The Council of St Monica Trust

Charterhouse Care Home

Inspection report

The Chocolate Quarter
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Bristol
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11 October 2018

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 10 and 11 October 2018 and was unannounced. It was our first inspection of this service since it was registered on 20 October 2017.

Since Charterhouse had opened a year ago there had been three different managers. The current interim registered manager told us this had had an impact on the running of the service in respect of implementation and development of the care model. A new manager had now been recruited and was on induction and had begun the process of applying to be registered.

Charterhouse 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.

Charterhouse accommodates up to 77 people across three separate units, each of which have separate adapted facilities. One of the units specialises in providing care to people needing re-ablement care to return home. At the time of our inspection there were 44 people living at the service.

The service is situated in a development called The Chocolate Quarter which is a complex of retirement apartments and offers people care in their own homes. The complex has a cinema, swimming pool, spa and restaurant. These are accessible to the community as well as people living in The Chocolate Quarter.

People and their relatives were very positive about the service. People told us they felt safe, well cared for and had good relationships with the staff. Relatives were complimentary about the quality of the service and the environment.

Staff were skilled, well-trained and treated people with kindness and compassion.Staff knew people well, their likes and dislikes and how to comfort them if they were upset.

The service aimed to help people remain as integrated as possible in the community, however, as a new service some aspects of this were still being developed. People's relatives were involved in the planning of care and said staff always made time to discuss their relatives.

The service was purpose-built and aimed to have a hotel rather than care home feel. The environment was light, airy, clean and fresh. However, it may have been difficult for some people to identify their rooms as the doors to different rooms were not easily distinguished.

People received a good standard of nursing care, however, records were not always completed fully. Some needs identified on the nursing handover sheet did not have a care plan in people's electronic records. Daily nursing tasks such as turning and fluid intake and output were not always recorded. This meant that nursing staff could not be sure people were receiving all the care they needed at the correct frequency.

The provider had a comprehensive governance system in place which looked at incidents both on a service and at a corporate level. Where shortfalls were found action had been taken.

Staff morale was good, staff told us they enjoyed their jobs and spoke positively about their colleagues and the provider

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.

People were protected from the risks of abuse.

Risks to people were assessed and plans were in place to manage these.

Staff were recruited safely

Medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not effective.

Care plans did not always reflect people's assessed needs.

Nursing staff could not be sure people were supported to eat and drink enough as records of intake were not always completed.

People had access to an inhouse physiotherapist and chiropodist.

Staff were trained and supervised.

Is the service caring?

Good

The service was caring.

People told us they felt cared for and had good relationships with the staff.

Spoke treated people with kindness and compassion.

Staff respected people's privacy and dignity and supported their independence.

Is the service responsive?

Good

The service was responsive.

People received person-centred care which respected their preferences.

Relatives were involved in people's care.

People had access to activities and the community.

People received good care at the end of their lives, however care plans did not reflect this.

Is the service well-led?

Good

The service was well-led.

There was a comprehensive governance system in place.

Accidents, incidents and safeguardings were recorded and analysed.

Staff morale was good and staff felt well-supported.

The provider had identified future improvements for the service.

Charterhouse 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 inspection took place on 10 and 11 October 2018 and was unannounced.

The inspection team comprised two inspectors, a specialist advisor who was an experienced nurse, and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we had about the service including statutory notifications. Notifications are information about specific events that the service is legally required to send us.

During the inspection we spoke with eight people living at the home, nine relatives and 23 staff members, this included senior staff, and the registered manager. We also spoke with one health professional. We reviewed 25 people's care and support records and four staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies, audits and complaints.

Good

Is the service safe?

Our findings

People told us they felt safe at Charterhouse. We were told, "I'm safe here – absolutely. Staff are watching all the time to make sure we're alright and help us if we need it." A relative told us, "It is very well monitored here, people have seat alarms, and alarms hanging round their necks and in the beds as well."

The provider had policies and procedures in place for safeguarding vulnerable adults. This contained guidance on what staff should do in response to any concerns identified. Staff received training in safeguarding vulnerable adults and were knowledgeable about the correct action to take if they had any concerns. Staff told us, "I would log it on the electronic record and speak to my manager". Staff said they knew what to look out for as possible indicators of abuse, "If the person wasn't their normal self, bruises, new marks, not eating or their appetite has gone." Records showed that all relevant concerns were forwarded to the local safeguarding adults team and reported internally within The Council of St Monica Trust.

Risks to people were assessed and their safety was managed and monitored so they were supported to stay safe and their freedom respected. People were free to move around the service independently. Risks to people's health and well-being were assessed and plans were in place to keep them safe. For example, falls assessments were completed and reviewed. Falls records included a summary of what had happened, actions that were needed and any further considerations. People were assessed by the in-house physiotherapist following a fall. Staff used pressure sensors where appropriate to monitor people's movements.

There were sufficient numbers of staff to keep people safe and to meet their needs. The service employed a combination of registered nurses, care staff, a physiotherapist and had just recruited an occupational therapist. People told us that call bells and alarms were usually answered promptly. We were told by relatives, "The staffing is good, I feel like there are always enough people around", and, "When we're here they always seem to respond quickly to a call bell". People were attended to quickly but in a calm and unhurried fashion. Throughout the day we observed staff spending time chatting to people.

Staff gave mixed feedback about staffing levels. They told us that sometimes there were enough or too many staff but sometimes not enough. Rotas showed that there were some difficulties in maintaining required staffing levels and shifts were regularly either over or under filled. We discussed this with the management team who explained that, as the service was new, initially there had been very high staffing levels. This was because staff had been recruited for the full unit but people were admitted gradually. They said this meant that staffing appeared to be low but actually was at planned levels. However, rotas we looked at showed that staff levels did fluctuate.

The provider followed a recruitment procedure to reduce the risk of employing unsuitable staff. Staff files showed the provider had carried out checks before employing new members of staff. All contained a Disclosure and Barring number (DBS) this is a check that is made to ensure potential staff have not been convicted of any offence which would make them unsuitable to work with vulnerable people. Staff files also

contained proof of identity, an application form, a record of their interview and two references.

The provider ensured medicines were received, stored, audited and destroyed or removed in safe manner.

The clinical room and drug fridge temperatures were audited to ensure medicines were stored at the correct temperatures. Medicines no longer required were recorded on a register, stored in a specific bin and signed for when collected. Registered nursing staff rechecked all MAR charts at the end of each drug round to identify any gaps in records. The checks showed several failures to record administration by agency nursing staff. The provider has contacted the nursing agency and asked them to investigate and take action. The tablets were subsequently counted to identify if they probably had been administered but not signed for.

The majority of 'as required' (PRN) medicines had a specific PRN instruction within the person's medicines administration record (MAR). Staff had detailed information about how people preferred to take their medicines, for example from a spoon. One person had their medicine crushed and staff had checked with a pharmacist to ensure this did not affect the action of the medicine.
Several residents had hand written MAR charts which had two signatures to confirm the administration instructions had been checked.

We discussed medicines administration with two care staff who were trained to administer medicines. One member of staff said they received face to face training whilst another said the training was on-line. We identified that the current training failed to cover many routine administration routes that required specific administration, timing or routines to ensure patient safety. We recommend the provider implement additional training for care staff regarding the non-oral administration of medicines.

The provider had systems in place to protect people from the risk of cross-infection. The service was bright and clean and smelt fresh. Staff understood how to avoid cross infection and told us they used personal protective equipment which they changed between providing care to people. There was a clear system in place to separate and manage laundry which all staff were aware. Staff undertook regular audits of kitchens and food preparation areas on each unit. The infection control lead carried out unannounced infection control audits twice yearly. Any risks identified had a clear action plan with actions signed and dated when they had been completed.

During our inspection housekeeping staff were present throughout the service and communal areas were kept clean and tidy. Bathrooms were clean and contained liquid soap and disposable hand towels in line with best practice guidance.

The provider had an electronic incident reporting system. Staff knew how and what to report. Incidents were followed up by both local management and the provider to look for trends and themes. Lessons were learnt when things went wrong. For example, there had been an incident involving one of the balconies which resulted in greater awareness of risk for people using the balconies.

Requires Improvement

Is the service effective?

Our findings

There were some shortfalls in the care plans for specific needs such as urinary catheter, diabetes, seizures, and Parkinson's disease where care plans were generic and not tailored to individuals. People's needs identified on the handover for staff did not always have an associated care plan. For example, one person's handover notes stated they should do exercises every day but there was no plan to guide staff as to what exercises.

People's diabetes care provision was not always clear for example no specific targets for each diabetic resident requiring their blood sugars measured. People prescribed insulin were prescribed a hypoglycaemic agent but instructions for its use were unclear. There was no guidelines or instructions on when and how to administer.

Staff did not always record people needing to be turned regularly had been turned at the correct intervals as records were inconsistent. However, people's skin was in good condition and there was no evidence people had not been turned as needed.

People told us they were supported to eat and drink enough. However, staff had not always completed records to evidence people had drunk enough. For example, fluid intake and output were not recorded consistently. This meant nursing staff could not be sure people had drunk enough. Meals were provided by the restaurant within The Chocolate Quarter complex. The majority of comments about food were positive and included, "The food is lovely- look at my tummy- I get too much to eat!" and, "The food is lovely- just the same as they serve downstairs [the restaurant]". However, three people on Severn told us their food was often cold.

Staff had completed a holistic assessment of individuals' needs on admission to the service. This was contained in their electronic care records (ECP) and informed the staff team about the care the person needed.

People's nursing care needs had been assessed and plans were in place. Staff had followed best practice in checking blood levels for a person prescribed lithium, administration of sedatives and provision of individual slide sheets and slings. Another person's records demonstrated best practice in administration of medicine for angina, and we noted clear wound management and recording for a third person.

People were supported by staff who were trained, experienced and supervised. People told us, "Oh yes – the staff are well trained here." Staff told us, "I told them I wanted to do all training possible, I've been booked on another training this Friday. They always provide training".

Nursing staff employed by the service had undergone competency checks for administering medicines. Staff received regular supervision and records showed they received positive feedback as well as any performance issues being discussed. Staff files contained reflective accounts by nursing staff which demonstrated they had identified areas of good practice and areas for learning and development.

Staff all received a five day induction before commencing work. This was mandatory and included specific training to help them perform their job role. All staff received a one day training in dementia. Staff could access additional training if they identified the need.

We observed lunchtime on Avon South, Avon North and Severn. It was very unhurried, and people were not rushed in any way. Music was played in the background and some people sang and joined in which staff encouraged. People were asked what they wanted and shown the choices on two plates. Quite often people changed their minds and were offered alternatives quickly. One person had both choices at the same time mixed together. People who needed assistance with their meal were helped appropriately; staff sat down, maintained eye contact and chatted whilst describing the food they were offering. Meals served to people in their rooms were served on trays using plate covers.

The food smelt appetising and looked attractive and people appeared to enjoy their meals. Staff asked everyone if they had finished before removing their plate. People were offered drinks throughout the meal and tea and coffee were served at the end of the meal. Tea was served from a large china teapot with matching china teacups.

The provider worked in partnership with external healthcare providers such as GPs and members of the community mental health team. Records showed evidence of pharmacist and tissue viability input.

People's needs were mostly met by the design and adaptation of the building. Each person's room and bathroom had a ceiling hoist and motion activated lighting in the bathroom. The environment was light, airy and spacious with plenty of room for wheelchair access. People had access to a lift. Furniture was clean and comfortable and arranged in groupings so that people could choose to watch TV or sit elsewhere.

However, some further adjustments were needed for people living with dementia We noted that the colour scheme of bedroom doors may be confusing for people living with dementia as the doors were not easy to distinguish. Rooms had numbers on them and a very small name plaque at the side. People with limited vision would not be able to read this, and people with dementia may not always be able to read easily. The lounge area had carpet which differed from the rest of the flooring and may potentially confuse people with dementia. Dementia-friendly best practice is to have flooring of one uniform colour.

We discussed the environment with senior staff who told us that they had held a focus group with people who did not want it to look like a care home. However, the service still felt very new and did not yet have a homely feel.

Staff had a clear understanding of the Mental Capacity Act 2005 (the MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. 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.

Staff had undertaken capacity assessments for people, for example, if they were able to decide to live at Charterhouse. Where people did not have capacity for specific decisions this was recorded along with evidence. Where people had capacity for decisions this was also assessed and recorded.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their

best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider had applied for DOLS where needed. Some people had conditions attached to this. For example, one person had a condition about accessing the community. Records showed that this person had been able to go out for a walk and to visit the onsite café.

Good

Is the service caring?

Our findings

People received kind and compassionate care. People told us, "The staff are very comforting and supportive- even the really young ones," and, "Staff are kind. They're all friends here- we have fun together." Comments from relatives included, "It's a wonderful place. The staff are so caring," and, "we are more than happy with the care she is receiving."

All staff interacted with residents in a friendly, caring manner. Staff used first names and treated everyone with equal respect. Staff we spoke with knew people well and were able to give background information regarding likes and dislikes and previous history. Staff told us, "I like helping residents, putting a smile on their face and making them happy," and, "People are very well cared for. We are not rushed in our jobs at all."

People's care plans started with information about who they were and what mattered to them. There was clear information available for staff about people's preferences and what was important to them. Information included statements such as, "It is important for [Name] to stay in touch with their family as [Name] has always been family orientated." Another person's records said they liked to watch TV in bed with a glass of Bailey's.

Staff supported people to be cared for in ways they preferred. One person's care plan advised staff that they benefited from one to one support and holding hands.

Relatives told us they were involved in care planning. One relative told us, "They phoned us in the early days and used our input as a family to understand how best to look after him. People don't always listen to you but here they do -it is very person centred. They are very flexible they let him eat where he wants. They have done everything they can to help with his paranoia."
People were supported to be independent where possible. For example, one person found it difficult to be living in at Charterhouse and their records stated, "[Name] values their independence and finds it difficult to be in a care home."

People's privacy and dignity were respected and promoted. People received support with continence discreetly. All personal care was carried out in private with doors closed. Staff knocked before entering people's bedrooms.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. People told us, "They come quickly when I ring my bell." Relatives comments included, "Staff are very responsive- I mentioned he needed a haircut the other day in passing and when I came in again they had done it. A member of staff had brought their own clippers in," and, "He used to refuse [activities] regularly and wouldn't join in but they listened when we told them what he enjoyed doing and implemented it."

People's care records were developed around individual needs and contained information about what was important to each person. Staff told us, "[It's] A lot more like a community and people are treated like individuals." Another member of staff said, "Feels like a big family." Staff told us that generally they had time to respond to people's needs and that they were able to deliver care in the way and at a time that people preferred.

The manager told us that the service aimed to deliver the 'Greenhouse' model of care. This involved people having a member of staff identified as a 'key friend'. The model aimed for staff to be homemakers as well as providing care and support so that there was a 'home' rather than 'care home' environment. The manager told us that this was in its infancy and that staff were not yet engaged in working in this way.

Charterhouse did not have a program of daily activities as staff were expected to support people individually to take part in things that interested them. Relatives told us, "They took [Name] down to the cinema the other day. Staff interact and take them all around the complex (The Chocolate Quarter) to keep them occupied." People were supported to attend the cinema on site, the swimming pool and were able to go to the restaurant for meals or just coffee. The service had access to a minibus and we were told, "They've taken him out in the minibus to the Lakes. It's ladies one week and men the next- I think the ladies prefer shopping!"

People were supported to be involved with the wider community. For example, Avon Unit had a regular mother and baby group on the unit. One member of staff told us children from a local school visited and another person was supported to visit their church. Charterhouse was located in the middle of the community which meant people could access the same facilities as people living nearby as the restaurant, cinema and swimming pool were all open to the public.

The provider responded to complaints in line with their policy in an open and respectful way. Records showed complaints had been taken seriously and investigated. The provider had apologised for any shortfalls in the standard of care found. Actions had been implemented to reduce the likelihood of a similar issue re-occurring. The provider had a log of complaints and had kept a record of all responses.

People received caring and compassionate end of life care. Relatives had given feedback praising the quality of care their relative received and the support staff also offered to relatives. One relative had written, "I was exhausted. Staff assured me one of them would sit with [Name] all night. The support I received until [Name] passed away was exemplary." Another relative wrote to the service to say, "We were so grateful to you all for

making [Name] comfortable in their last hours and for the kindness and compassion you showed to us."

However, written care plans for people's end of life wishes were of poor quality. Whilst records had been completed regarding people's wishes for resuscitation and what level of medical treatment should be offered there was no further information. The plans contained only information about any funeral director and who would collect the person's belongings.

Good

Is the service well-led?

Our findings

People told us they felt the service was well-led. They said, "We are very impressed with the whole approach here to what could be a very daunting process." Relatives told us that both the interim manager and newly recruited manager were approachable, visible and easy to talk to. The newly appointed manager had written to everyone to introduce herself and had a meeting planned to meet people living at the service and their relatives.

Since Charterhouse had opened a year ago there had been four different managers. The interim manager told us this had had an impact on the running of the service in respect of implementation and development of the care model. A new manager had now been recruited and was on induction and had begun the process of applying to be registered.

The provider had a clear strategy in place to deliver high quality, person-centred care. The provider had a clear set of values. Staff received a five day trust induction which included what the values were and how to implement them in their work. During our inspection we observed the way staff behaved towards, and spoke with us about, people reflected the provider's values.
Staff were complementary about the leadership in the service. They told us, "Managers are approachable," and, "I love the residents, I love the staff and I love the company." Staff told us they had met senior leaders in the organisation including the chief executive and found them open and approachable.

Staff were very positive about their work and morale was high. Staff felt they worked as part of a tight-knit and supportive team with a common aim of providing high quality care. They told us they received an induction, training and could have additional training if needed.

There was an effective and comprehensive governance system in place. A range of audits were carried out to monitor the safety and effectiveness of the service. Where shortfalls were found the registered manager had developed an action plan. The plan was signed and dated to evidence when actions had been completed. For example, there had been a number of medicines errors identified in the medicines audit. The manager had identified the member of staff who was responsible and acted.

The provider had oversight of governance at a corporate as well as service level. For example, all safeguarding incidents were discussed at a quarterly trust meeting to identify any trends or learning.

The provider had a system in place to identify learning from accidents and incidents. Nursing staff had completed written reflective accounts following incidents which identified good practice and also any learning.

We found some shortfalls in recording which had not been identified. These related, in the main, to recordings of food and fluid and turn charts. People's general health was good and there was no evidence to suggest these nursing actions were not being carried out. We discussed this with senior staff who were aware of this and discussed the impact of four different managers since the service opened last year. They

told us that with the new manager in post consistency would improve.

Staff told us that they were able to make suggestions about the running of the service, had supervision and staff meetings. The provider carried out surveys amongst people living at the service and their relatives to obtain feedback.

The provider had submitted a Provider Information Return (PIR) before the inspection which contained information about improvements they planned to the service. These included the use of a nurse prescriber and an improved supervision and appraisal system for staff.

Staff at the service worked in partnership with other healthcare providers such as a dietician, speech and language therapist and GPs. A member of nursing staff attended the local authority end of life strategy group.