Catholic Blind Institute

Christopher Grange Rhona House

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?	Good

Summary of findings

Overall summary

This inspection was carried out on 19 and 30 April 2018. The first day of the inspection was unannounced.

Christopher Grange Rhona House 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.

Rhona House is part of a larger complex that also provides a separately registered care home without nursing. The site has a reception area, chapel, main kitchen and laundry which are shared by both care homes. Some staff including activities, laundry and maintenance staff work across both homes and people can attend activities held anywhere on the site.

All accommodation at Rhona House is provided in single bedrooms and is at ground floor level. An enclosed garden and shared lounge and dining room are also available within Rhona House.

Rhona House accommodates up to 28 people. At the time of the inspection 26 people were living there.

At our last inspection of the home in October 2016 published in January 2017 the service was rated requires Improvement overall. We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in respect of Regulations 9 and17.

This was because people's care was not always designed in such a way as to meet their needs and reflect their preferences and the provider's systems and processes to assess, monitor and improve the quality of the services, required further development to ensure they were consistently effective.

After that inspection the provider wrote to us to say what they would do to meet its legal requirements. At this inspection we identified that improvements had been made and the provider was no longer in breach of these regulations.

The home has 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.

Comments we received from relatives and people living at Rhona House included, "They get very good care here. I wish they were all like this," and "The care is very good."

Systems were in place for safeguarding people from the risk of abuse and reporting any concerns that arose. Staff had received training and knew what action to take if they felt people were at risk of abuse. A system was also in place for raising and addressing concerns or complaints and people living at the home and their

relatives told us they would feel confident to raise a concern.

Equipment and the building were monitored regularly to ensure they were safe. The building had adaptations and equipment to support people with their mobility and personal care. This included hoists, stand aids and call bells.

People's medication was safely managed and they received it on time and as prescribed. Staff provided people with the support they needed to manage their personal and health care needs.

Assessments of people's care needs had been carried out and where they required support this was detailed in their care plans which provided guidance for staff on how to meet people's needs safely and well. These had been regularly reviewed to check they were up to date and accurate.

There was enough staff working at the home to meet people's care needs. Systems were in place and followed to recruit staff and check they were suitable to work with people at risk of abuse or neglect.

People liked the staff team and told us they were kind and caring. Staff had received training to help them understand and meet the care needs of people living at the home. Staff told us they felt supported and we saw that they had regular staff meetings and supervisions with senior staff. They told us that the registered manager listened to their point of view and was clear about the standards she expected from them.

Staff spent time interacting with people as well as meeting their care needs. They were attentive to and anticipated people's care needs and tried to make people as comfortable as possible. They spent time with people and took time to understand people's different ways of communicating.

When with people living at the home staff were respectful and treated them with dignity. Some of the language used within care records and by staff was old fashioned and not dignified. We discussed this with the registered manager who told us she would make a concerted effort to support staff to update their terminology.

A number of activities took place on the overall site including at Rhona House. People were welcome to attend any activities they enjoyed. These included attending services at the on-site chapel, armchair exercises and entertainers.

The provider met the requirements of the Mental Capacity Act 2005. People were supported to make choices and decisions for themselves. Where people lacked the capacity to make important decisions for themselves then the provider took steps to protect them. This included applying to the local authority for a Deprivation of Liberty Safeguard (DoLS) for the person.

Mealtimes were relaxed social occasions with people able to eat in the dining room or their bedroom as they preferred. People had a choice of meals and we saw that staff offered people support to eat, drink and monitor their nutritional needs.

Systems were in place for checking the quality of the service provided. These were used to plan improvements to the service provided and ensure the improvements had been made.

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.

Systems were in place and followed to monitor risks to the environment and people's safety and reduce the risk of these occurring.

Enough staff were available to support people in a safe, unrushed manner. Systems were in place and followed to check new staff were suitable to work with people who may be vulnerable.

People's medication was safely managed.

Is the service effective?

Good

The service was effective.

Staff received training and support to understand and meet people's needs.

People were supported to make decisions and choices for themselves. Where they were unable to do so the provider took steps to make decisions in the person's best interests or obtain legal protections for them.

Meals were sociable occasions which people enjoyed. Support was provided to people to meet their nutritional needs.

Is the service caring?

Good

The service was caring.

Staff spent time interacting socially with people as well as anticipating and meeting their care and support needs.

People liked and trusted the staff team and described them as caring.

Some of the terminology staff used was out of date and did not reflect their practice.

Is the service responsive?

Good

The service was responsive.

A variety of activities were available that people could participate in. People told us they enjoyed the activities provided and we saw people found these engaging.

Care plans provided clear guidance to staff on how to meet people's needs and choices. Staff were aware of this information and followed it.

People felt confident to raise any concerns or complaints that they may have and these were investigated and responded to.

Is the service well-led?

Good

The service was well-led.

The registered manager was experienced and enthusiastic about her role. She knew how the home operated and worked towards continually improving the service they provided.

Systems were in place for assessing the quality of the service, acting on issues identified and planning future improvements.

Christopher Grange Rhona House

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.

The inspection was carried out on 19 and 30 April 2018. An Adult Social Care (ASC) inspector carried out the inspection and the first day was unannounced.

Prior to our visit we looked at any information we had received about the home including any contact from people using the service or their relatives and any information sent to us by the home.

During the inspection we looked around the premises and met with many of the people living at the home, five of whom we spoke individually with. We spoke with relatives of seven people living at the home and with 14 members of staff who held different roles within the home. We also spoke with two visiting healthcare professionals who were familiar with the home.

We spent time observing the day to day care and support provided to people, looked at a range of records including medication records, care records for four of the people living there, recruitment records for four members of staff and training records for all staff. We also looked at records relating to health and safety and quality assurance.

Good

Is the service safe?

Our findings

The home had a policy in place to guide staff on the actions to take in the event of a safeguarding concern. In addition staff had received training in safeguarding vulnerable adults and were able to explain to us how they would identify a concern and report it. Records confirmed that safeguarding concerns had been identified and reported to the relevant authorities appropriately.

A whistle blowing policy was also in place to advise staff on the actions to take and the support they would receive if they raised a concern about something in their workplace that was in the public interest. Staff we spoke with were aware of this policy.

Risks to people's safety had been identified within their care plan and appropriate action recorded to minimise the risks occurring or causing harm. Assessments of the environment had also been undertaken with measures put into place to reduce risks associated with environmental factors.

The home had a series of internal and external checks in place for the safety of the premises and equipment. This included checks of equipment, water temperatures, lighting, fire system, small electrical appliances and the gas and electrical supply. These checks showed that the building and equipment were safe to use.

Information on how to support people in an emergency was available in the home. This included a fire evacuation plan and individual personal emergency evacuation plans for people. These were located along with a high visibility jacket in the office so that they could be easily accessed in an emergency.

The home was clean and tidy during our inspection and we saw that colour coded cleaning equipment was used to minimise the risks of cross infection. Hand soap and paper towels were available to staff along with disposable gloves. Recent staff meetings had included a presentation on infection control to update staff knowledge.

We observed part of a medication round. The nurse took time with each person and we observed her spending time with one person establishing if they wanted pain relief and waiting for the person to understand and respond to the question.

We looked at a sample of medication including medications prescribed for 'as required' use, in variable doses, medication subject to misuse and medication prescribed short term. We also looked at medication that was given to people via injection or through a tube in their stomach. Records were clear as to the dose, time and route of application and stocks tallied with records indicating people had received their medications as prescribed.

One person had their medication prescribed to be given 'covertly' – without their knowledge - if needed. Records were clear as to the reason for this which was that the person lacked the ability to understand the benefits and it was assessed as in their best interests. Clear guidance was in place for staff to follow to ensure they offered the medication first and only gave it covertly in line with the guidance.

Medication was stored correctly with the temperatures of the fridge and room monitored regularly.

Any accidents that occurred had been logged on an accident form. These were then collated and sent to the registered manager in the form of a monthly report. This provided details of the time, place, person and type of accident that had occurred. The registered manager could then review monthly reports to identity any emerging patterns and opportunities to reduce future occurrences.

Two of the people living at the home said were enough staff available to meet their needs. A relative told us "There is plenty of staff, always someone passing." A second relative told us that they found staff "A bit rushed but available."

A third relative said they did not think there were enough staff describing them as "Thin on the ground" and that their Mum had told them staff said, "Just a minute – a minute never comes."

A senior member of staff said the registered manager had listened to care staff and was recruiting new carers with the aim of having six care staff in a morning to support people. Care staff said that when there were six staff available to support people then they felt there were enough staff and they were aware the registered manager was working towards increasing staffing levels. During our inspection we observed staff were busy but had time to meet people's needs in a patient and unrushed manner.

We looked at recruitment records for four members of staff who had commenced working at the home recently. These showed us that staff had undergone an interview process and checks including obtaining a Disclosure and Barring Service check, references and identification had been carried out. These recruitment processes helped to ensure staff were suitable to work with people who may be vulnerable.

Checks had been carried out to ensure nurses were registered to practice by the Nursing and Midwifery Council. Where agency nurses or carers were used the home had obtained details of their registration and training from the agency in order to establish that the nurse had the skills required to work at the home.

Records were securely stored in a locked office or on a password protected computer. Records we asked for during the inspection were available, up to date and accurate.

Good

Is the service effective?

Our findings

Prior to people moving into the home a member of staff met with them and with people relevant to them and carried out an assessment of their needs. This was then used to establish whether the home could meet the person's needs and commence a care plan to guide staff on how to support the person safely and well. Completed pre-admission assessments were comprehensive documents that contained sufficient information to carry out this process.

Staff told us that they had received training to enable them to carry out their role safely and well. One member of staff explained "It's very good we get a fair amount." An external healthcare professional expressed the view that the home needed little external input as they kept up to date with their training and were able to provide knowledge based health support to people.

Records showed that staff had received training in a variety of subjects suitable to their role. This had included training in understanding dementia, fire awareness, infection control, moving and handling people and catheter care. They had not received specific training in understanding mental capacity and Deprivation of Liberty Safeguards (DoLS) however this had been booked to take place shortly after the inspection.

All staff had had one to one supervision from a senior member of staff. This provided staff and their manager with the opportunity to discuss their role, any concerns they may have and their training needs. Staff told us that they felt supported and could express their views at staff meetings which were held regularly.

The registered manager told us that in order to offer a smooth introduction to the home and minimise distress for people they would not accept admissions after 2pm. She explained this gave the person time to settle in a little and staff time to complete the paperwork required.

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 be as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application 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 or authorisations to deprive a person of their liberty were being met and found that they were.

People's capacity to understand and make decisions had been assessed. Where the person had been assessed as lacking the ability to make an important decision such as taking their medication or living in a care home then a 'best interest' decision had been made recording the reasons why the decision had been

made for the person. DoLS applications had been made to the relevant authorities for people who were assessed as requiring the protection a DoLS could offer them.

Information was recorded within people's care files of anyone who had the legal right to make a decision for the person, for example through the use of a Lasting Power of Attorney.

People living at the home told us "I recommend the food," "There is no rush I have breakfast in bed," "The food is nice," and "I love the soups." Menus of meals were displayed and we saw that people were offered a choice. Some people had a soft diet or required their food blending and the menu stated that a choice of these meals was also available. Staff were able to tell us what the blended food was and we saw that it was served with each component separated. This meant people would have the opportunity to taste the components of their meal rather than it being mixed together.

We observed part of the lunchtime meals. These were relaxed occasions with staff sitting next to people and offering unrushed support. Meals were nicely served in the dining room. For people eating in their bedroom their meal was well presented on a tray and looked as appetising as possible.

People's nutritional needs had been assessed and where they required extra support to maintain their weight or ensure they had an adequate intake of food and drink then a care plan was in place for the person. Their nutritional intake and weight had been monitored and reviewed regularly to ensure any changes could be quickly noted and acted upon.

Some people required a thickening agent adding to their drinks to enable them to swallow safely. Care staff had their competency to understand how to use these assessed regularly. This is good practice as their use differs depending on the person and the type of thickener used.

A relative told us that they had been pleased with the health care the home provided. They said staff had monitored their relative's health care needs and as a result their health had improved. A second relative told us that their relative's health was, "Well monitored" by staff.

An external healthcare professional told us that staff worked well with them. They said staff sought and followed advice appropriately and engaged in new initiatives to improve people's health.

A second external healthcare professional told us that staff "Listen and engage," and made appropriate referrals to them. They added that it could be balancing act as to whether staff always had the time and commitment to carry through some of their requests.

Records showed that people had been supported to access health professionals as needed. This included the GP, podiatrist, optician and dentist. Specific care plans were in place for people's individual health care needs and contained sufficient information to guide staff on how to meet these. Daily records showed us that care plans had been followed and people's health monitored regularly.

As a single story building Rhona House was easy for people to get around using mobility aids. Other adaptions to the building and equipment included call bells, specialist beds, accessible bathrooms and stand aids. These made it easier for people to be as independent as possible and receive support with their mobility, personal care and health.

Good

Is the service caring?

Our findings

One of the people living at the home described staff as "Good fun." A second person told us staff were, "Approachable, caring and friendly," and explained "All staff go out of their way, nothing is too much trouble."

Visitors were similarly complimentary about the staff team telling us they were friendly and welcoming to families too. One relative commented "They do a marvellous job. It's like a family." A second relative told us "I know my Mums happy here so we are happy."

The majority of relatives told us that they were kept informed by staff of how their relative had been and any changes to the person's health or wellbeing.

A catholic convent is based on the overall site. Nuns from the convent provided pastoral support to people at Rhona House and to their families and visitors when needed or requested. The on-site chapel was open all day and people of any faith could go in when they wished to. Senior staff told us that people or their families could use the chapel to hold services including funerals and that it had been used in the past for a baptism.

We saw staff supporting people to use mobility equipment. Staff took their time and reassured the person, giving a clear explanation of the things they would do and the things the person should do to use the equipment safely and well. We also observed staff spending time with people chatting and laughing. Staff talked with people constantly, sought their permission for providing care, asked if they wanted to wear an apron at mealtimes to protect their clothes and reassured people throughout the day.

We also saw that staff joined in activities and encouraged people who were less able to do the same. Staff were observant to people's needs, for example asking if they wanted a drink and offering to get them a cardigan if they appeared to feel the cold. People who were sat for a long time had blankets provided and we saw that people looked comfortable and cosy.

Some people had their breakfast in bed and we saw that they looked warm and comfortable. This arrangement meant that people were not rushed to get up in a morning but could have their personal care at a more leisurely pace.

In conversation with staff they provided us with examples of how they communicated with people who could not talk very well. They also explained how they took time to establish the things people liked or that were important to them. For example, a member of staff explained that they had established one person's religion was important to them and asked if they wanted to go to the daily church service. The member of staff explained that since then all staff offered the person this opportunity daily and we saw this occurring during the inspection.

Information on the choices people could make was recorded within their care plan. We looked at one care

plan which recorded the person's choice as to whether they agreed to staff of the opposite sex to themselves to provide their personal care. People who were able to do so had been offered the opportunity to discuss and agree with their care plan contents. Where applicable people's relatives had also had the opportunity to read and agree with the contents of the person's plan.

Some of the language used in records and by staff was not respectful. For example rather than referring to supporting people with their meals and / or a soft diet we were told "We feed the blends first. Then the normals." We also saw records referring to 'blends' and 'feeding' and referring to people as 'compliant'. These are not respectful terms to use about people and did not reflect the way in which we saw staff interacting with people. We discussed this with the registered manager who told us that she would make a concerted effort to support staff to update their language and records to be more respectful of people.

Good

Is the service responsive?

Our findings

During the inspection we saw that staff were responsive to and anticipated people's needs. Staff responded quickly to requests for help and support. We observed that when people took time to communicate staff waited patiently and took the time to understand what the person was telling them. Staff also anticipated people's needs, for example we saw them offering extra clothing or to open or close a lounge window as well as offering people extra drinks as it was a warm day.

Individual care plans were in place for the people living at Rhona House. These contained sufficient information to assess the person's needs and provide guidance to staff on how to support the person.

Assessments of the person's care needs had been undertaken and reviewed regularly. Where they identified a need for support then a care plan was in place to guide staff on how to provide this safely and well. Assessments and care plans had been reviewed and updated regularly to check the information was accurate and up to date. In addition a series of risk assessments for individuals had been carried out. These included looking at risks to the person in using equipment, risks to their nutrition and to their mobility. Where a risk was identified measures were recorded to minimise this and the care plan reflected the steps staff should take.

A notice board advertised activities for the week including, reminiscence, crosswords, quiz, armchair exercise and games. One of the people living at the home told us, "There is something to do every day." A relative told us, "Activities are excellent. Rhona House will take Mum outside to other activities on the site too." A second relative told us, "They come round and ask if people want to attend activities." We saw people taking part in an armchair exercise group which the appeared to find engaging and fun.

There is a chapel on site which has a catholic mass daily and we saw people being offered the opportunity to attend. The chapel also has a monthly Anglican service and can be used by people of any denomination to hold a service.

We checked whether the provider was following the Accessible information Standard (AIS). The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. Staff were able to verbally tell us how they made information accessible to people and care plans contained information about how people communicated. We discussed with the registered manager who agreed to look at more formal ways of recording how the home were meeting this standard.

People's care plans recorded the choices they made in their everyday lives and their ability to make decisions. Where people could not make a major choice this was recorded along with how the choice had been made on their behalf. Throughout the inspection we saw staff offering people everyday choices such as what to eat or drink, what activities they wanted to join and what they wanted to wear.

Information on how to make a complaint was located at the entrance to the home, making it easily accessible to people living there and their visitors. People told us that they would feel comfortable raising a concern. One person said, "Oh I would tell them." A relative explained, "I go to them straight way and they sort it."

The complaints procedure provided people with information on how to raise a complaint or concern and the details of how it would be investigated. We looked at records for three complaints received in 2018. These showed us that the complaint had been investigated and the outcome had identified areas where action should be taken. An action plan had been implemented and the complainant informed of the outcome.

Relatives of two people told us that they had raised concerns regarding laundry going missing or people's clothes getting mixed up. They said that although there had been some improvement this was still a concern at times.

Until recently the home took part in a scheme whereby a number of beds were contracted to provide palliative (end of life) care for people. This meant that staff had received training in how to provide palliative care including the use of pain relieving medications and equipment.

A registered nurse told us that they had been supported to undertake a five month course in palliative care. She explained that registered nurses at the home were trained to use equipment to deliver medication to people receiving palliative care. She also explained that the home would refuse to admit people for palliative care without the correct medication and support in place in order to plan for and deliver the best care for the person.

Good

Is the service well-led?

Our findings

The home had a registered manager who had been in post since June 2015. Staff told us the registered manager had high expectations of them and was supportive. Their comments included, "Incredibly supportive,", "She is supportive, she listens, compromises," and "She is very supportive. She has an understanding of all our jobs."

A senior member of staff told us "I feel safe working here. [Registered manager] is by the book. We have to work to certain standards". Another member of staff told us "You can challenge [registered manager] she is passionate but does listen."

We found the registered manager enthusiastic and knowledgeable about the service and the people they supported. She displayed a willingness to learn and was working with other organisations to improve the overall experiences people living in care received. This included working with a local hospital on a project to plan people's hospital to care home discharges in a better way. An external healthcare professional described the registered manager as "Forward thinking and transparent."

A series of checks and audits were in place at the home to check the environment and the care people received were safe. This included regular audits of fire systems and water temperatures and equipment people used including hoists and electrical mattresses.

Audits of care plans and medication were also regularly undertaken. Where an issue was noted during a check or audit then an action plan was drawn up and implemented. Audits we looked at were working documents that had been checked and updated to show actions taken.

Meetings were arranged for people living at the home and their visitors to enable them to express their views on how the home operated and any future improvements that could be made.

Records were accurate, up to date and regularly reviewed. They were also stored confidentially and used as 'working documents' to help plan and monitor the service people were receiving was safe and effective.

The provider had notified the Care Quality Commission (CQC) of all incidents that had occurred in the home in accordance with our statutory requirements. This meant that CQC were able to accurately monitor information and risks regarding Rhona House.

Ratings from the last inspection were displayed within the home and on the provider's website as required. From April 2015 it is a legal requirement for providers to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.