of meetings, staff rotas and staff training records. We also reviewed the quality assurance audits the management team had completed.

Good

Is the service safe?

Our findings

People's relatives told us they felt their family member was safe at the service. A relative said, "100% there are lots of staff and (family member) is very happy." Staff were aware of the actions they needed to take to support people and keep them safe from avoidable harm.

The registered manager was aware of their responsibility for safeguarding people from abuse. Staff were aware of the signs of abuse and the importance of observing changes in people's behaviours when they may not be able to communicate their feelings verbally. They told us they would report any concerns to the management team and they were confident concerns would be listened to and addressed.

Staff assessed risks to people's health and safety, so they were supported to stay safe while not unnecessarily restricting their freedom. A relative commented on the wide range of activities their family member had access to and said, "They are as adventurous as they can be, without putting (family member) at risk. They are far more independent than when they were at home with us." People's care records contained detailed risk assessments to ensure staff understood the person's behaviour and cared for the person in a way that kept them safe during day to day activities.

Where people experienced behaviours that may challenge others, staff knew how to respond to help alleviate any distress or risk of injury to the person or others. Risk assessments detailed an immediate appropriate person-centred response to the situation and further strategies to minimise the risks.

Staff completed incident forms when incidents and accidents occurred and the registered manager reviewed these, kept a log of all incidents and completed a post incident analysis to identify learning from them.

Staffing levels were calculated according to people's needs. There were enough staff to support people safely and to ensure people's needs could be met, including providing staff support for participating in activities and outings. For example, on the day of the inspection, two additional staff were allocated to take a person out for most of the day. A member of staff said, "The (registered) manager likes two staff to go with (the person) in case something unexpected occurs. That way we know we are always safe and the person benefits."

Safe recruitment practices were followed to ensure staff were suitable to work with vulnerable people and those with complex needs. These practices included criminal record checks, obtaining a sufficient number of references from previous employers and proof of identity.

Medicines were stored and managed safely. Detailed information was available for staff about each person's medicines, how they preferred to take their medicines and any allergies they had. People's medicines records also contained a photograph of the person to aid identification and prevent misadministration. We observed some crossing out, on one medicines administration record which the registered manager told us had been identified during their most recent medicines audit and was being addressed with the staff

concerned. The county council medicines policy was displayed for staff. Staff received medicines administration training and had their competency checked regularly. Audits of medicines management were completed routinely to ensure standards were maintained.

The premises and equipment were maintained to ensure people's safety and the required safety checks were completed regularly. Personal emergency evacuation plans were in place to inform emergency services of the support people required in the event of an emergency evacuation of the building. Processes were in place for the prevention and control of infection. Staff were clear about their responsibilities to maintain cleanliness and the actions they needed to take to prevent the spread of infection.

Good

Is the service effective?

Our findings

The provider supported staff to deliver care based on best practice, by ensuring they had access to up to date policies and guidance. Staff completed comprehensive assessments of people's care and support needs and from these developed detailed care plans. They ensured their assessments and care plans were regularly reviewed. People's protected characteristics under the Equalities Act 2010 were identified as part of their needs assessments and care plans reflected these.

Staff were very knowledgeable about people's individual care and support needs and told us they felt they received sufficient training to enable them to provide effective care. Staff were provided with a thorough induction and time to familiarise themselves with people's care plans, followed by shadowing more experienced staff members, before providing support independently. Staff had access to training and the registered manager monitored staff completion of training including when additional training or updates were due. We saw that the training requirements for the current year were identified to ensure that training was booked when required. Staff told us of additional training they had accessed and how they had used the knowledge gained to inform their practice. Staff were provided with regular supervision.

People had a health action plan that gave an overview of people's healthcare needs. Information was recorded about appointments to see healthcare professionals, which showed concerns were acted on and treatment guidance was available to staff. People accessed community services such as a podiatrist, dentist and continence services. Staff promoted people's independence through participation in activities within the service such as food preparation, baking, or taking their clothes to the laundry. When appropriate they set goals to maintain and improve their health and mobility, such as walking a specific distance each day.

The environment was accessible, comfortable and decorated with photos that showed people participating in activities and examples of arts and crafts completed by people. It provided a homely environment, while being adapted to support people's mobility needs.

People were able to choose what they wanted to eat and drink. We observed people were supported to choose their breakfast and staff explained the different ways they used to determine people's preferences, when they could not verbalise their wishes. A member of staff had developed a pictorial menu plan and clear pictures of each meal, with detailed instructions for staff as to how each meal should be prepared and any precautions in relation to meet the needs of each person. Staff monitored people's eating and drinking and maintained a record of their weight. When people had difficulties in eating or swallowing, they sought advice from a dietitian or speech and language therapist.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 make 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of

Liberty Safeguards (DoLS). We checked that the principles of the MCA and DoLS were followed and we found they were. Staff had a good understanding of the principles, and people were supported wherever possible to make their own decisions. When people could not make a decision, staff completed a mental capacity assessments and the best interest decision making process was followed. DoLS authorisations had been gained when required.

Good

Is the service caring?

Our findings

People told us they liked living at Church Street and they were happy there. Staff were kind and caring in their approach. A relative said, "All the staff are very caring; I would be able to tell through their communication if my (family member) wasn't happy." They went on to say, "When they go out with us, they are always very happy to go back (to Church Street)." Another relative said, "Staff are very good; (family member) enjoys the banter and it is lovely to see the relationships they have with the staff." A relative spoke about staff going 'above and beyond' and said when they were unable to visit their family member, staff brought their family member over to them.

Staff responded sensitively to people's support needs and showed a good awareness of their individual preferences. They spoke about people with respect and showed empathy for them. We observed people were very comfortable with staff and relaxed with them. People showed pride in their appearance and the things they did. When people were admitted to hospital, staff stayed with them 24 hours a day to support and advocate for them.

People's care plans indicated how people's dignity should be protected and how they should be supported to maintain their privacy, including giving them private time in their room or other areas. People were encouraged to do what they could for themselves, including participating in cooking, cleaning or helping with their laundry.

People were supported to express their views and be involved in decision making about their care. Staff used information boards and pictures to enable people to understand and make choices. These were used in people's bedrooms and in communal areas of the service including bathrooms.

People had access to an advocacy service and an advocate visited the home at least twice a year. People were encouraged to maintain personal and family relationships. One person's close relatives lived overseas and the registered manager had purchased a tablet computer to enable the person to use the video link to speak with their relatives when they wished.

Good

Is the service responsive?

Our findings

Staff demonstrated they knew people they cared for, and their preferences in relation to their care and support, very well. People were not always able to express themselves verbally and staff were quick to respond to signs, or people's body language, that showed they needed support. We observed staff asking a person whether they wanted a shower and when they said they did and were going out afterwards, staff then checked whether the person wanted their hair washed. Staff spoke to us about activities each person particularly enjoyed, their interests and how they liked to spend their time.

Staff assessed people's care needs and care plans were developed to meet those needs. Care plans provided a good level of detail about the amount of support the person required and their personal preferences in relation to their care. They were reviewed and changed as people's needs changed. 'Pen pictures' were completed for each person to give an overview of their care needs, things that affected their behaviour and how to distract them, or respond, when they showed anxiety or aggression towards others.

The provider ensured people were protected under the Equality Act 2010 and the Accessible Information Standard which applies to people who have information or communication needs relating to a disability, impairment or sensory loss. Staff used picture card communication aids and boards to aid people's understanding and promote choice. They also used puppetry to explain issues through drama and used photographs of objects of reference. For example, safeguarding scenarios. When tree work in the grounds was planned and maintenance staff were to be on-site, staff used photographs and 'before' and 'after' pictures to explain what was going to happen. The meals each day were pictorially displayed on a menu board with place settings.

Staff had developed communication care plans that provided detailed information on how people communicated their needs and preferences. For example, one person used a recognised sign language as part of their communication and had a very limited vocabulary. Their risk assessments identified how they could become easily frustrated, anxious, or distressed and agitated, if they were not able to understand what was being communicated. Information was also provided as to how staff should respond and actions they could take to minimise the person's distress.

People participated in a wide variety of activities inside the home and externally, based on their interests. Staff identified that people enjoyed visits to local wildlife centres and farms and as a result purchased some chickens for the home. People using the service enjoyed feeding them and collecting eggs. Some people attended a day centre, and others participated in activities in the local community on a regular basis. For example, one person went swimming each week, another went to a local disco and another had a season ticket for a local football team they supported. Staff kept photo books for each person and for the home, that contained a photo diary of activities and visits each person had undertaken to help create and re-visit personal memories. We saw these included day to day activities such as a walk around the garden, baking a cake for example and external visits such as attending the dancing on ice show or a pub lunch.

Processes were in place for the timely and appropriate management of complaints. Relatives told us they

were very happy with the service provided. However, if they had a concern, they said they would speak to the registered manager and they had complete confidence it would be dealt with immediately.

There was no one receiving end of life care at the time of the inspection, however, basic end of life care plans identifying people's wishes were in place and some staff had attended training in end of life care.

Good

Is the service well-led?

Our findings

An experienced registered manager was in post. '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 aware of their responsibilities in relation to this. The ratings from out last inspection in 2016 were displayed in the front entrance to the service and on the provider's website.

The culture was open and everyone's input was listened to and valued. During our visit we found the atmosphere was friendly and relaxed. Staff were highly motivated and worked well together and supported each other.

The registered manager was well known to people using the service and their relatives. Relatives and staff praised the registered manager for their commitment to the service and their supportive and open approach. When we spoke with the registered manager they demonstrated they were continually exploring ways of improving the quality of the service provided and were proactive in ensuring it continued to meet the needs of people using the service as they became older. For example, they had recently installed hand rails at the entrance and internal corridors. They told us that, as they observed people using these, they also planned to install them along the outside paths and car park. They told us the chickens had been a tremendous hit with people, and as a result they were exploring other ways to bring other animals into the home. They were also introducing music at meal times and were developing play lists for each person.

People and their relatives were engaged in service developments. When the home was re-decorated, the registered manager obtained a variety of samples of wallpapers and people chose their favourites. Each person's door was painted in the colour of their choice. Regular meetings were held with people and we observed the minutes of the meetings were provided in accessible formats. People were encouraged to access the local community and the registered manager told us they were passionate about people with disabilities having access to people without disabilities. In addition to the opportunities they had to access community events and activities, they said they wanted to further explore how to bring the community into the home.

Staff confirmed they had regular team meetings and they were encouraged to express their views. They told us communication was very good and they were kept up to date with developments. There was a whistleblowing policy in place and staff told us they would be confident to use it if necessary.

The registered manager was a member of the registered managers skills for care group and used this forum to discuss quality development and opportunities for improvement. The service had provided work experience for two medical students a few months prior to the inspection and they had received very positive feedback from the students on the quality of their experience. The registered manager had approached the local authority to discuss further opportunities for providing work experience.

Effective systems were in place to monitor the quality of the service and the care provided. A range of quality audits were completed by the registered manager, assistant managers and provider. The registered manager had an action plan to address areas for improvement identified in the audits.