Renal Health Limited

Chase Park Neuro Centre

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 4 and 14 July 2017 and was unannounced. This was the first inspection of the home since the current provider took over management in July 2016.

Chase Park Neuro Centre is registered to provide care to 60 people aged 18 years or over. At the time of this inspection there were 47 people living at the home, three of these were respite admissions. The home provides rehabilitation and nursing care to people with a neurological condition as well as older people. The service is provided across two buildings.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider's approach to gathering feedback about the service from people and relatives lacked structure. Regular meetings did not take place. People had not been included in previous consultation. We have made a recommendation about this.

People told us they were well cared for. They said staff were kind and caring and they were treated with respect. Staff supported people with developing and maintaining their independence. People and staff told us the home was safe.

Staff had a good understanding of safeguarding and the provider's whistleblowing procedure. Although they had no concerns about people's safety, they knew how to raise concerns if needed.

Previous safeguarding concerns had been dealt with in line with the provider's safeguarding procedure and referrals made to the local authority safeguarding team.

The provider had taken measures to ensure there was enough staff on duty to meet people's needs. Most people said staffing levels had improved. Staff confirmed there was sufficient staff to meet people's needs. Staffing levels were monitored periodically to check they were still appropriate to meet people's needs.

There were effective recruitment procedures in place to check new care workers were suitable to work with people living at the home.

Records confirmed medicines were managed safely. People received their medicines from trained and competent staff.

Regular health and safety checks and risk assessments were carried out to help keep the home safe. For example checks of electrical safety, gas safety, fire-fighting equipment, emergency lighting and specialist

moving and handling equipment. Procedures were in place to help ensure people continued to receive care in emergency situations.

Accidents and incidents were logged, investigated and monitored.

Staff confirmed they received the support and training they needed. Records we viewed confirmed this.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People's cultural and religious needs had been assessed and adaptations made to their care. For example, offering an adapted diet to meet religious requirements.

People were supported to have enough to eat and drink. Where people required specific support or specialist advice and guidance this was provided.

People had access to external health care services in line with their assessed needs. This included GPs, community nurses, speech and language therapists, physiotherapists and occupational therapists.

People had the opportunity to be involved in planning their care. People's needs had been assessed including identifying their preferences and the information was used to develop individualised support plans. These had been reviewed to keep them up to date with people's changing needs.

Activities were provided and people could choose to participate. These included activities both inside the home and in the local community, such as shopping, going to discos, outings, themed activities and a cookery club.

People knew how to raise any concerns they had. Previous complaints had been investigated and where required action taken to resolve the complaint.

The provider had invested in improving the environment and providing the facilities and equipment people needed. The registered manager told us about plans for continuous improvement of the home. However, these were not documented within a service development or improvement plan. Staff were enthusiastic and optimistic about how the future of the home.

Staff had opportunities to give their views and suggestions about the home.

The provider carried out regular quality assurance checks, such as checks of medicines, accidents, complaints, safeguarding concerns, staff files and care records. Where required action had been taken to deal with any issues identified through quality assurance checks.

Feedback from relatives during the last consultation was mostly positive. Regular staff meetings were held.

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.

Staff knew how identify and report safeguarding concerns and knew how to use the whistle blowing procedure.

There were sufficient staff deployed to meet people's needs.

The provider had effective recruitment procedures in place.

People received their medicines in a safe and timely manner.

There were up to date checks, risk assessments and emergency procedures to assess health and safety in the home.

Accidents and incidents were dealt with appropriately.

Is the service effective?

Good

The service was effective.

People said staff had appropriate skills and knowledge.

Staff received good support and relevant training.

The provider followed the requirements of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS).

People were supported to meet their nutrition and health care needs.

Is the service caring?

Good

The service was caring.

People told us they were well care for.

People were treated with dignity and respect.

People were supported to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

People were supported to be involved in planning their care.

People's needs had been assessed and personalised support plans had been developed.

Activities were provided for people to participate in if they chose to.

People knew how to complain and previous complaints had been investigated.

Is the service well-led?

Requires Improvement

The service was not always well led.

Opportunities for people, relatives and staff to give their views and suggestions about the home required further development. We have made a recommendation about this.

The home had a registered manager.

Improvements had been made to the environment and new equipment purchased.

The registered manager had a clear plan to further develop the home.

There was an effective system of quality assurance checks in place.

Chase Park Neuro Centre

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 checked 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 4 and 14 2017. The first day of inspection was unannounced. The second day was announced. This meant the provider knew we would be coming.

On 4 July 2017 the inspection was carried out by one inspector 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. On 14 July 2017 the inspection was carried by one inspector.

Before the inspection we reviewed the information we held about the home. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We contacted the local authority commissioners of the service, the clinical commissioning group (CCG) and the local Health Watch.

The provider completed a provider information return (PIR) prior to the inspection. 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.

During the inspection we spoke with seven people who used the service and one relative. We also spoke with the registered manager, one nurse, two nursing assistants, three support workers, a chef, an activity co-ordinator and one member of domestic staff. We looked at a range of records which included the care records for four people, medicines records, recruitment records for five staff members and other records relating to the management, quality and safety of the service.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. Their comments included: "The staff are present all of the time this makes me feel very safe"; "I feel very safe all over it is marvellous"; and, "I feel safe here the staff and surroundings are good."

Staff also told us they felt people were safe living at the home. One staff member said, "We all gelled as a team, we all work well together across the board so that makes it safe." Another staff member told us, "I think it is [safe]. We all work together to make sure it is safe and the management. I have no concerns about safety."

Staff showed a good understanding of safeguarding and knew about the importance of raising concerns. They said they would report concerns to the registered manager straightaway. One staff member said, "I would document it [a concern]. I would go to speak to [manager] and raise concerns." Another staff member said, "I would go to the nurse in charge, she would address it and would deal with it straightaway."

We viewed the provider's safeguarding file which showed safeguarding concerns were referred to the local authority safeguarding team and had been thoroughly investigated. Actions and lessons learnt were identified and implemented to help keep people safe. Actions taken included additional support for people, providing female only staff, police involvement, increased observations and reviewing care plans and risk assessments. Where required disciplinary action had been taken. Detailed records were kept of the investigation and of any action taken following a disciplinary hearing.

Staff knew how to raise concerns using the provider's whistle blowing procedure. Whistle blowing is when a person tells someone they have concerns about the service they work for. They told us this had not been necessary but they wouldn't hesitate if needed. One staff member commented, "I have not needed to use whistle blowing. Any concerns I have I feel perfectly fine to go to management." Another staff member said, "In all honesty we have a good relationship with management so if I had an issue I feel like you could go straight to them."

The provider had taken over the service during a period of administration. As a consequence there had been an unsettled period with some staff retention issues experienced. At the time of our inspection this had been addressed with new staff having been recruited. One staff member said, "Staffing levels are getting better. It wasn't for a while, we were running on agency for a while. That is kept to a minimum as they have employed a lot of [new] staff. We are definitely getting there, the quality of staff we are getting is on a much better scale." Another staff member told us, "There has been a massive difference, we definitely can meet needs. There are plenty of staff, they have doubled the amount of staff." A third staff member commented, "Definitely good at the minute. We have just taken on new staff, staffing levels are good."

People also commented they had seen improvements in the staffing levels and the consistency of staff this year. Most people also told us when they needed assistance staff responded quickly. One person and a relative continued to have concerns about staffing levels. They commented, "Definitely not [enough staff],

especially at nights. Staffing numbers are an issue." They had raised these concerns directly with the registered manager.

The provider had a detailed staff dependency tool to help with monitoring staffing levels. This confirmed people's needs had been reviewed frequently to assess whether staffing levels were appropriate. The tools considered other factors that could impact on staffing levels such as the layout of the home. However, this was only used as a guide. For example, the dependency tool suggested that one nurse was required overnight. The home was split into two separate buildings so the provider deployed a nurse in each building. Rotas showed more staff were usually on duty than recommended by the dependency tool. The registered manager told us day time staffing levels were 15 care staff including three nurse and eight care staff including two nurses on a night time.

The provider had effective recruitment procedures to ensure new care workers were suitable to work at the home. These included carrying out a range of pre-employment checks. For example, requesting and receiving two references and Disclosure and Barring Service (DBS) checks. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with vulnerable adults. This helps employers make safer recruiting decisions and also helps to prevent unsuitable people from working with vulnerable adults.

Medicines were managed safely. Medicines administration records (MARs) accurately accounted for the medicines people had received from care workers. Where medicines had not been given a non-administration code was input onto MARs to show the reason for this. Other records we viewed showed medicines were received, stored and disposed of effectively. This included medicines liable to misuse (controlled drugs). Nurses had completed relevant training and had been assessed as competent to administer medicines.

The provider carried out regular health and safety checks to help ensure the home was a safe place for people to live. This included checks on electrical safety, gas safety, fire-fighting equipment, emergency lighting and specialist moving and handling equipment. These were up to date when we inspected the service. There were also procedures to deal with emergency situations which covered a range of potential scenarios, such as severe weather, staff disruption and heating loss. Each person had a personal emergency evacuation plan (PEEP) which gave details of their individual support requirements in an emergency.

Risk assessments had been carried out where potential hazards had been identified. For instance, a fire risk assessment and Legionella assessment were in place. These identified the measures required to minimise the risk and had been reviewed to ensure they remained relevant.

Accidents and incidents were logged, investigated and monitored. We viewed the most recent trend analysis which considered when and how accidents had occurred and reviewed the action taken following accidents. Actions were clearly recorded and included medical intervention, hospital admission, increased observations and referrals to external health professionals.

Good

Is the service effective?

Our findings

Most people told us staff had the skills to provide the care they needed. Comments made included; "I feel the staff support me very well"; and, "The staff here look after me very well."

There were structured opportunities for staff to have regular one to one 'job chats' with a manager. One staff member commented job chats looked at "strengths and weaknesses." They went on to say, "They check knowledge of health and safety, safeguarding, things like that. Any issues we might have." Another staff member said, "We have job chats every six week. They are good, they are useful." Records confirmed 'job chats' and appraisals took place regularly.

Staff confirmed they received good support whilst working at the home. One staff member said, "Every two months [frequency of job chats] but anytime if there is something you want to talk about you can approach the manager at any time." Another staff member told us, "I feel very well supported. All the nurses we have are very supportive. If you need anything from management I find them great." A third staff member commented, "I feel supported definitely, we have a good team.

Staff were encouraged to complete relevant training so they had the knowledge they needed to carry out their role effectively. One staff member commented, "Training is quite good. Part of 'job chats' is to ask staff what training they would like." Another staff member said, "We are getting a lot of training at the moment." We viewed the provider's training matrix which showed essential training was up to date.

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 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).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Where people lacked capacity, DoLS authorisations had either been applied for or authorised. We saw examples of MCA assessments and best interest decisions in people's care records. For example, where a person was unable to consent to their admission and continuing stay in the home and the use of specialist equipment.

Staff completed specific training on MCA including DoLS. One staff member commented, "In job chats we have to give an explanation of MCA, safeguarding and DoLS." They were readily able to describe how they supported people with decision making. This included verbal communication, a communication board, gestures, gathering information from families and professionals and referring to people's care plans. One

staff member said, "We are very person centred because we work with OT's [occupational therapists] and SALT [speech and language therapy]. They can help us."

One person told us about the way staff adapted how they presented information to enable them to fully understand and be involved in decision making. They said, "They explain things in a way I would understand without it being childish. If I don't understand something they will explain it in a different way or put it in an example so I understand it better."

We observed staff sought consent from people both before and during care provision. One person said, "Staff always consult with me when they are providing care." Another told us, "I feel very involved in my care."

The home had a number of small dining areas where people could sit and eat their meals. Care had been taken to make the dining rooms well presented. For example, they were laid out like a small restaurant with menus and folded napkins. People did not raise any concerns with us about the meals provided at the home. People had been assessed to identify their needs and risks associated with nutrition. Meals were cooked from scratch using fresh ingredients.

Care plans and risk assessments were developed to help ensure people received the support they needed. Where required the provider sought advice and guidance from health professionals. For example, for one person who had a Percutaneous Endoscopic Gastrostomy (PEG) in place, a specific feeding regimen had been drawn up with a dietitian to ensure this was done safely and in line with the person's specific needs. A PEG is a feeding tube which passes directly into the stomach so that food, water and medication can be given without swallowing. Another person required a specific diet to fit in with their cultural and religious beliefs. The chef was knowledgeable about what the person required and was able to provide the specialist diet. The provider was also able to provide a range of altered textures where for example people had swallowing difficulties, such as soft and pureed diets. The chef told us with the new provider quality is encouraged. They said, "There is a budget but the customers come first. There is more emphasis on client's needs and what they want to eat, this is promoted throughout."

People told us they could access external medical care when required. Care records showed people had regular input from a range of external health professionals when required. Some people had retained their original GP services. The home provided a range of therapy services, such as physiotherapy, speech and language therapy and occupational therapy to people who were on a rehabilitation programme. This was provided through a contract with a local hospital. We spoke with one of the therapists who gave us positive feedback about the improvements made since the provider took over management of the service.

Good

Is the service caring?

Our findings

People told us they received good care. Their comments included: "Everyone here looks after me"; "I love living here I get very good care and I get to go shopping and go to discos"; and, "Absolutely fantastic because if I am ever upset [staff member] always makes time for me, as do all the staff. If you seen where I came from before it is like a palace. I give it five stars."

We observed throughout our inspection there were many positive interactions between staff and people which were always caring and respectful. It was clear from the conversations we heard staff knew people well. One person commented, "Me and [staff member] are going to have a one to one session later. [Staff member] is good." Another person told us, "There are always people [staff] around and I trust the people [staff] here." Staff also described positive relationships with people. One staff member said, "We laugh so much with clients."

People told us they were treated with dignity and respect. One person commented, "Staff are definitely caring and respectful." Another person said, "When helping me to dress … staff respect my privacy and dignity." Staff described how they adapted their care practice to promote dignity and respect when supporting people. For example, keeping people covered as much as possible, keeping doors and curtains closed, gaining consent from people and explaining what was happening at all times.

People were supported to be in control of their care and make choices. For example, people confirmed they were able to get up and go to bed when they wanted. People commented; "My care is given at the times I choose"; "I can change the times if I want to"; and, "My care requires more than one member of staff and is therefore provided more on the timetable of the home but there is some flexibility."

Staff supported people to be as independent as possible. Comments from people included: "They [staff] are very good I am as independent as I can be"; "I feel supported to be as independent as I can be"; and, "I am as independent as I can be." Staff told us about how one person who was nursed in bed had made significant progress since moving to the home. They said, "[Person] had been encouraged by carers to do a bit of physio. [Person] wants to get out bed now. It has given [person] a new lease of life."

Care records contained detailed information which was used to help staff better understand people's needs and provide personalised care. Each person had a 'one page profile' which gave brief information about the personality and personal qualities of each person. This included information such as what made people happy and sad and how they wanted to be supported. People also had a 'life history' with information about their childhood, work life and family.

During the initial assessment staff gathered information about any cultural, religious or spiritual needs people had. This information was used to develop relevant support plans. We found one person living at the home had specific cultural and religious needs. In order to guide staff a spiritual and cultural support plan had been written containing information about the person's religion, resuscitation wishes and end of life wishes. The support plan was written using a pictorial format to help with the person's understanding of the

information.

Information about independent advocacy services was displayed prominently on notice boards. Most people we spoke with were either able to advocate for themselves or had family or friends who would speak on their behalf.

Good

Is the service responsive?

Our findings

People told us they were able to participate in the planning of their care if they wanted. Where appropriate family members were invited to attend care planning meetings. People's comments included: "My husband was allowed to attend meetings to discuss my care plans"; "I am not involved in my care plan but I am 99 years old and I am quite happy"; and, "I am involved in the planning of my care."

Staff described how they supported people to take part in care planning. One staff member told us, "We involve them from the very beginning, the pre-assessment is in-depth. We discuss with them how would you like it done. We get them to read it. We are very family orientated and involve them from the beginning."

People's needs had been assessed and the information used to develop personalised support plans. Support plans we viewed were detailed and provided step by step guidance about what support people needed including any specific preferences they had. For example, one person had a preference for female only support staff. Another person liked background music and the bathroom light on when sleeping. Support plans had been reviewed to help ensure they reflected people's current needs.

People had opportunities to participate in activities both inside the home and in the local community. One person told us, "I like to go shopping and to discos and I love going on holiday." Another person said, "I choose not to go on outings but I do take part in activities when I want to." A third person said, "There is always something going on." One person told us about a recent holiday they had been on with staff members. They also told us they were also looking forward to another trip later in the year. Some activities were based around developing daily living skills, such as a cookery club. There was a list of available activities on the notice board so that people could see what activities were available.

We observed the activities team were very active during our inspection. In the morning we attended a group session themed around American Independence Day. The session was led by one of the activity co-ordinators and involved arts and crafts. Other members of staff popped in and out of the session and joined in the group's conversation. In the afternoon we saw staff playing games with a group of people. Again other members of staff, including the registered manager, joined in the games. The registered manager knew each person's name. It was apparent from the conversations that the registered manager was familiar with people's circumstances.

People knew who to speak with if they had concerns about their care. Where people had raised an issue these had been resolved usually to their satisfaction. One person said, "I know exactly who to inform if I am not happy about anything." Another person commented, "I know who to speak to if there is something I am unhappy about." We viewed the provider's complaint log which confirmed previous complaints had been fully investigated. Records showed action had been taken to address concerns including increased observations, providing additional guidance for staff and specific one to one with staff.

Requires Improvement

Is the service well-led?

Our findings

The provider did not have a structured approach to on-going formal communication with people and relatives. We found there was no evidence to show the provider regularly met with people and relatives to provide opportunities for discussion and to provide feedback about the home. One person commented there had been "no surveys or meetings". The registered manager told us two meetings had taken place but they had not been well attended. Although the provider had consulted with staff and relatives in January 2017, people using the service had not been part of this consultation process.

The provider had issued questionnaires to relatives and staff in January 2017 to gather their views about the home. The registered manager had reviewed analysed the feedback. The provider had issued 23 questionnaires to relatives with 11 replies received. Topics covered on the questionnaire included dignity, privacy, meeting religious and cultural needs and the quality of care. Most of the feedback provided was positive. For example, for the overall quality of care two eight relatives had responded either 'excellent' or 'good' whilst the remaining three relatives responded 'satisfactory'.

Where minor concerns were identified, the registered manager told us they met with relatives to address these issues. However, we noted these discussions had not been recorded. The registered manager told us further surveys were planned for August 2017.

We recommend the provider reviews the current systems in place for consulting with people, relatives and staff and updates these systems in line with current good practice.

The home had a registered manager. They had been proactive in submitting the required notifications to CQC in a timely manner. Notifications are changes, events or incidents that the provider is legally obliged to tell us about.

Staff told us the registered manager was approachable. One staff member said, "We are very lucky to have [registered manager]. She is very interested and knows her staff. She knows what she is doing. [Director] is here quite a lot and is very approachable." People told us they knew who the registered was and found her easy to relate to.

Staff described how management had improved since the new provider took over ownership of the home. One staff member told us, "Management are more approachable and visible. There is an open door policy. The gap between management and employees is much less than it was. The atmosphere has improved and staff morale is improving." Another staff member commented, "The atmosphere is much nicer now, everyone feels safe and secure. A nice bunch of staff make it a pleasant experience [to be at work]."

The provider had invested in improving the environment and ensuring the specialist equipment people needed was available. One staff member said, "There has been a lot of refurbishment. They have updated the equipment, they are definitely investing in the service. The service is thriving to be honest." Another staff member told us, "The new owners listen when we need anything. They will get what they believe we need. It

has changed for the better." A third staff member told us, "There are more facilities for people to use."

The registered manager articulated a clear plan for the future development of the service. This included enabling people to become involved in staff interviews, developing more activities and developing champion roles within the home to promote good practice. Staff we spoke with were enthusiastic and optimistic about how the service was developing. One staff member said, "I am very positive about the future of the service." We noted the provider did not have a documented improvement plan for the home. The registered manager told us this was being developed but had not yet been completed.

Staff had opportunities to give their views and suggestions about the home. One staff member told us, "Staff meetings are every month usually. The manager always says if there is anything you don't want to raise here you can come to my office. There is nothing to raise negatively at the moment, it is all good." Another staff member said, "[Staff meetings] are very informative. We are encouraged to give our views." A third staff member commented, "We have regular staff meetings. They tell you about updates and anything that needs sorting out."

The provider carried out regular checks and audits to help ensure people received a good standard of care. For examples, checks of medicines, accidents, complaints, safeguarding concerns, staff files and care records. All checks had been completed regularly and were up to date when we inspected. We saw action had been taken following these checks where areas for improvement had been identified.

The provider had received four compliments from relatives about the care provided at the home. Some of these referred to having seen improvements made at the service. One relative described how 'care had altered for the better' since their last visit. Another relative felt the home was 'getting better now'.