Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

St Christopher's Residential Home

47-49 Rutland Gardens, Hove, BN3 5PD

Tel: 01273327210

Date of Inspection: 03 January 2014

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We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Management of medicines	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard

Details about this location

Registered Provider	Mrs T Hounsome and D S Sandhu
Registered Manager	Mrs. Theresa Hounsome
Overview of the service	The home provides accommodation and personal care for up to 19 older people. Apart from one double occupancy room, people live in single rooms located over three floors, which are connected by stair lifts. Communal rooms are all on the ground floor.
Type of service	Care home service without nursing
Regulated activity	Accommodation for persons who require nursing or personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 3 January 2014, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information sent to us by commissioners of services.

What people told us and what we found

We spent a day at St Christopher's Residential Home. We spoke with four people who lived there, four visiting relatives, three of the care staff and the two provider's, one of whom is the registered manager. We looked at care plans and records for the people we spoke with.

People's descriptions to us of the care they received matched the contents of their care plans. People told us staff were attentive to health needs and communicated well. Records showed GP visits to the home were requested promptly in response to health concerns.

All people we spoke with considered the home a safe place to live. Staff were clear about indicators of possible abuse, and their responsibilities should they identify any concerns about people's safety.

Medicines were safely stored and were administered only by staff who had been trained in safe handling of medicines.

There was an appropriate system for checking that prospective staff were suitable for working with vulnerable people. Newly appointed staff received an induction followed by time shadowing experienced staff before starting to work on their own. This was to enable them to develop confidence and for people living in the home to get to know them.

The provider communicated with people in the home both informally and through meetings. An annual quality survey of people in the home and visitors showed high levels of satisfaction. People saw management as approachable. We saw they were responsive to good practice guidance and to individual comments and preferences.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

Care and treatment was planned and delivered in a way that was intended to ensure people's safety and welfare.

Reasons for our judgement

People's needs were assessed before they moved into the home. This assessment formed the basis of a person's care plan. Each care plan began with a summary of why the person had moved into the home and how to meet their main assessed needs. This approach provided for continuity of care between a person's former living arrangements and life in the home. Plans showed in what ways people could be supported to maintain independence and skills. They showed sensitivity to emotional as well as physical needs.

People's descriptions to us of the care they received matched the contents of their care plans. One person said they had felt very involved in an initial decision to move into the home and later to stay there. They had not experienced any ill health there but said staff had definitely helped improve their mobility.

Care plans made provision for people to sign agreement to their care plans, but the provider may find it useful to note this had not been done in all plans that we saw. There was evidence of an effective quarterly review system. For example, for one person the review form showed dietary changes recommended by their GP had been incorporated into the care plan, with guidance to staff on what this meant in practice. Records of people's weight were kept routinely and we saw that significant changes in weight were taken into account in recognising possible changing needs.

We saw the care plans were working documents. Daily records of staff provision of care showed they were observant of people's wellbeing and they indicated where incoming staff needed to refer to changes made within care plans. Staff received a 15 minute handover before starting any shift. We sat in on a staff handover. The wellbeing of all people in the home was considered. Staff told us they would be told of any changes to care plans in this process. They also told us about training they had received within the previous year to assist their understanding of diabetes and dementia.

There were good links with GP surgeries where people were registered. Records showed

GP visits to the home were requested promptly in response to health concerns. In case someone needed to be admitted to hospital from the home, all care plans included a hospital transfer letter. This contained essential details so the receiving hospital would be able to provide continuity of care. We also saw the home liaised with district nurses, about both routine visits and when requesting treatment to minor injuries. For one person there was a working link with mental health services. We spoke with four people who lived in the home and two visiting relatives. People told us staff were attentive to health needs and gave examples of swift actions leading to medical referrals. Visitors told us the home communicated well with them about any health matters.

Care plans included arrangements for supporting people with daily living and social activities. Some people who lived in the home were able to access the local community independently, or with staff support. For example, one person had been accompanied on a theatre trip in the evening before our visit. Staff told us they aimed to offer spontaneous stimulation to people in the lounge each afternoon. An activities diary showed this was largely achieved and it recorded which people took part. Activities included quizzes, word games and physical games such as skittles. We saw a word game carried out informally but successfully by a member of staff as they served hot drinks in the lounge. Care plans noted people's interests. The provider may find it useful to note there was scope for making such information more detailed and therefore more useful in guiding staff on supporting people. For example, notes that people liked reading or watching television did not expand on what kinds of programmes, magazines or books they enjoyed.

Staff were aware of those people who were less keen or able to join group activities. They told us they engaged people individually in conversation and they invited people to assist tasks such as folding linens and laying tables. These activities were recorded in the diary. In addition to in-house activities, an outside facilitator led exercise sessions two mornings a week and there were occasional visits by musical entertainers. People in the home we spoke with said they chose how much they joined in organised activities. They spoke about staff maintaining a lot of contact with people whether in the communal rooms or bedrooms, mainly by delivering hot drinks and showing a pleasant and engaging manner. However, the provider may find it useful to note people's perceptions were that opportunities for sustained conversation were largely confined to people in evident need of emotional support.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

We spoke with four people who lived in the home. They all told us they felt safe as a result of living there. Relatives of two people said they felt reassured their relatives were living in a safe place.

Training records showed all staff received training in abuse awareness and safeguarding processes every year. There was a hub space in the home where care plans and medicines were kept and staff discussed care issues. The local multi agency arrangements for safeguarding were kept in a prominent place there, as was guidance on the deprivation of liberty safeguards and how staff were to raise an alert about any concern of unsafe practice in the home. Staff received separate training about how the Mental Capacity Act related to their work.

An incident book was maintained for management or staff to record details of any untoward incident as soon as it had occurred. This is good practice as a means of ensuring accuracy. However, we asked the provider to note that the unstructured format meant there was no audit trail of actions and decision making following an incident being recorded. The record did not specifically show, for example, whether a safeguarding referral, notification to the Commission or review of the person's risk assessments had been considered or made.

Where people could display behaviours or attitudes that might disturb others, these were described in care plans. There was guidance on recognising how people might become distressed and how to take proactive steps to reduce the likelihood of this arising. A person living in the home told us they saw staff interactions with another person as "amazing, they spend time with them and involve them in things so they don't get upset or upset others." A staff newsletter included guidance on managing a particular relationship issue within the home at the time.

The providers, one of whom was the registered manager, were available 'on call' to staff when away from the home so staff could contact them for consultation. For example, staff would be required to obtain management agreement about administration of some

medicines prescribed for use 'as needed'. There was a reciprocal agreement with the provider of another care home to provide on call support in the absence of the providers. A member of staff told us "the manager wants to know every day how everyone is. I'm confident how to pass on any concern and it would be taken seriously."

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

We saw that medicines were safely stored. All staff, apart from two recently appointed, had received certificates after undertaking an accredited distance learning course on safe handling of medicines. Staff told us they always undertook medicines administration in pairs, to ensure accuracy of reading and following the directions in the Medicines Administration Record (MAR). They said they routinely checked the MAR entries of the previous shift for errors. The manager told us they audited the MAR and quantities of medicines held every week. The incident book showed that where a medicines error had been identified, the cause had been ascertained for sharing as a learning experience and the staff member responsible had been subject of disciplinary action.

A person we spoke with was managing their own medicines. We saw this was subject of a risk assessment, which was reviewed periodically. The risk assessment process included ensuring the person had a good understanding of their medicines and associated risks, and how to keep them safely. There were records of checks of the quantities of medicines the person held, to ensure these were in line with how they were prescribed to be taken. Relatives of another person told us "(Our relative) knows exactly what they are taking and why."

Care plans included letters from people's GPs to confirm what 'homely medicines' could be given alongside prescribed medicines. This meant staff had guidance on responding to people's requests for cold remedies or constipation relief, within safe limits. Any use of homely medicines was recorded. Some medicines, mainly for pain relief, were prescribed for use 'as needed'. Usually people were asked if they wished to take these, and the MAR was completed to show when they were given, which meant people would not exceed the maximum dose. However, the provider may find it useful to note there were no detailed individual protocols for 'as needed' prescriptions, for example if a person could not indicate if they were in pain, or to guide use of a medicine prescribed for very specific circumstances.

Requirements relating to workers ✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for by suitably qualified and skilled staff because the provider followed safe recruitment practice.

Reasons for our judgement

We looked at recruitment records for two night care workers who had been recruited during 2013. We found the recruitment process was conducted consistently.

There was an appropriate system for checking that prospective staff were suitable for working with vulnerable people. They were subject to vetting and barring checks and could not commence work before evidence was received that they were not barred from working in such employment and were not unsuitable on account of a record of convictions. Two references were in place for each person appointed, before they commenced employment. For one person, a previous employer had not supplied a sufficient written reference. The manager had telephoned them and made a record of a verbal reference. The provider may find it useful to note there were no records of interview to show the basis of decisions to appoint people.

Newly appointed staff received an induction followed by time shadowing experienced staff before starting to work on their own. This was to enable them to develop confidence and for people living in the home to get to know them. We saw the new night staff had each spent two or three night shifts with experienced night staff before undertaking night duties alone. The manager told us additional shadowing shifts would be provided if staff did not feel ready to work alone.

Assessing and monitoring the quality of service provision ✓ Met this standard

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was meeting this standard.

The provider had effective systems to regularly assess and monitor the quality of service that people received and to identify, assess and manage risks to the health, safety and welfare of people who use the service and others.

Reasons for our judgement

The providers used questionnaires to consult people who lived in the home and their relatives about their experience of the service provided. The manager said they found people responded most effectively to single issue surveys. We saw the most recent had been about nutrition and catering, with some responses indicating wishes for greater variety of foods. This had been followed up by an exercise with people in the home to establish preferences in detail and changes were made, with a further review scheduled. Planned surveys were to look at care, and recreation.

Relatives we spoke with, and people living in the home, described the providers as approachable and responsive to suggestions and comments. One relative said the manager often asked if they were satisfied with how the home operated for their relative. Another spoke of a "very supportive discussion" they had with the manager.

Some people in the home benefited from funding by the local authority. A contracts monitoring officer visited the home in March 2013. Actions recommended in their report had been acted on, showing the management were responsive to suggestions for development. For example, recommended improvements had been made to medicines documentation. The providers told us they had a building maintenance plan. This had incorporated recent requirements of a fire safety report. There were detailed regular audits of cleaning and infection control measures in the home. The providers told us there was a maintenance plan for the fabric of the building.

There were records of accidents and incidents that occurred in the home. These were detailed and, in the case of accidents, it was clear what actions were taken to address issues arising and reduce risks. The manager told us they were informed quickly about accidents and incidents and thus had a good knowledge of existing and emergent risks and how they were managed at any time. They agreed our observation that the records themselves did not confirm when matters became subject of management oversight.

The management produced a newsletter for staff most months of the year and held staff

meetings approximately quarterly. These had a standing agenda, including health and safety matters and infection control. Minutes showed the meetings covered both operational matters and consideration of the changing needs of people who lived in the home. Staff told us the mix of formal and informal meetings and written guidance worked well in ensuring they knew how issues arising were being addressed. They felt their opinions were valued.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

Phone:	03000 616161
Email:	enquiries@cqc.org.uk
Write to us at:	Care Quality Commission Citygate Gallowgate Newcastle upon Tyne NE1 4PA
Website:	www.cqc.org.uk