Thorngate Almshouse Trust

Russell Churcher Court

Inspection report

Melrose Gardens
Gosport
Hampshire
PO12 3BE

Tel: 02392527600

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 14 November 2016 and was unannounced.

Russell Churcher is a care home that does not provide nursing. It provides support for up to 44 older people, some of whom are living with dementia. At the time of our inspection there were 44 people living at the home. Accommodation is over two floors and lifts were available.

A registered manager was in place. 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.

Medicines were not managed safely as records did not show how to administer covert medicines and records did not always reflect how much medicines had been given.
People's care had been appropriately assessed however, plans had not consistently been developed to ensure that staff met people's needs consistently and reduced and identified risks.

People confirmed they felt safe and that staff involved them in making decisions and staff knew people well.

Observation demonstrated people's consent was sought before staff provided care.

People described staff as lovely and caring. Staff treated people with respect and recognised the importance of promoting independence, dignity and privacy.

Staff demonstrated a good understanding of safeguarding people at risk. They were confident any concerns raised would be acted upon by management and knew what action to take if they were not. However, they were unsure about the Mental Capacity Act and Deprivation of Liberty Safeguards. The manager told us that they had yet to make ten DoLS assessments for people where it was felt they were at risk of being deprived of their liberty. We have asked that we be informed on when they have made their assessments.

Recruitment checks were carried out and the provider ensured there were enough staff on duty to meet people's needs. Staff received an induction when they first started work which helped them to understand their roles and responsibilities. They felt supported through supervision and training.

People and their relatives knew how to make a complaint and these were managed in line with the provider's policy. Systems were in place to gather people's views and assess and monitor the quality of the service. Records were not appropriately maintained in a number of areas including care plans and risk assessments.
We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You

can see what action we told the provider to take at the back of the full version of this report.

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.

Identified risks associated with people's care were not always assessed and plans developed to mitigate such risks.

Staff had a good understand of safeguarding. They knew what to look for and how to report both internally and externally.

Recruitment processes ensured staff were safe to work with people at risk and the provider ensured appropriate staffing levels to meet people's needs.

Medicines were not managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were well supported to understand their roles and responsibilities thorough effective supervision and training.

Whilst staff demonstrated they involved people in making decisions and respected the decisions they made, they did not have a good knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Mental capacity assessments were not available and DoLS had not been requested when appropriate.

People's nutritional needs were met and they had access to healthcare professionals when they required this.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and respect.

They demonstrated a good understanding of the importance of promoting independence, dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Staff knew people well and the planning of care was personalised but did not always reflect people's needs.

A complaints procedure was in place and people knew how to use this. Where concerns had been raised the registered manager had implemented the complaints procedure and people had been satisfied with the outcome.

Is the service well-led?

Requires Improvement

The service was not always well led.

People's records were not accurate and complete and did not reflect their needs.

Systems were in place which monitored the service and gathered people's feedback. However, there were issues with care plans and medicines that had not been picked up as the audit for medicines took place monthly.

The manager was visible and staff were encouraged to share concerns and make suggestions.

Russell Churcher Court

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The inspection took place on the 14 November and was unannounced. The inspection was carried out by an 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.

Prior to the inspection we reviewed previous inspection reports and information we held about the service including notifications (a notification is information about important events which the service is required to tell us about by law). This Information helped us to identify and address potential areas of concern.

During the inspection we spoke to eight people living at Russell Churcher, three visitors and two external health professionals. To help us understand the experience of people who could not talk with us we spent time observing interactions between staff and people who lived in the home. We also spoke to the registered manager, the chief executive of the charity, five care staff, housekeeping staff and the cook. We looked at the care records for four people and sampled another two and the medicines administration records for 22 people. We reviewed five staff files in relation to their recruitment, supervision and appraisals, the staff training matrix and the staff duty rota for four weeks. We also looked at a range of records relating to the management of the service such as accidents, complaints, quality audits and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

We spoke with eight people living at the home and observed others. One person when asked if they felt safe and supported said, "Oh yes it's very nice here, the staff are very nice." Relatives said when asked about safety in the home, "Security is very good here, we like that. We've had other relatives here, I'd rate it highly."

We looked at how medicines were managed. Medicines were stored appropriately in a clinic room in two trolleys attached to a wall and a locked cupboard on the wall. Controlled medicines were stored safely within the locked wall cupboard in a locked cupboard within the one on the wall. Medicines were administered by people who had received the appropriate training to do so. Storage was clean, tidy and secure so that medicines were fit for use. There were procedures in place for the ordering and safe disposal of medicines.

We saw that staff did not always record the amount they had administered when people were prescribed one or two tablets or a sliding amount of liquid medicines such as 5ml – 20mls. Staff did not record the time, reason or effect of any 'as required' medicines they had administered.

Where people were self-administering their medicines there were no assessments available to evidence their capacity and understanding of what they were doing.

One person stated their blood sugars should be taken daily however the records in the MAR folder showed this was not the case with a gap from 20 October 2016 to 7 November 2016. The person's blood sugars ranged between 6.6 and 20.8. We saw that they received both tablets and insulin. There was no information on when staff should contact the nurse or doctor, or a normal range for the person. The person's MAR record stated they are on Insulin for their diabetes and their care plans said they have type 2 diabetes and are on tablets to help control it. The pieces of information were not consistent

For another person there was a letter from the GP re giving medicines covertly which explained that the person's medicine may be mixed with their food. However, there was no mental capacity assessment for the person. Their medicines care plan stated staff were to "Encourage [name] to take their medicines if they refused to try again an hour later and if still refuses to dispose of them." The risk assessment stated the risk was, "Exacerbating and the action was to continue to offer and inform GP and discuss possible covert, and monitor."

However, we observed a member of staff who was administering medicines, crush a second person's tablets and take them to the person. When we looked at their records there was no record of a letter from the GP saying they could do this. The MAR records stated that medicines could be given covertly if the person refused them. There was no evidence on the MAR records that the person had been offered the medicine and staff had crushed them anyway. We spoke to staff who showed us that there was information on how to give medicines, we highlighted that it does not say how to give the medicines covertly.

Whilst staff were able to tell us who had their medicines administered covertly, there was no information on

the MAR records on how this should be done or that the medicines were administered covertly at all.

Medicines that were to be administered 'as needed' had protocols in place, however they did not always give staff a full description of the medicines, amount to be administered and side effects that may be seen.

There was no information or protocols for medicines which were prescribed to be given regularly, such as, what the medicine was for, when it should be given, any side effects and what to do in the event of any concerns. For example, Metformin (used to treat type 2 diabetes) whose side effects include, stomach pain, sleepiness and diarrhoea.

The poor record keeping, not recording how much medicine is given and inconsistent information about medicines and the lack of information on medicines means that medicines were not safely administered and this was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed there were sufficient staff on duty to provide care and support to meet people's needs. Staff told us there were enough staff, with seven staff on duty throughout the day including seniors. There were two staff allocated to work upstairs and two downstairs with others who 'floated' and supported where needed. We observed that call buzzers were answered promptly and care staff did not appear to be rushed in their duties.

The provider had a robust recruitment and selection procedure in place. They carried out relevant checks when they employed staff in order to make sure they were suitable to work with people who used the service. This included Disclosure and Barring Service (DBS) checks and at least two written references. DBS checks help employers to make safe recruitment decisions by preventing unsuitable people from working with people. Proof of identity was obtained from each member of staff, including copies of their passport, driving licence and birth certificate. Staff confirmed that they had undergone the required checks before starting to work at the service. Staff disciplinary procedures were followed where issues were identified in their work practice in order to make sure people were kept safe.

The premises and equipment were appropriately maintained. Records showed that equipment was serviced and checked in line with the manufacturer's guidance to ensure that it was safe to use. Gas, electric and water services were maintained and checked annually. Records also confirmed that appropriate checks were carried out on hoists, pressure relieving mattresses and fire alarms to ensure they were safe to use and in good working order. A fire risk assessment was in place and staff were aware of the evacuation process and the procedure to follow in an emergency.

During this inspection we looked at records of the accidents and incidents that had occurred since our last visit. We saw that where necessary appropriate treatment had been sought and notifications to the appropriate authorities had been made. All the records we looked at showed appropriate action had been taken in response to incidents to promote the safety and wellbeing of people who lived there.

Staff had a good understanding of safeguarding adults at risk. They were able to identify the correct safeguarding and whistleblowing procedures to follow should they suspect abuse had taken place. They were aware that a referral to an agency, such as the local Adult Services Safeguarding team should be made, anonymously if necessary. One member of staff said, "I would always tell someone". Another member of staff said, "I'd report anything straight away". Staff confirmed to us the manager operated an 'open door' policy and that they felt able to share any concerns they may have in confidence.

Requires Improvement

Is the service effective?

Our findings

Relatives told us their loved ones received the care and support that met their needs and that staff carried out their duties effectively. For example, "I'm more than happy with mum's care here, you can tell she is relaxed with them [staff]."

Induction training was provided for new staff and this involved them working alongside more experienced staff members. They did this for a period of time to help them develop the required level of skills and knowledge to support people safely. A new member of staff confirmed they had competed their induction training before they worked independently. They also explained they had begun working on the 'Skills for Care' Care Certificate to further support staff in carrying out their role. The Care Certificate, is the standard employees working in adult social care should meet before they can safely work unsupervised. It gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff told us that the essential training they had completed such as moving and handling people and infection control was good and provided them with the necessary skills to undertake their role.
They told us some of their training could be updated easily with eLearning or workbooks which were sent away for marking. Other training such as medicines, involved an assessment of their competencies.

One member of staff said, "[name] has held training sessions, not just for me. I have had basic training." When we asked about Mental Capacity Act 2005 (MCA), the staff member did not know what this was.

Another member of staff said "I have been here 5 years. I have had in house training and also attended training at a local college. We covered medicines, team leader training, dementia, customer services and MCA." When we asked about the MCA assessments the member of staff could not elaborate.

Other staff told us they had received in house training on manual handling, food hygiene, infection control, fire, first aid and dementia. They had also received a brief overview on MCA. One member of staff told us they felt they needed "More training on dementia, I don't always know what to say to residents who want to go home." They went on to say "The staff all pull together here, we help each other, I feel the home is well run."

Training information stated staff had completed training in regards to the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). However when we asked staff about this, they had a limited knowledge of what this meant in practice. In addition the manager told us that they had identified several people where a DoLS was needed but they had yet to make the applications. This meant staff may not recognise how to apply the MCA and DoLS appropriately placing people at risk of being unlawfully restricted and or not being able to be supported to make choices.

We saw people were involved in everyday decisions about their care such as where they sat, what they ate, and what drinks they would like. Some people were independent with some of their care so did not always

require staff support.

We recommend that the service to action to ensure staff are given a refresher on the Mental Capacity Act and DoLS and that the knowledge is verified by registered persons in a way to ensure staff understanding.

Staff told us they handed over any information of concern about people to staff starting the next shift to ensure any risks associated with their care were managed.

We saw that staff carried bags around with them, we asked why and they told us they were used to carry gloves, aprons and other personal protective equipment, and the tablet computer they used to update the care records. They said one of the staff had the responsibility for updating the food and fluid charts after each meal and drink. On the day we found that not all records had been updated as the member of staff responsible had finished work before everyone had finished their meals and drinks. No one else had picked this work up. We saw this had occurred on several days. The manager said they would ensure staff handed over work that needed to be completed before they finished their shift.

New staff, as well as existing staff, sometimes had supervision meetings with the registered manager to discuss their ongoing work performance. These meetings provided staff with an opportunity to discuss personal development and training requirements.

We asked the registered manager about their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The Care Quality Commission is required by law to monitor the operation of the MCA and DoLS and to report on what we find. The MCA ensures the rights of people who lack mental capacity are protected when making particular decisions. DoLS referrals are made when decisions about depriving people of their liberty are required, to make sure people get the care and treatment they need in the least restrictive way.

The registered manager was able to explain the principles of MCA which showed they had understanding of the legislation. They told us they had yet to make any referral and there were several that needed completing.

We saw people were involved in everyday decisions about their care such as where they sat, what they ate, and what drinks they would like. Some people were independent with some of their care so did not always require staff support.

We observed the lunchtime meal. The tables were well laid with clean tablecloths and set nicely with clean cutlery. People were asked where they wanted to sit in the room. Everyone had glasses of squash type juice with their meals.

All the staff wore clean tabards and meals were plated in the kitchen and passed through a large hatch. There was an unhurried relaxed atmosphere in the dining room. One person required assistance to eat. A staff member stood next to them which made eye contact difficult. However, when there was space next to the person the staff member sat next to them to help them finish the meal. One person who had been holding a doll all morning continued to hold it throughout the meal, staff were supportive to them with the doll.

Two care staff pushed the dessert trolley round the room. They offered people a choice of desserts. Available were, chocolate tart, almond tart and mousse. There was also custard or cream as an accompaniment to the dessert. Tea and coffee were served at the tables.

One person had not eaten her meal, they had a cough. The person was offered alternative meals and decided on soup which was served in the other lounge. Comments from people about the food included, "By and large the foods good here, I'm very fussy on meat I don't enjoy eating meat." "My pudding was lovely", "Very nice" "I don't eat meat but I enjoyed my lunch."

The cook told us that every meal was cooked fresh on the day it was to be eaten. They were reviewing the menus and were hoping to introduce pictorial menus soon. Breakfast menus had been created and staff would use these daily to see what people liked, it included cereals as well as a hot choice such as eggs and bacon. The cook told us they were aware of who had soft foods and the meals we saw that had been softened looked as pleasant as the other meals served.

Where people were not eating and drinking sufficiently to maintain their health, the registered manager had introduced food and drink charts to monitor the amount of food and drink they had consumed. The food and fluid charts we looked at had not been completed sufficiently to establish whether the person had eaten and drunk enough each day. The food chart did not always show the amount of food the person had eaten, as it just stated a percentage and did not indicate how large the meal had been at the start. With regard to the fluid charts; although staff recorded how much people had consumed, each person did not have a daily target on the charts to indicate to staff how much fluid the person should have each day.

Staff spoken with had a good understanding of people's health care needs. All the people we spoke with told us if they needed a doctor the staff team would make an appointment for them. We could see in people's care plans that there was effective working with other health care professionals and support agencies such as local GPs, community nurses, mental health teams and social services. We spoke with health care professionals who supported people who lived in the home. They told us that the staff were good at contacting them and asking for advice and support promptly and made appropriate referrals where necessary.

Good

Is the service caring?

Our findings

We asked people about living at the home. Comments included, "I like it as much as anyone can like a place that's not their home", "The carers are all friendly, I get on with them all." "There's not so many people for me to talk to now, so I keep myself busy", "I go out with friends and family we have coffee mornings for different charities and [name] makes the cakes, she makes extra cakes that are suitable for people that are diabetic."

Staff were seen to be caring. We observed that several people had coughs. There were jugs of water and squash in the lounge and people were encouraged to drink. The care staff spoke to people by name and treated them in a dignified but relaxed way. People were asked where they wanted to sit and with whom.

Staff spoke clearly and repeated things so people understood what was being said to them. They were treated with dignity and respect and people felt listened to.

We spoke to several people and observed others. Several people were asleep. One person was looking at a cross which had been used a few days earlier at the home's remembrance day service. The cross consisted of knitted poppies which some of the people had made in the regular knitting group. The activities co-ordinator used it to incorporate reminiscence into talking about the cross and remembrance.

Staff mostly demonstrated a good understanding of the need to respect people's dignity and privacy. However, when a visiting professional arrived they came into the clinic room to carry out foot care, when they saw us in the room staff said they would take the person to their room. However, the clinic room contained people's medicines and staff were in and out, this meant there was a lack of privacy and a possible infection control issue.

A relative also commented "My [name] has very good hearing and hears the staff talking in the corridor about people; they need to remember they can hear clearly." However we did not make a similar observation on the day.

When assisting with meals or drinks staff supported with dignity and engaged with the person in the activity.

Staff recognised the importance of encouraging people's independence. One told us "I don't interfere if I think someone can do something for themselves". We saw people were supported to maintain their independence inside the home.

People and relatives confirmed they were asked their views about the care and support their relatives received. The manager told us they spoke with relatives as they needed to and the relatives we spoke with confirmed this. We saw that staff asked people their opinion and choices on foods and favourite meals as part of the preparation of the new menus.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us they felt welcomed into the home and were asked for their views about the care provided. A healthcare professional told us they felt the staff and service were person centred, understood people's needs and were responsive to changing needs. They said they made referrals at appropriate times and always acted upon advice they were given.

Staff had a good knowledge of person centred care and were able to tell us what this meant. They knew the people they cared for and the support they needed. However although plans of care were personalised they did not always reflect people's individual needs. For example, behaviours that might be expressed by the person and mental capacity were not evident. However where people were able to meet their own needs the care plans clearly reflected this.

One person invited us into their room to talk. There was a stair gate across the doorway which they walked over to and let us in. The gate was their idea; they said, "It's to stop other residents just walking into my room, I don't like that." They had a small table on which was a telephone, snacks and a glass of squash in a wine glass. Asked about the glass they said "That's how I like it, it looks more inviting." When we asked about food served in the home they said "The foods nice here, but I have to have mine mashed up for me, because of my mouth.", "I prefer to eat in my room in private." They talked about their telephone which had large buttons on for easy use, "It's to keep in touch with the family." "

Another person also invited us into their room and they had a large calendar in their room on which their family note when they will visit, they said "The carers remind me when my daughters coming in."

There was a complaints procedure in place and on display in the hallway. People knew who to speak to if they had any concerns or complaints. They told us they could talk to staff and felt listened to. The complaints policy included clear guidelines on how, and by when, issues should be resolved. It also contained the contact details of relevant external agencies, such as the Local Government Ombudsman and the Care Quality Commission. We asked relatives whether they felt they could raise concerns if they had any. One said, "I know about the complaint policy but I've never had to use it." Visiting health professionals told us, "We've never had cause to worry or complain about the Home." This meant that people knew how to make a complaint should they need to. No one had made a formal complaint since our last visit.

Records we looked at during this inspection showed when incidents had happened people's records and risk assessments had been reviewed. However, care plans were not always being reviewed and updated regularly.

We looked at the care records for four people. We saw that information for staff about how to support individuals was very detailed. We saw from the care records that people's health and support needs were clearly documented in their care plans along with personal information and histories. However, when there were changes in needs for example health needs and dependency, care plans were not updated to reflect these needs although staff we spoke with knew people well.

We could see that people's families had been involved in gathering background information and life stories. Staff had a good understanding of people's backgrounds and lives and this helped them to support them socially and be more aware of things that might cause them anxiety.

Requires Improvement

Is the service well-led?

Our findings

Relatives told us, "We like it here, it's got a good feel to it." they told us how they admired how the carers helped people who had dementia. Of the other people and visitors she said "We keep an eye on each other, talk to the other residents." "We can turn up any time; [name] is always ok.
Staff are approachable we can ask them anything." "I think the home is run well."

Staff we spoke with told us they thought the home was well managed. They told us that they felt well supported by the manager and said that they enjoyed working in the home. One member of staff told us, "I am happy working here. It's like a well-oiled machine here. Feels like I'm working in a big family setting. I feel well supported." " Another said, "It's well run."

There were systems in place to audit records; however these were not consistently effective. For example, where people had been identified as being at risk of dehydration and they required support with fluids. The recording had not been consistent and fluid targets and totals were not clear. This meant that it was not clear if the person had received adequate fluids in a specific period. We spoke to a staff member about this. They were able to evidence through recording in handover sheets and care records that the person had received adequate fluids; however this was not obvious from the fluid monitoring chart. Other examples were the care plans not reflecting people's needs or reviewed regularly, and medicine protocols and administration records where staff had not recorded the amount of medicines they had given.

This system had not identified the issues that we noted. This meant that registered persons could not be assured that good quality care was always delivered.
The lack of accurate records in relation to each person and the lack of the efficiency of the quality assurance system to identify issues with the records and medicines was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Maintenance checks were being done regularly and we could see that any repairs or faults had been highlighted and acted upon. The manager had identified an ongoing improvement plan for the home and outside areas. There was a cleaning schedule and records relating to the premises and equipment checks, to make sure they were clean and fit for the people living there.

There were processes in place for reporting incidents and we saw that these were being followed. There was regular monitoring of incidents and these were reviewed by the manager to identify any patterns that needed to be addressed.

Since our last inspection the manager had been notifying CQC of all incidents and events that were required under the regulations.

Regular meetings with people and staff took place. The minutes contained a review of the minutes of the previous meeting and a plan to decide what action would be taken as a result of the current meeting, by when and by whom. The staff we spoke with felt the meetings were held in an open and honest manner in

which they could share ideas and raise concerns. Asked about resident's meetings people told us they attended them regularly. "I try to think of something to say every month." They felt encouraged to join in and express their opinions. "It is run quite well here I think." "I don't complain. If there's any problem my family comes in and the manager sorts it out."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The poor record keeping, not recording how much medicine is given and inconsistent information about medicines and the lack of information on medicines means that medicines were not safely administered and is a breach of Regulation 12 (safe care and treatment), of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The lack of accurate records in relation to each person and the lack of the efficiency of the quality assurance system to identify issues with the records and medicines was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.