Crescent Home Limited

Crescent 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 unannounced inspection took place over two days on 2 and 3 November 2016.

Crescent House is registered to provide residential care for up to 33 older people. At the time of this inspection there were 33 people living in the home.

There was a registered manager in post at the time of our inspection. 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.

People felt safe in the home and relatives said they had no concerns about people's safety. Staff understood the need to protect people from harm and abuse and knew what action they should take if they had any concerns. There were sufficient staff to meet the care needs of the people and recruitment procedures protected people from receiving unsafe care from care staff that were unsuitable to work at the service. Staff received training in areas that enabled them to understand and meet the care needs of each person.

Staff had good relationships with the people that lived in the home. Staff responded to complaints promptly and in line with the provider's policy. People and staff were confident that issues would be addressed and that any concerns they had would be listened to and acted upon. There was a stable and accessible management team in place.

Care records contained individual risk assessments and risk management plans to protect people from identified risks and help to keep them safe. They provided information to staff about action to be taken to minimise any risks whilst allowing people to be as independent as possible.

People were supported to take their medicines as prescribed. Medicines were obtained, stored, administered and disposed of safely. People were supported to maintain good health and had access to healthcare services when needed.

Care plans were written in a person centred approach and detailed how people wished to be supported. Where possible people were involved in making decisions about their care and support needs. There were formal systems in place to assess people's capacity for decision making under the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

People were not always able to access suitable levels of social interaction and activity. In response to feedback from people, relatives and staff the provider has reviewed and increased staffing levels to support this.

There were systems in place to monitor the quality and safety of the service. Where these had required

strengthening in some areas the provider had acted promptly to ensure that people's care and support needs were being met appropriately.

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.

Staffing levels ensured that people's care and support needs were met.

People felt safe and comfortable in the home and staff were clear on their roles and responsibilities to safeguard them.

Risk assessments were in place and were reviewed and managed in a way which enabled people to receive safe support.

There were systems in place to manage medicines in a safe way and people were supported to take their prescribed medicines.

Safe recruitment practices were in place.

Is the service effective?

Good

The service was effective.

People were actively involved in decisions about their care and support needs and how they spent their day. Staff demonstrated their understanding of the Mental Capacity Act, 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS).

People received the support they required to ensure that their nutritional needs were met.

People received personalised care and support. Staff received training to
ensure they had the skills and knowledge to support people appropriately.

People were supported to access appropriate health and social care professionals to ensure they received the care, support and treatment that they needed.

Is the service caring?

Good

The service was caring.

Staff had a good understanding of people's needs and preferences and worked with people to enable them to communicate these.

People were encouraged to make decisions about how their care was provided and their privacy and dignity were protected and promoted.

There were positive interactions between people living at the home and staff.

Is the service responsive?

Good

The service was responsive.

Staff did not always have the time to support people with sufficient social stimulation and activity. The provider has taken action to increase the level of activity available to people.

People were listened to, their views were acknowledged and acted upon and care and support was delivered in the way that people chose and preferred.

People using the service and their relatives knew how to raise a concern or
make a complaint and a system for managing complaints was in place.

Is the service well-led?

Good

The service was well-led.

There were systems in place to monitor the quality and safety of the service. The provider has taken action to strengthen these in some areas.

A registered manager was in post and they were active and visible in the home. They provided staff with regular support and guidance.

The provider responded to any concerns or areas for improvement. They were innovative in implementing strategies to secure improvements.

Crescent 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.

This inspection took place on 2 and 3 November 2016. The inspection was unannounced and was undertaken by one inspector.

We reviewed the information we held about the service, including safeguarding information and statutory notifications that the provider had sent us. A statutory notification is information about important events which the provider is required to send us by law. We also spoke to local commissioners about the service.

During this inspection we visited the home and spoke with six people who lived there and spoke with four of their relatives. We also looked at care records relating to three people. We spoke with the provider, registered manager and eight members of staff, including the deputy manager, senior care staff and care staff. We also spoke with a hairdresser, chiropodist and a general practitioner (GP) who was visiting the home. We looked at four records in relation to staff recruitment, as well as records related to staff training and the quality monitoring of the service. We made observations about the service and the way that care was provided. We also used the Short Observational Framework Inspection (SOFI); SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People looked happy and relaxed around staff and we observed people laughing and joking with staff as they supported them. A number of people commented that they felt safe in the home and would ask staff for help if they needed it. One person said "I feel safe and well looked after, the staff really do their best". People's relatives also had confidence in the ability of the staff to maintain people's safety; one person's relative said "I do think [Name] is safe, they are well looked after and they like it here". The provider had carried out a survey of people living in the home and their relatives in July 2016 and this showed that people were happy with the care and support they received, thought that there were enough staff on duty to keep them safe and that staff responded promptly to their requests for support.

The staff we spoke with all understood their roles and responsibilities in relation to keeping people safe and all knew how to report any concerns, although stated that they had not needed to do so. We saw from staff training records that all the staff had undertaken training in safeguarding and that this was regularly refreshed. There was an up to date policy and the contact details of the local safeguarding team were all readily available to staff. Staff told us that if they had any concerns they would speak to the registered manager or deputy manager and if they were not satisfied with what happened they would report the incident outside of the home. For example one member of staff said "If I had concerns I would go to the manager, but if they didn't act I would report it outside the home and if I thought it necessary I would report it to the police". Where safeguarding referrals had been made we saw that the issues raised had been appropriately investigated and action taken to mitigate any risks.

People were safeguarded against the risk of being cared for by unsuitable staff. Recruitment files contained evidence that criminal record checks were carried out and satisfactory employment references were obtained before staff were allowed to work in the home. Staff we spoke with confirmed that these checks were carried out before they commenced their employment.

Staff told us that they were able to meet people's care and support needs, but that this was stressful to achieve and they felt that they were often rushing from one person to the next. One member of staff said "It is busy, the [call] bells are ringing one after another and we are running around like mad. It is stressful because people want you straight away". The provider had carried out an anonymous staff survey in July 2016 and this showed that staff had a positive view of their ability to provide appropriate care to people. However, during the inspection four members of staff raised concerns regarding their ability to answer call bells effectively and we observed that staff were very busy with care tasks. One member of staff said "A lot of people use call bells, we can answer them quickly but we have to tell them that we will come back later; once we've finished what we're doing".

The provider confirmed that, although, having initially attended a call, staff may tell people they would come back later if the person's need was assessed as not being urgent, for urgent calls staff would deal with the call at the time of their initial attendance. The provider had a system in place to monitor call bell response times and, in addition to the traditional electronic call bell system, was currently trialling a new call bell system which once enabled; people would be able to use the new system to call for assistance using

tablet devices or a watch that they could wear. This would mean that people had more flexible access to call for staff assistance and support. The provider was trialling this in ten people's rooms at the time of inspection and informed the inspector that this would be increased at a rate of one room per week. This system was not fully in use at the time of the inspection and it is therefore difficult to assess the impact that it would have on the quality and safety of care provided to people.

The provider had determined that three staff were needed to work in the home overnight. However, staff told us that when colleagues were unavailable at short notice, the shift sometimes ran with two members of staff. We spoke with the provider about the provision of night staff and reviewed rotas for the last eight weeks prior to the inspection. Although there had been a recent problem with staff informing the home at short notice that they could not attend for their shift, the registered manager had been deployed to cover these shifts. The provider explained that the registered manager usually acted as on call support for the home and sometimes spent time in the home during the night. As such, staff spoken to may not have recognised that the registered manager was covering for the absent member staff. People that we spoke to did not raise any concerns about their care overnight; they told us that staff answered their call bells promptly and provided the support they needed when they needed it. One person told us that they often had bad dreams and that staff would bring them a cup of tea and stay and chat with them until they felt better.

People's medicines were safely managed and the provider had a policy in place to cover receipt, storage, administration and disposal of medicines. Staff were trained in the administration of medicines and had their competency checked by senior staff. Our observations confirmed that this training was followed in practice; staff encouraged people to take their medicines and told people what their medicines were for. The provider was using a computerised system to manage medicines and staff referred to medicines administration records on hand held devices, checking the medicines that were due to be given to people before administration. The system also alerted staff if there was a risk that time specific medicine was going to be administered too close to the previous dose or if a medicine that should have been administered had not been signed for. Staff followed guidelines for medicines that were only given at times when they were needed, for example Paracetamol for when people were in pain. One person told us "I get my Paracetamol when I need it and I always tell the staff whether I need one or two".

There were a range of individual risk assessments in place to identify areas where people may need additional support to manage their safety and these were regularly reviewed. These guided staff how to support people in a safe way and covered all aspects of their lives. Staff demonstrated an understanding of risk assessment and the need to adapt the level of support they provided depending on the person's support needs and identified risks. For example a member of staff described how one person's individual risk assessments regarding their emotional and psychological needs helped them to understand how to keep the person safe, whilst supporting them to be as independent as possible. When accidents had occurred, staff took appropriate action to ensure that people received appropriate and timely treatment from health professionals if required.

People lived in an environment that was safe. There were environmental risk assessments in place and equipment was regularly checked and well maintained. Contingency plans were in place in case the home needed to be evacuated and each person had a Personal Emergency Evacuation Plan (PEEP) in place to provide information to emergency services in the event of an evacuation. Regular fire drills took place to ensure that staff knew how to respond in a fire.

Good

Is the service effective?

Our findings

People's needs were met by staff that had the required knowledge and skills to support them appropriately. New staff received an induction which included DVD based learning, practical training in areas such as manual handling and shadowing experienced members of the staff team. Staff did not work with people on their own until they had completed the provider's mandatory training and they felt confident to undertake the role. One member of staff said "The induction was good; I had enough time to learn and felt confident before working on my own". Newly recruited staff also undertook the Care Certificate; this is based on 15 standards that aim to give employers and people who receive care, the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

People were supported by staff who had received training that was relevant to their role. Training records showed that staff had accessed training in key areas such as mental capacity and infection control on a regular basis and that the provider had a plan in place to ensure that staff training was updated periodically. Staff told us that they received the training they required to support people effectively. One member of staff said "We watch DVDs in things like safeguarding, we also do manual handling as a practical; [Provider] shows us how to do it and then watches us to make sure we are doing it correctly". Additional training, relevant to the needs of some of the people staff were supporting was also provided; this included training in dementia awareness.

People's needs were met by staff that were effectively supported and supervised. Staff were able to gain support and advice from senior staff, the registered manager and provider when necessary and regular supervision meetings were available to all staff. The meetings were used to assess staff performance and identify on-going support and training needs. One member of care staff said "Supervision is helpful, it's a chance to talk about what's going well and anything else we want to talk about."

People received care and support from staff that had received the training they needed to ensure that support provided was in people's best interest. Staff were aware of their responsibilities under the Mental Capacity Act 2005 (MCA 2005) and applied this knowledge appropriately. The MCA 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty 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. The registered manager and staff were aware of their responsibilities under the MCA and DoLS codes of practice. Care plans contained assessments of people's capacity to make decisions and when 'best interest' decisions had been made following the codes of practice. The provider had followed the legal process when applying for DoLS

authorisations to place restrictions on people's freedom and was in contact with the relevant local authority regarding applications that were yet to be authorised. Appropriate plans of care were in place to ensure that people's care and support needs were met in the least restrictive way and we observed that staff asked for people's consent before providing care.

Nutritional assessments were carried out to ensure that staff were aware of people who were at risk of not eating and drinking enough. These assessments provided guidance on meeting people's nutritional needs and checking whether people were losing or gaining weight. The management guidelines in use stated that people at low risk of malnutrition should be weighed monthly and in the main this happened. To ensure that key aspects of care were not missed the provider had implemented a process that prompted staff to undertake these and if any activity was not completed on the allocated day, it was carried it over to the following day, for example when people were due to be weighed.

People received the support that they needed to maintain adequate nutrition. People's choices and any special diets were catered for and people were provided with a fortified diet if needed. The majority of people said that they enjoyed the food; one person told us that they only ate vegetarian food and we observed that they were provided with this, another person said "The food is good and you always get a choice". We observed lunch being served in the home and people were provided with a choice of meal and an alternative to this if they did not like what was on the menu. Staff serving lunch engaged with people in a positive way; asking if people had had enough to eat and drink, and checking that they had enjoyed their meal. Care plans contained detailed instructions about people's individual dietary needs, including managing diabetes and food allergies.

People's healthcare needs were monitored and care plans ensured that staff had information on how care should be delivered effectively. People had prompt access to health care support, as the doctor attended the home weekly as well as visiting people for acute health problems when needed. One person said "They get the Dr out quickly if needed, I had a particular problem and they got the Dr out straight away". A GP was visiting the home during the inspection and told us that the staff effectively monitored people's health and well being and responded promptly and appropriately to health concerns. We saw evidence of regular health checks taking place and people were supported to access a range of healthcare professionals such as the chiropodist, diabetic services and district nurses.

Good

Is the service caring?

Our findings

Staff supported people in a kind and caring way and involved them as much as possible in day to day choices and arrangements. Staff had good relationships with people, one person said "They're so friendly and cosy, you can talk to them". Another person said "The staff know me as a person and treat me as an individual". Staff knew about people's life histories and the people and things that were important to them and the deputy manager was in the process of completing more in depth life histories with people.

People told us that their family could visit whenever they liked. We spoke with people's relatives who told us they were very pleased with the care and support provided for their family members, one relative said "The staff are nice, kind and caring; they are all really cheerful". Another said "The staff have done a really good job of helping [Name] to settle here".

We observed that staff were open and warm towards the people they were supporting, interaction was often light hearted and we observed that people enjoyed having a laugh and a joke with staff. Staff told us that they understood the importance of supporting people in a way that enhanced their well-being; one member of staff told us ""I always chat with people whilst I'm helping them with personal care; it makes them feel more comfortable". We observed staff bending down to communicate with people who were sitting down and using eye contact to assist communication.

People were encouraged to express their views and to make choices. There was information in people's care plans about their preferences and choices regarding how they wanted to be supported by staff and we saw that this was respected. One person's relative told us "[Name] is always given the opportunity to choose what she does; for example, sometimes she likes to eat in her room and other times she will go to the dining room for company". A screen in the entrance hall of the home displayed information regarding an outside entertainer that would be visiting the home that afternoon and a religious service that would be taking place that day. Photos and information about the staff on duty was also displayed.

Staff knew people well and understood the importance of supporting people to maintain their independence. A member of staff described how one person was having increasing difficulty getting up from their chair, but had told staff that they did not want them to assist them, as they wanted to do it themselves. We saw that staff observed them from a distance to maintain their safety and independence. One person told us "I'm much more independent than when I first came here; I can move better and do more to wash and dress myself now; the staff have helped me to do that".

Staff understood the need to respect people's confidentiality and understood not to discuss issues in public or disclose information to people who did not need to know. During induction new staff were given the confidentiality policy to read and signed to confirm that they understood the importance of this. People's dignity and right to privacy was protected by staff. One person said "The staff are always very respectful to the people who live here". Staff were able to explain how they upheld people's privacy and dignity by taking into account their personal situation and needs and attending to these in a person centred way. For example, one member of staff said "I make sure I keep doors and curtains closed when helping someone

with personal care". Another said "It's important to do things the way people want and make sure that they feel comfortable". We observed that staff knocked on people's bedroom doors and waited to be invited in before entering the room.

The provider was aware of how to access advocacy services on behalf of people and information was available regarding people who had a lasting power of attorney or an advocate in place.

Good

Is the service responsive?

Our findings

People's care and support needs were assessed before they came to live at Crescent House to determine if the service could meet their needs. One person's relative told us "The deputy manager came to meet [Name] before they came into the home, to find out about the things that [Name] needs help with". Initial risk assessments and care plans were produced and these were monitored and updated as necessary.

Person centred care plans were up to date, reviewed as needed and contained information about people and their preferences. Risk assessments and care plans were linked together and cross referenced to give a full picture of people's needs. They covered areas such as personal care, eating and drinking and mental capacity. One person had diabetes and their care plan explained how staff should support them to make healthy choices with regards to eating and drinking, we saw that staff offered them an appropriate choice of dessert at lunch time. We saw that where people needed specific equipment to support them this was in place. For example pressure relief equipment was in place for people who may be at risk of pressure ulcers.

The provider told us that people or their representative were involved in planning their care as much as they were able, however because care plans were stored electronically there was no formal way for people to demonstrate their consent to care and support, for example by signing their care plan. This was discussed with the provider during the inspection and they immediately put measures in place for people's consent to be recorded.

Care and support was planned and delivered in line with people's individual preferences, choices and needs and people chose how and where to spend their time. Meals were served in either people's own rooms or in the lounge and dining area. Some people liked to spend time in their bedrooms; others spent time in the lounge areas or outside in the patio gardens linked to their rooms. We spoke to one person who was sitting in their garden and they said "I love sitting out here, my own little area outside". We observed that two people who wanted to be able to go out for a walk without staff support had been provided with swipe cards that opened the door; these sent a computerised message to staff to let them know they had gone out.

The assessment and care planning process considered people's hobbies and past interests as well as their current support needs. However people told us and we saw that there was not always enough social interaction and activity available to ensure that sufficient mental stimulation was available to people living in the home. Staff did their best to engage people in activities but they did not always have time to ensure that there were things for people to do. We observed staff talking briefly with people during the day as they supported them; for example whilst in the dining room supporting people with lunch. One person said "Staff pop in and see me when they can, but they're busy, busy, busy". People's relatives told us that they did not think there were enough activities available in the home. One person's relative said "The staff and management are lovely but there are not enough activities for people to take part in", another said "The carers are lovely but they don't have a lot of time to spend talking to [Name]". Staff also felt that they did not have time to support people with activities, one member of staff said "We are busy giving care, we don't have time to do activities or talk to people, there is no activity other than the group entertainment; we just haven't got time". These concerns were discussed with the provider and in response they have reviewed and

increased staffing levels.

The registered manager provided some social stimulation for people as they were involved in the day to day life of the home. They told us that they and the deputy manager were on hand to support staff and often spent one to one time with people. The provider also sourced external group activity provision and this mainly occurred three times a week, for example musical entertainment or group exercises. Some people had access to their own patio garden areas and one person told us how much they enjoyed looking after their plants and watching the birds. A screen in the entrance hall of the home displayed information regarding the entertainer that would be visiting that afternoon and a church service that would be taking place that day. There was also information about the staff on duty that day. We observed the entertainment that was taking place and saw that people enjoyed this; joining in singing and dancing with the person performing

There was a complaints policy and procedure in place and complaints were logged and investigated promptly and thoroughly by the provider. People and their relatives told us that they knew who to speak to if they were unhappy with any aspect of the service, one person said "I haven't had any complaints but I would speak to [registered manager] if I did and I am confident something would be done". Staff were knowledgeable about how to respond to complaints, one member of staff said "If anyone complained to me, I would document it and report it to [Provider]".

Good

Is the service well-led?

Our findings

The provider had some arrangements in place to monitor the quality of the service that people received, as regular audits had been carried out by the provider and registered manager. Examples of audits undertaken included; health and safety, care plans and complaints. We saw that actions required as a result of these audits were taken in a timely manner, for example the provider had recently improved the way in which people's manual handling needs were assessed and recorded in people's care plans.

The monitoring of some areas of people's care provision required strengthening. Falls were logged and informally monitored and people who had experienced falls were appropriately assessed and referred to the falls prevention team. However, one person had experienced further falls following the assessment and referral. Sufficient action had not been taken following these falls; meaning that appropriate measures had not been put in place to reduce the risk of harm to the person. This was discussed with the provider during inspection and they immediately put measures in place to reduce risks to the person's safety and implemented a formal means of monitoring and analysing falls that occurred within the home in future.

Although systems had not always been effective at highlighting shortfalls in people's care in a timely manner, the provider had improved these systems as soon any shortfalls were identified. For example during the inspection we saw that for a period of time some people had not been weighed as often as their malnutrition assessment directed; one of the reasons given by the provider for this was that the deputy manager who oversaw the monitoring of people's weight had been on annual leave. This oversight had been recognised prior to the inspection and the provider had acted promptly to adapt the systems in place to minimise the risk of this re-occurring.

The provider was committed to improving all areas of quality monitoring within the service and had implemented automatic, electronic processes to support auditing processes. One area in which these particularly enhanced the quality and safety of the service provided was medicines management. A computerised management system reduced the likelihood of errors occurring and ensured that any errors that did occur would be identified in a timely manner.

People said that the provider and registered manager were approachable and they had confidence in their ability to manage the home. One person said "I'm very happy, the managers are visible, not stuck in the office, they're lovely". The registered manager and provider were directly involved in the management of the home and demonstrated an awareness of their responsibilities for the way in which the home was run on a day-to-day basis and for the quality of care provided for people in the home. One person's relative said "They [registered manager] is very supportive and involved, I know exactly who to speak to about different aspects of [Name's] care".

The culture within the home focussed on providing individualised care in a homely environment, one member of staff told us "[Registered Manager] and [Provider] really care about the people who live here, they want things done in the correct way and we all want to provide good care". All of the staff we spoke to were committed to providing a high standard of personalised care and support. Staff were aware of the

standards expected of them and focussed on the outcomes for the people who lived at the home. Staff were clear on their roles and responsibilities and there was a shared commitment to ensuring that support was provided to people in the best way possible. One member of staff said ""The management are very supportive, if they can help us out with anything they will". Staff were confident in the managerial oversight and leadership of the provider and registered manager and found them to be approachable and friendly. They told us that they felt able to ask for support, advice and guidance about all aspects of their work. We observed that the provider and registered manager were accessible to staff and people living in the home and worked innovatively to continually improve the service they were providing.

Policies and procedures to guide staff were in place and had been updated when required. We spoke with staff that were able to demonstrate a good understanding of policies which underpinned their job role, such as safeguarding people and mental capacity. Staff were aware of the whistleblowing policy and were able to explain the process that they would follow if they needed to raise concerns outside of the company.

The provider had a process in place to gather feedback from people, their relatives and staff as they carried out regular surveys. We saw that questionnaires completed by residents, relatives and staff had been analysed by the provider and action taken in response to comments made. For example in response to feedback, the provider had implemented a system whereby regular visitors to the home were provided with a swipe card that would enable them to access the building independently and automatically update the electronic record of people in the building.