Ashwood Park Healthcare Ltd

# Cumbria House Care Home

## Inspection report

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## Ratings

| Overall rating for this service | Requires Improvement |
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| Is the service safe? | Good |
| Is the service effective? | Requires Improvement |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Requires Improvement |

# Summary of findings

## Overall summary

The inspection was unannounced and took place on 5 July 2017. The service is a large detached house in a residential area of the town of Folkestone. The service is close to public transport and there is some parking at the service and in nearby roads. The service provides accommodation for up to 32 older people some of whom may have mild dementia type illnesses. At inspection there were 24 people living in the service.

Accommodation is provided over three floors; although there are some double rooms all people currently accommodated have single occupancy accommodation. Some people have ensuite washing and toilet facilities in their rooms. People have access to two lounges and a dining room. A pleasant garden provides good accessible outside space. We last inspected this service in July 2016 when we found the provider was not meeting all the regulations in regard to assessment of environmental risks, medicines management and the implementation of an effective quality monitoring system. We asked the provider to tell us how and in what timescale they intended to address these issues. This inspection showed that previous requirements had been addressed.

There was a  registered manager in post who was present at inspection. A registered manager is a person who is 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.

There had been improvements in the range of quality audits and monitoring of the service provided to people. However, the range and depth of provider visits needed improvement to ensure all aspects of service quality were looked at, highlighted shortfalls and gave clear timescales for addressing these. Quality audits needed to maintain the upward trend to provide the registered manager and provider with the information and assurance they needed about service quality.
People were given choices in the food they ate but there were mixed views about overall food quality and this remains an area for improvement. People deemed at risk of poor nutrition or hydration had fluid and food intake monitoring in place. Those who were a source of concern because of poor intake were referred to dieticians for support and guidance to staff, peoples weights were taken regularly. Peoples health needs were monitored and staff ensured people were referred to health professionals as needed.

People told us that they were happy living in the service and felt safe; they got on well with staff and found them kind and caring. People relatives and staff found the registered manager approachable and felt she listened to them. Health and social care professionals said staff communicated well with them.

The premises provided a comfortable clean and well maintained environment, equipment was routinely serviced. Staff understood how to keep people safe from harm and abuse and to evacuate them safely from the service in an emergency.

Required recruitment checks and procedures ensured that only suitable staff were employed to support

people. There were enough staff available to meet people's needs. Medicines were managed safely. Risks were appropriately assessed and accident and incidents reported and acted on appropriately; the registered manager analysed these for trends and patterns and ensured people who experienced accidents were referred to medical professionals for investigation as to possible causes.

New staff received an induction into their role; they were provided with basic knowledge and skills to support people safely. A programme of regular training updates and access to specialist training courses was provided. Staff said they felt supported and listened to and that there were always opportunities to discuss things with the Registered or deputy manager in relation to work issues. Handovers were held at the beginning of each shift so that incoming staff were made aware of changes to people's wellbeing and also changes in operational practices. Staff had formal supervision of their training, development and practice, with competency assessments of their care delivery and medicine practice undertaken annually. Appraisals to assess annual work performance were undertaken by the registered manager of all staff.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff sought consent and people were supported by staff to make their own daily choices and decisions. The least restrictive measures were in place for two people who required additional support to keep them safe or for staff to make decisions on their behalf. Deprivation of Liberty Safeguarding (DoLS) authorisations were in place for those people and the service was meeting the requirements of the Deprivation of Liberty Safeguards. Staff understood and were working to the principles of the Mental Capacity Act 2005 (MCA). The MCA provides a framework for acting and making decisions on behalf of people who lack mental capacity to make particular decisions for themselves.

People were supported to maintain links with the important people in their lives and relatives told us they were always consulted and kept informed of important changes. Visitors were made welcome and visiting times were flexible. Observations showed staff behaved in a kind patient manner with people, treating them with dignity and respect.

People referred to the service were assessed by the registered manager prior to admission to ensure their needs could be met and their impact on other people I the service considered. Individualised care plans were developed with the involvement of the person and or their relatives. Care plans reflected people's assessed needs and how they preferred these to be supported by staff. Daily reports by staff recorded people's wellbeing and mood on a daily basis.

A complaints procedure was displayed, people were provided with their own copies. Complaints were rare but people told us how minor concerns they had raised as informal complaints had been addressed immediately. People felt confident of using the complaints procedure if they needed to and of approaching the registered manager or other staff with any concerns.

People were routinely asked to share their views through surveys and resident/relative meetings. Survey feedback was analysed by the registered manager and individual comments addressed with the people concerned to ensure these were addressed to their satisfaction. Analysis of survey information was published for people to read and gave them confidence that their views were listened to.

We have made two recommendations:

We recommend that a competent person monitors that all staff attend fire drills at least twice annually and all staff can demonstrate they know how to use evacuation equipment safely.

We have recommended more in depth checks by the provider.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe

People felt safe and staff knew how to recognise and report abuse. Medicines were managed safely. Risks were appropriately assessed but this was an area for improvement that the service was receiving support with.

There was a safe recruitment process in operation and enough staff to support people and meet their individual needs

The premises were well kept and maintenance arrangements established. Equipment was serviced regularly; fire safety arrangements were in place to keep people safe but fire drill attendance was still an area for improvement.

Accidents and incidents were recorded and audited to identify patterns.

### Is the service effective?

Requires Improvement

The service was not consistently effective

People's dietary needs were not always met. The quality of food people received requires improvement.

Staff felt listened to and supported, new staff received an induction into their role and regular training was provided. Staff received regular supervision and appraisal of their performance and development.

The provider had a good understanding of the Mental Capacity Act and was working within the principles of the Act.

People were supported to make their own choices around their food and drink. People received attention promptly for their health needs and were supported to access healthcare professionals and planned appointments.

### Is the service caring?

Good

The service was caring

People spoke positively about the attitudes of staff and the care and support they received from them.

People's privacy and dignity was respected by each other and staff.

Relatives told us they were made to feel welcome when they visited the home.

## Is the service responsive?

**Good**

The service was responsive

There was a programme of activities and people choose whether to participate or not.

People were assessed prior to admission to ensure needs could be met.

Care plans were individualised reflecting people's needs and preferred support from staff; people and their relatives were involved in planning their care.

An accessible complaints procedure was in place.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well led.

Quality monitoring processes were in place but required further improvements.

People and staff were positive about the leadership at the service.

People's views about the quality of the service they received were sought.

# Cumbria House Care Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 5 July 2017 and was unannounced. The inspection team consisted of an inspector and also an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at the information provided in the PIR and used this to help inform our inspection. We reviewed the records we held about the service, including the details of any safeguarding events and statutory notifications sent by the provider. Statutory notifications are reports of events that the provider is required by law to inform us about.

People told us about their experience of living in the service. We spoke with 10 people at inspection and five relatives. We observed staff supporting people with daily activities and communicating with people throughout the day. We saw the communal areas of the home and a small number of bedrooms and communal bathrooms and toilets on every floor.  We spoke to the registered manager, deputy manager and four staff including the cook and three care staff.

After the inspection we contacted three health and social care professionals who have contact with the service.

We spoke with people and observed how they interacted with each other and with staff. We observed staff carrying out their duties and how they communicated and interacted with each other and the people they supported.

We looked at five people's care plans, we viewed risk assessments, medicine records, staff recruitment

training and supervision records, staff rotas, accident and incident reports, servicing and maintenance records and quality assurance surveys and audits.

Good

# Is the service safe?

## Our findings

When asked if they felt safe people said: "I feel very safe; I know that if anything goes wrong I've got someone to call on. ""The staff check on me through the night.". "I like the company it was too quiet living on my own. "People said that staff were able to spend time with them and commented: "Nice girls, nice that you can joke with them. ""They come round regularly with the medicines, they trust me with the tablets so just leave them on the table" (we observed there were no tablets left on the table). "Medicines are always on time, I have one for my heart and one for blood pressure"

At the previous inspection we were concerned about the high temperatures in the room where medicines were stored which could impact on their effectiveness. Good hand washing for staff was compromised because the hand basin was not supplied with hand wash or paper towels. Boxed and bottled medicines were not routinely dated upon opening to inform the audit of medicines and monitoring of expiry dates. Medicines received mid cycle were not always booked in appropriately and handwritten changes to the medicine administration sheets were not signed and dated. All these shortfalls compromised people's safety. The provider sent us an action plan of the improvements they intended to make and we assessed whether these had been implemented and sustained at this inspection.

An air conditioning system had been installed in the medicines room to keep room temperature below degrees Celsius a safe temperature for medicine storage. Medicines requiring colder storage were kept in a drug fridge and the temperature of this was monitored daily. Boxed and bottled medicines were now routinely dated upon opening, hand wash and paper towels were provided to staff to support good hand washing practices prior to and after medicine administration. Medicines when received were appropriately booked in. Changes to administration were clearly signed and dated on medicine administration records.

Risk assessments were in place for people whose creams were kept in their bedrooms. Capacity assessments and risk assessments were put in place for those people who were able to self-administer some or all of their medicines and wanted to do so. Body maps were used to record the placement of transdermal patches to ensure staff alternated the location of patches as required. Arrangements for the ordering receipt and disposal of medicines was managed appropriately. People's medicines records contained a photograph so that staff could ensure the right medicine was given to the right person. Staff were provided with information about people's allergies and individualised protocols were in place for people who received 'as required medicines'; these helped guide staff on when it was appropriate to give these and aided consistency of administration. Administering staff received training which was updated regularly. The competency of administering staff was assessed annually to ensure that good practice was maintained.

Previously, although we had noted that a risk framework existed for the assessment of environmental and individual risks; assessments had not always been developed in respect of some of the environmental hazards and risks posed to people in accessing the garden or from hot water outlets. At this inspection we noted these assessments had now been conducted and risk reduction measures implemented.

People were assessed for those aspects of their health conditions, or care needs that posed a risk to them or

others. For example, risks from diabetes. A health professional told us that although risks were appropriately assessed, there had sometimes been a dis-connect between the assessment and actual staff practice. For example, people at high risk of pressure ulcers were given airwave mattresses for 6 weeks; after this time the mattress had to be returned to the health store however the person remained at risk. The provider had purchased air mattresses to ensure this equipment was available but health and social care professionals had commented that people had sometimes been placed onto a mattress that did not meet their skin integrity needs. Support had been provided by health professionals to understand the risk process better and ensure the right resources were in place. A health professional spoke positively about the staff willingness to learn and improve, they commented "They really do care for their residents." With the support of the Clinical Commissioning Group (CCG) care homes team understanding risk assessment and ensuring the right responses were in place was an improving picture for the service.

The provider operated safe recruitment procedures. All required checks were undertaken before staff commenced work; these included proof of identity, written evidence of satisfactory conduct in previous employment and character references, a Disclosure and Barring Service (DBS) this is a criminal record check, a statement as to the health and fitness of the prospective staff member. All of these checks help the provider to make safer recruitment decisions and prevent unsuitable people from working with people who use care and support services.

There were enough staff to support people. The Provider information Return sent to us by the registered manager told us that a staffing tool was used to calculate the number of staff needed to meet people's needs. This assessed the individual dependency of each person to inform the registered manager how many staff were needed overall to meet everyone's needs. This was reviewed monthly. People and relatives expressed satisfaction with staffing levels and we observed staff to be visible in communal areas and around the premises throughout the inspection. Staff told us that there were always enough staff and rotas were followed. At inspection the rota reflected the staff on duty. Rotas showed that agency staff were not used and gaps in shift were covered from within the staff team; this helped to ensure continuity in people's care and support.

The registered manager tried to ensure that people considered for placement did not have complex needs to ensure their needs could be met. One staff member said it had been very busy recently when they had several people at end of life and a few people who required support from two staff due to physical deterioration. People and relatives raised no concerns in regard to staffing levels and this did not feature as a topic in feedback received to surveys.

The premises were decorated to a good standard. A maintenance person was available to help with repairs and general maintenance issues. All visual and manual checks, tests of equipment and installations and regular servicing were conducted to ensure they met the required standard and did not pose a risk to people or staff. Appropriate fire prevention measures were in place, the fire risk assessment was kept updated and the registered manager confirmed that recommendations made as a result of this assessment had been implemented. A fire plan was in place, Staff knew how to protect people in the event of fire as they had undertaken fire training; individual emergency plans informed staff what help people needed to evacuate the building. Fire drills were held regularly for staff with six held since 12 May 2017;records of staff attending had only recently been kept but showed that two night staff were still to attend a drill, staff needed reminding of the arrangement in place for relocation to a nearby home should an evacuation last for hours. We and we brought this to the attention of the registered manager to ensure they were included on future drills, and understood longer term evacuation arrangements.

We recommend that a competent person monitors that all staff attend fire drills at least twice annually and

all staff can demonstrate they know how to use evacuation equipment safely.

Equipment used for the delivery of care and support to people such as a hoist, stand aid and auto lift equipment in the bathrooms was routinely serviced by a contractor. The contractor had confirmed that through an oversight they had fallen behind schedule in updating the services moving and handling equipment. The registered manager took immediate action for this servicing to take place, to ensure people's safety was not compromised.

Staff received training in how to recognise and respond to potential harm or abuse people may experience. Staff were familiar with the safeguarding process and felt confident of identifying and raising concerns through this process or through the whistleblowing process. They understood there were other agencies they could go to if they thought their concerns were not being addressed.

Accident and incident levels rose and fell dependent on the needs of the people in residence. Between May and July 2017 there had been an increase in accidents due to deterioration in the health of four people no longer at the service. Levels had fallen again following their departure. The registered manager told us that people without a history of falling were referred to their GP if no cause in the environment could account for the fall. The GP would try to discount potential medical causes. This process of elimination might end in the need for a referral to the falls team who would assess and review the person's needs and current support, identify where improvements could be made to reduce likelihood of falls.

Requires Improvement

# Is the service effective?

## Our findings

People said that they were encouraged to be independent as they could be; we observed them moving around freely within the communal areas with some making use of the patio and garden areas, which were used regularly in good weather. We observed and people told us that staff consulted with them and sought their consent or input when providing support with daily tasks. People said staff attended to their health needs "They notice if I'm not my usual self and ask if I'm OK." People were very satisfied with living in the service but shared mixed views about food quality.

At the previous inspection we had recommended that the service seek advice from a competent source to demonstrate how fluid monitoring should be undertaken to improve effectiveness and consistency of monitoring. Action had been taken; staff now worked to a clear guide when recording how much someone had drunk. The registered manager was aware of a small number of people who ate and drank very little fluid charts recorded the average amount the person should drink and recorded what they had actually drunk during the course of the day. Drinks were available to people and staff were seen offering drinks at different times of the day. Some people chose not to drink a lot and their fluid intake was monitored by staff; where there were concerns they were appropriately referred to health professionals. Some people had been prescribed and received food supplements to boost their nutritional intake. Health professionals confirmed that the service was proactive in referring people for support with a range of needs including diet and nutrition.

People told us they could choose where to eat and drinks were always available to them. People shared mixed views about food quality; some of the comments in survey questionnaires and resident meetings highlighted aspects of food variety and quality that people were not happy with or would prefer; their views were taken in to consideration when menus were devised. People's required dietary needs and food preferences were recorded upon admission to the service and the cook was made aware of them. Menu development ensured everyone had one of more favourite meals included and that menus reflected the types of meals people have said they enjoyed. The cook said that different meals were tried out and changed dependent on how well they were received.

The service operated a winter and summer menu and these were arranged over a four week cycle. Menus provided a varied range of nutritious balanced meals; these were freshly cooked, looked visually appetising and ample in portion size. People's views of food quality however were mixed ranging from "food is very good, lots of choice." To "food is mediocre not much choice, ""Food is passable, the meat isn't very tender, the worst thing about the place is the food." We checked food choices for the day and noted several people had chosen different options one was vegetarian another person had mince.

We spoke with the cook about how they knew about people's individual requirements such as allergies, portion sizes, soft or normal diets; the cook maintained a kitchen record which recorded people's daily choices of meals. This record also held basic information about each person's dietary requirements to guide the cook and staff in respect of allergies, foods to avoid and type of diet. One person receiving assistance to eat had a softer diet of mince but still had roast potatoes which some people had said were firm. The person

struggled to eat this meal and further consideration was needed with a dietician as to whether a soft mashed diet was still the right consistency of food for this person to encourage better eating, as we noted in their food diary they tended to eat mainly puddings which were of a softer consistency. We discussed with the registered manager if this could be looked into with the dietician. Staff supporting the person were attentive. Other people required minimal support from staff to cut up their food so that they could continue to eat independently. People ate at different paces and people were given time to finish their meal, this sometimes meant that different people on the same table could still be eating their main course whilst others ate their pudding. One person had specifically asked for a small portion but was brought a large plate of food by staff instead; the person ate what they could but was upset and apologetic that they could not eat it all.

Feedback from people about food quality was provided through resident meetings, survey feedback and by direct comments from people about how they had enjoyed their meal or not. The registered manager was aware of some criticisms in regard to the quality of meals and supper choices. These issues were raised with the cook when they arose to show people that they were listened to and to bring about improvement. There was a clear need however, for the cook and for staff to take account of people's individual dietary requests and sustain the support they provided around this. The inspection highlighted that meeting people's preferences and requirements around the food they received and how this was delivered was not always person centred; this is a breach of Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they received visits from healthcare professionals including GP's, community nurses, the optician and chiropodist. People's health records recorded visits from health care professionals for example appointments for blood tests and check-ups, medication reviews, wound care, insulin administration. Some staff had been trained to take blood glucose readings for those people who were diabetic, this was a new skill and community nurses were still monitoring how well staff were recording and responding to hi and low blood sugar, individualised plans of care were in place for people with diabetes.

All existing and new staff were required to complete the Care Certificate. This was introduced in April 2015 by Skills for Care. This qualification comprises of an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life. All new staff were given a two week induction during which they shadowed more experienced staff and were supernumerary on the rota; this was so they could spend time completing mandatory training and familiarising themselves with peoples care needs and routines within the service.

All new staff completed a probationary period of three months there was evidence that their progress was reviewed during this period and probation extended if they had not demonstrated they had all the necessary competencies. All new staff completed the basic essential skills training they needed for example safeguarding, first aid, food hygiene, fire, moving and handling and health and safety, to help them to understand how to carry out their role safely and protect people from harm. For established members of the staff team this programme of training was routinely updated, with additional specialist training provided that was relevant to the needs they may have to support people with in the service for example diabetes, dementia awareness, stroke awareness, Parkinson's awareness

Staff were encouraged to develop their knowledge and skills and 16 out of 18 staff including the registered and deputy manager had achieved vocational care qualifications at level two or higher. These are work based awards that are achieved through assessment and training. Staff spoke positively about the support they received from the registered manager and deputy and valued the regular supervisions they received they said that they felt supported and listened to. They received supervision on a two monthly basis and the

registered manager had also implemented competency assessments of medicine administration and delivery of care and support. These assessments included an element of observational assessment; they gave the registered manager an understanding of how well staff fulfilled their role and if any further learning was identified for them. The registered manager confirmed that all staff received an annual appraisal of their work performance and personal development.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Staff had received training in MCA and Dols, they were observed consulting and seeking consent from people for all their everyday support of daily living tasks, capacity assessments were made of whether people could make decisions for themselves, where this was questionable staff understood best interest meetings could be held with relevant parties including the person to help make a decision on their behalf. We found that the registered manager understood when an application for a DoLS should be made and how to submit one. The PIR informed us that this had been undertaken on behalf of two people in the service where least restrictive measures needed to be in place to help maintain their safety and wellbeing.

Good

# Is the service caring?

## Our findings

People told us that they were encouraged to retain their independence and made their own choices and decisions about their daily living routines comments included: "I'm quite independent; I use the shower on my own." "I'm quite independent, that suits me." "I can go to bed when I like." "I go to bed about ten, no pressure to get up or go to bed." "I get up between 7.30am and 8.00am and have breakfast in my room. Then the carers come back and give me a strip wash. I have a shower once a week. I like to stay in my room in the morning. The carers come and fetch me for lunch."

People spoke positively about the attitudes and care delivered by staff that had time to spend with them; they described staff as: "Pleasant nice staff," "Lovely lot of girls really nice they'll do anything for you". Very nice staff." "They're angels without wings." "You couldn't wish for a better place." "I don't think you'll find a better place in Kent, all the staff and everybody here are excellent".

Relatives told us: "No criticism, they go beyond the normal job, they are very caring. "I find it very friendly, always welcoming." "Welcome any time." "The staff are excellent; she has improved leaps and bounds since she has been here".

Health and social care professionals commented positively about the service, comments included: "Staff were attentive to people." "She has settled better than I imagined and had a big smile on her face."

People told us that staff treated them with respect and dignity providing "gentle" and "sensitive " personal care in the way they wanted and offering them a choice of how this was delivered. They said that staff were discreet when supporting them with personal care and always ensured curtains and doors were closed. We observed staff speaking with people in a quiet, kind manner using peoples chosen names in a respectful way. People respected each other's privacy.

People said staff responded promptly to calls bells and we observed staff making sure people who stayed in their rooms had their call bells within reach.

People were provided with information in the entrance hall about forthcoming events and activities and were kept informed of the date, day, time, and weather through an information board in the main lounge.

People had their own bedrooms and had personalised these with possessions that were important to them and had helped them settle into their new home. One person told us "I've got my own double bed; the previous manager suggested I bring my own bed in as I kept rolling out of a single bed. "

People respected each other's privacy. People could be private when they wished and a number of people preferred their own bedroom space to that of the communal areas in the service. In communal lounges some people preferred to sit on their own and others liked the companionship of others and there were some friendship groups that had developed.

Relatives were made welcome and visiting times were flexible. The important people in people's lives were well documented in care records; this helped inform staff about family relationships and how these impacted on the person. The Provider Information Return told us that nine people had relatives or representatives who had lasting power of attorney authorisations to help them make decisions about their care and finances. We reminded the registered manager of the need to assure them self that relatives and representatives indeed had this legal authority legally had this authority through viewing and recording these authorisations.

No one was in receipt of end of life support at the time of inspection; care records however, showed that discussions had taken place with everyone to ascertain their final wishes in the event of their death. Eleven people had 'Do not attempt resuscitation' authorisations in place should they suffer cardiac arrest so care and medical staff were aware of the actions to take if this happened.

Good

# Is the service responsive?

## Our findings

People and relatives were able to talk to us about their experiences of the service. One person in describing how they had come to be there told us: "I tried three different homes for respite before I decided to stay here". People told us they could exercise choice in their daily routine and that staff were available to provide them with support. They told us that staff responded well to the call bells and people were not kept waiting too long: "Come quickly, they hear any little bang and they're up the stairs." "Quite good at coming quickly to answer the bell". "Last night I could not sleep so pushed the button, they came very quickly."

A Health professional told us that they had visited their client who had been newly admitted and was satisfied with the documentation in place and observed an activity they were participating in; they were impressed by the level of engagement from people and how they were enjoying themselves

People referred to the service were assessed by the registered manager or deputy manager. Pre admission information was gathered from the person and their relatives/representatives and this looked at the person's needs and how much support they required from staff to live their everyday life. Information was also sought from other sources such as health or social care professionals if necessary, and where they may not have been involved in the initial referral. All this information informed the registered manager about the type and complexity of the service the person needed. The registered manager reviewed the person's needs alongside those of other people in the service to ensure staffing levels, staff knowledge and skills could accommodate the person. We checked the pre-admission assessment for someone shortly moving from a short stay service, we also spoke with a health professional involved in this relocation subsequent to the inspection. They expressed satisfaction with the person's placement and was surprised at how well they were doing since admission.

Individual personalised care plans were developed from pre-admission assessments and additional staff knowledge of people's needs and preferred routines gathered in the first few days of their stay. Care plans contained a social history 'My life so far' and 'my life before you knew me', a record of the important people in the person's life and who they wanted involved in their care, a record of strengths and needs, equipment they needed for their daily living, and areas they needed help with such as medicines administration, moving and handling needs, day and night time personal care routines, medical history and assessments of risk in regard to medicines, falls, nutrition, skin integrity. People's capacity was assessed in regard to whether they needed support in making decisions about in some daily living activities. People's health care needs were clearly documented.

Plans were discussed with people and or their relatives and reviewed by the registered manager on a regular basis. People could participate in reviews or not. An entry was recorded for each shift regarding each person's general wellbeing and mood during the shift; any concerns were highlighted to incoming staff at shift handovers. Each person was also allocated a key work member of staff (this is a staff member who understands the persons needs more than other staff) most people we spoke with were unaware who their key worker was, key workers completed a monthly report about how the person was and any changes that had occurred this informed the registered managers review and update of the care plan. We viewed a

number of these reports and found them lacking in information. We discussed the value of the key worker system if people did not know who their key worker was and key workers reports lacked detail around needs and changes to inform reviews of the care plan. The registered manager had already identified that this was an area requiring further improvement and would be reviewing whether the key worker system was effective, and if so how it could be improved upon.

People said they were happy with how they spent their time, choosing to participate or not in planned activities. There was no specific staff member employed to facilitate activities, but, there was a monthly timetable of external entertainers and organisations booked to provide activities. The July plan was distributed during the inspection. On the morning of the inspection a lady was facilitating a session of armchair exercises, five people were active participants whilst others were active observers. People said about activities "I like to join in with the activities to pass the time." "We used to have a lot of entertainment but not so much now". The July entertainment programme showed that 14 entertainments had been scheduled during this month. People talked about other events "They have a garden party in the summer," and also activities that staff facilitated such as painting peoples nails for them if they wanted it, playing games. Some people chose not to participate preferring their own room and company, they did not feel isolated or comment on feeling bored or lonely. Some people who kept to their rooms did say that if there was something interesting on they might come down to participate, and others told us that staff always checked in on them to see how they were. A record of people's participation in planned activities was recorded but nothing was recorded for those who kept to their rooms to reflect the level of staff contact they had and this is an area for improvement.

There was a complaints procedure displayed and people were provided with a copy in their information pack when they arrived. Complaints were rare with only one formal complaint recorded since 2015. The service always received very positive compliments. We reviewed those received in the last 12 months; these thanked the service staff for specific events and also thanked them for looking after relatives so well. Compliments also came from people who had used the service for example "Thank you to all the staff at Cumbria House for all the care and attention I have received during my stay with you. Nothing seemed to be too much trouble."

In response to the question of what they would do if they had a complaint two people told us about complaints they had made and the action taken to resolve this "I complained about my room upstairs as I never saw anybody. I've been moved downstairs and I keep my door open so I can see what is going on". Another person said "I asked for a door stop it was put on straight away" this demonstrated that although peoples minor concerns were not recorded action was taken to address these where possible. Relatives told us: "We had a problem with the GP's decision we didn't blame the home they couldn't go against the GP". "I'd go straight to the manager, If there is a problem it is resolved quickly you only have to mention it".

Requires Improvement

# Is the service well-led?

## Our findings

Health and social care professionals spoke positively about the service and thought they supported people well; there was a view that there were always improvements that could be made and that the registered manager and staff were open to learning and making changes to improve their practice. They thought the service referred people or issues to them appropriately and listened and acted upon advice given, they thought the staff communicated appropriately in regard to people's health, care and support needs. The majority of relatives spoken with were satisfied with how well the staff communicated with them, for example "There is good communication; they notified me straight away when my wife had low blood pressure and I was able to accompany her to the hospital."

At the previous inspection the registered manager and provider were visible presences in the service; this gave them a clear understanding of what was happening in the service at that time and a limited number of checks and audits provided some insight into areas where improvements were needed. We had found however that the audits in place had not been that effective in identifying shortfalls and other areas of service quality were not checked at all and this was a breach of regulation and we issued a requirement notice.

At this inspection we found the range of audit checks had been increased and now included a daily walk around which looked at the safety of the environment and that other aspects of service quality had been addressed for example cleaning. A weekly and monthly medicines audit was conducted. We noted that where medicine errors were found action was taken to ensure the person was safe; investigation of root causes to the error were looked at, relevant staff were interviewed and learning from this shared with all staff during team handovers and meetings. Pressure relieving equipment and settings were checked weekly to ensure these were working properly and set to the right levels for each person, we noted some gaps in recording around this. Health and safety was routinely assessed to ensure no one was place at risk. Four care plans were randomly selected each month to review general content and that identified changes had been updated.

Quality audits and checks had increased in number and were conducted regularly to provide the registered manager with assurance that aspects of the service were operating well and highlighted those areas needing attention. The provider visited regularly and completed a monthly provider report; their focus at these visits however was more around the upkeep, maintenance and repairs to the premises to ensure people lived in a safe, comfortable home. Whilst the provider had some contact with staff and people in the service during these visits; this was not reflected in their reports. Details of what documentation they may have looked at during their visit was also not recorded and whether they had identified any shortfalls and action to be taken. We have discussed this with the registered manager who has agreed to develop with the provider an improved provider visit form and process.

We recommend that provider visits and the records made of these better reflect the content of visits and can evidence more operational oversight of all aspects of service delivery.

People knew who the manager was; they and staff spoke favourably about the registered manager and deputy. The registered manager was seen to be a visible presence who was approachable, willing to listen and supportive. We were told that the deputy was hands on and worked alongside staff on shift where needed and saw this in practice at the inspection; this enabled them to make observations of staff practice and highlight where improvements if any were needed. A handover meeting took place at every shift change; this was used to provide staff with up to date information about people's wellbeing and important changes to medicines or support that needed to be implemented.

We were informed that staff meetings were held quarterly with separate meetings held with seniors as and when required. A minute of each meeting was recorded so that staff not present could keep themselves updated. The registered manager and deputy were present weekdays and available for informal chats with staff, one or other of them were present for handovers so they were kept informed about what was happening and could also cascade information to staff. Staff felt they had opportunities to express their views and influence decisions through informal and formal processes, supervisions and appraisals. Staff said they felt comfortable raising issues when they needed to. The registered manager ensured the supervision and appraisal of staff happened and staff were supported to develop their skills through further training. The registered manager welcomed input from other professionals to help inform and guide staff practice.

When asked, people said they regularly attended 'resident' meetings. Joint meetings for relatives and people in the service were held once or twice each year, people were made aware of when these were going to happen in their monthly activity schedule, a poster of the forthcoming meeting was displayed on the notice board. Some relatives however needed more advance notice and there was a need to make the dates of meetings known widely to relatives in advance so they could make arrangements to attend if they wished to. This is an area for improvement.

People were surveyed annually for their views. The registered manager analysed these; where comments highlighted areas of concern or improvement the registered manager followed these up with people to try and resolve them to their satisfaction. The results of survey analysis were published for people to see so they knew their input was valued and listened to.

Information about individual people was clear, person specific and readily available. Staff were seen to work in accordance to people's routines and support needs. The language used within records reflected a positive and professional attitude towards the people supported.

Staff had access to policies and procedures, which were contained within a folder and was held in the service. Policies and procedures were reviewed regularly by the registered manager to ensure any changes in practice, or guidance was taken account of, staff were made aware of policy updates and reminded to read them.

The service notifies the Care Quality Commission appropriately of any notifiable events that occur in the service.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had ensured the rating was clearly visible in the reception area and on their website.

This section is primarily information for the provider

# Action we have told the provider to take

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

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>people's preferences and requirements around the food they received and how this was delivered was not always person centred 9 (1) (a) (b) (c) |