

Bupa Care Homes (GL) Limited

Cleveland House Care Home

Inspection report

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Tel: 01484512323

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28 March 2018

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

We inspected Cleveland House Care Home on 21 and 28 March 2018. Both days of the inspection were unannounced which meant the home did not know we were coming.

Cleveland House is registered to provide personal care and accommodation for up to 45 older people, some of whom live with dementia. The home has three floors accessed by passenger lifts. A lower ground floor and first floor contained single bedrooms and shared toilets and bathing facilities; the ground floor contains single bedrooms, toilet and bathing facilities, plus shared lounges and a dining area. On the first day of our inspection there were 24 people living at Cleveland House and on day two this number was 23. The bedrooms on the lower ground floor were not in use. Outside there is a garden with seating areas.

Cleveland House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The home did not have a registered manager in post and although a home manager was employed, they were unavailable on both days of our inspection. The regional director for recovery made us aware the home manager was leaving and a new home manager would commence working in the home from mid-April 2018 and they would be expected to register shortly afterwards. 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 gave us mixed feedback about staffing levels which had been kept at the same levels since our last inspection. Records of staff response times to nurse call bells showed a number of examples of unexplained lengthy delays and the analysis of these incidents was not thorough.

Examples were identified when some staff did not demonstrate appropriate values to maintain people's privacy and dignity. People were complimentary about the care provided by staff who were sufficiently skilled. Staff received an appropriate induction and training as part of their development, although supervisions and appraisals were not happening in line with the registered provider's policy and good practice recognised by the National Institute for Clinical Excellence (NICE).

The management of medicines was not always safe as oxygen cylinders had not been secured since we commented on this in our last inspection and risk assessments for prescribed thickener stored in people's rooms had not been considered. Topical medicine administration records were not in place for all prescribed creams, gels and ointments in use.

People and their relatives told us people were safe living at Cleveland House Care Home. Recruitment processes were mostly safe, although one staff member had commenced their employment without a last

employer reference.

Some examples of unsafe moving and handling transfers were seen which were discussed with the management team. Individual risks to people with one exception had been assessed to reduce the risk of harm.

People's nutritional and hydration needs were being met as staff had sufficient knowledge and records were in place to support this.

People were supported in accordance with the Mental Capacity Act (2005), although this was not always reflected in their care records. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Applications for Deprivation of Liberty Safeguards had been made appropriately.

Accidents and incidents were recorded, although the analysis of these events required improvement. A new system was in place to support this.

People's care records were person-centred, although some issues remained with record-keeping and consistency. Some improvements had been made with recording end of life care wishes, although these lacked detail. Care records showed staff supported people to access healthcare services from a range of professionals.

Activities were taking place during our inspection, although people told us they were unsure when and where activities were taking place. The incoming home manager wanted to use the gardens more effectively.

Relatives and staff were complimentary about the home manager in post at the time of our inspection, although it was noted they lacked a visible presence in the home.

Meetings with people, relatives and staff were taking place. Some audits were not fully effective as they were missing actions and dates. New quality management initiatives had been introduced to improve performance since our last inspection.

We recommend the registered provider reviews the mealtime experience to remove avoidable delays in people receiving their meals and also to develop links with services in the local community.

We found three breaches of the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have told the provider to take at the end of this report.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

The management of topical creams and thickeners required improvement. Moving and handling practices were not always safe.

People gave us mixed feedback about the timeliness of staff responses. Recruitment practices were not always robust.

People and relatives felt safe.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Staff worked within the principles of the Mental Capacity Act (2005) although recording needed to be improved.

Staff supported people to access healthcare services. People's nutritional and hydration needs were being met

Supervision and appraisal required some improvement. Training records showed high completion rates.

Is the service caring?

Requires Improvement ●

The service was not always caring.

Staff did not always provide care which was dignified and respectful. People and relatives were complimentary about staff.

Information was stored securely.

Improvements were needed to ensure people's equality, diversity and human rights were respected.

Is the service responsive?

Requires Improvement ●

The service was not always responsive.

People's care records were person-centred, although some

issues remained with record-keeping and consistency.

Staff communication regarding activities required improvement. Some activities were taking place.

Some aspects of the management of complaints required improvement.

Is the service well-led?

The service was not always well-led.

Meetings with people, relatives and staff had been taking place. Feedback was actively sought by the registered provider.

Some audits were not fully effective as they were missing actions and dates.

New quality management initiatives had been introduced to improve performance since our last inspection.

Requires Improvement 

Cleveland 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 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 21 and 28 March 2018; both days were unannounced. On the first day of our inspection the team consisted of two adult social care inspectors, a pharmacy inspector, an inspection manager and two experts 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. On the second day the team comprised of one adult social care inspector. On day one of our inspection there were 23 people living in the home. On day two this number was 23.

Before our inspections we usually ask the provider to send us 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 did not ask the provider to complete a PIR prior to this inspection.

To prepare for the inspection we reviewed the information we held about the service and requested feedback from other stakeholders. These included Healthwatch Kirklees, the local authority safeguarding team, the local authority infection prevention and control team, and the Clinical Commissioning Group. We spoke with a visiting healthcare professional during the inspection.

During this inspection we spoke with 15 people who lived at the home and three of their relatives to obtain their views of the support provided. We spoke with members of staff which included four care workers, two regional support managers, the regional director for recovery, a quality manager, the care manager, the clinical services manager, an administrative assistant and the cook.

We spent time observing care in the communal lounge and dining areas to help us understand the experience of people using the service who could not express their views to us. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us

We reviewed a range of records which included four people's care files. We also inspected three staff members' recruitment and supervision documents, staff training records, six people's medicines administration records, accident and incident records, and various other documentation related to the running of the service.

Is the service safe?

Our findings

At our last inspection we rated this domain as inadequate as there were insufficient numbers of staff to meet people's needs, medicines and risks to people were not safely managed and recruitment practice was unsafe. At this inspection we saw some improvements had been made.

People we spoke with who lived at Cleveland home told us they felt safe living there. One person told us, "Staff are always there both day and night so that makes me feel safe that there is someone there." One relative we spoke with told us "I feel safe for [relative]."

Staff we spoke with were able to describe different types of abuse as they had received training in this subject. One staff member told us, "I would report it to the nurse if I was concerned." Staff were also familiar with the registered provider's whistleblowing policy. 'Whistleblowing' is when a worker reports suspected wrongdoing at work.

Records showed safeguarding concerns were logged, dated and referred to the local safeguarding team where appropriate. This showed us there were the right systems in place to protect people who used the service from the risks associated with abuse.

We looked at the maintenance of the building and records relating to this and found this was in order. This included up-to-date certificates in relation to electrical and gas safety. Checks regarding the cold water supply and temperatures of water in people's room had been completed. Equipment used for the purpose of lifting such as slings and hoists had been thoroughly checked within the last six months. A fire risk assessment dated January 2018 showed all actions due for completion before our inspection had been done. Fire drills had been carried out in January, February and March and included one occasion when this was done on a night shift.

People's care files contained personal emergency evacuation plans and this information had also been written up as a 'grab sheet' for staff to use in an emergency. This record was accessible to staff in the reception area and was up to date when we arrived on day one of our inspection.

Staff were seen wearing gloves when going in and out of people's rooms which meant they had sufficient personal protective equipment to help maintain good infection control. We observed people's rooms were clean and the care home was odour free.

The regional support manager told us 'chart champions' had recently been introduced to ensure records relating to the administration of creams, food and fluid intake and repositioning were robustly recorded. A second regional support manager told us they regularly checked these charts and reported any concerns to the home manager who they said would raise these during '10 at 10' meetings for department heads. The clinical services manager who commented on the charts told us, "They're not perfect, but they're much improved since Christmas." One staff member shared with us they had recently been reminded by a chart champion to complete a chart entry they had missed.

We asked people whether there were sufficient numbers of staff to promptly respond to their needs. One person said, "The longest wait for the buzzer to be answered is around five minutes and they usually answer it then ask me if I can wait, and sometimes I ask them how long, as it can be a minute or 15, then I ring again, but generally they answer it." Another person said, "When I buzz, I would like the carer to come soon." One relative said, "The ratio of staff now means they can cope better as they have reduced the residents from 48 to 24 which is so much better."

One staff member told us, "There's no teamwork. If someone's busy, you're meant to answer each other's buzzers. It's just not happening. We asked the same staff member if there were enough staff on shift to meet people's needs. They told us, "Most of the time, we have." Other staff we spoke with told us they felt there was sufficient staffing cover to meet people's needs.

We looked at staff rotas covering a four week period between February and March 2018. Through the day, two nursing staff were always on shift, although on occasions the number of carers on the same shift was five, rather than six which is the number indicated during a '10 @ 10' meeting. We saw night shifts had sufficient cover to meet people's needs as per the registered provider's dependency tool which was used to calculate the number of staff required. At the time of our inspection, no one was living on the lower ground floor which meant it was more manageable to meet people's care needs across the two other floors.

People we spoke with who lived at Cleveland House told us nursing staff ensured they received their medicines on time.

During our inspection we looked at the systems in place for managing medicines. We spoke with four staff involved in the governance and administration of medicines, observed medicine administration for five peoples, examined six people's medicines administration records (MARs) and four people's topical medicine administration records (TMARs).

Medicines were stored securely in the medicine room and medicine trollies. Staff recorded fridge and room temperatures daily, the records demonstrated medicines were stored at the correct temperatures.

At the last inspection, it was noted that the oxygen cylinders were not stored securely. At this inspection the four oxygen cylinders in the medicine room were not stored securely. Guidance states that oxygen cylinders should be stored securely to prevent them falling and potentially causing harm to people. The regional support manager told us they would rectify this following our inspection.

One person was prescribed Nitrofurantoin which was written on the MAR for bedtime. However, this should be taken with, or just after a meal. A staff member told us they would request a change on the MAR to a tea-time administration. We saw this medicine was to be changed after an eight week period, although nursing staff had not identified this. A staff member told us they would contact the GP to get a supply of the new antibiotic.

The care home had a process for ordering and checking stock which ensured medicines were available for people. Medicines no longer required were clearly separated from other stock and unwanted medicines were disposed of in a pharmaceutical waste bin. Staff recorded the disposal in a log.

Medicines which require additional controls because of their potential for abuse (controlled drugs) were stored in a suitable cupboard. When a controlled drug was administered the records showed the signature of the person administering the medicine and a witness signature. Staff did a weekly stock check that was recorded in the controlled drug record book.

Nurses administered medicines with care and patience and tailored the administration to the needs of the individual. Staff followed a safe method for giving and recording medicines administration. Medicines prescribed 'as required' were offered to people, but there were not always protocols in place as two were missing from a total of 16. These protocols identify when it is safe and appropriate to administer medicines prescribed 'as required'.

The dispensing pharmacy supplied the medicine administration records (MARs) and staff completed the MARs accurately to show what medicines people had taken. Staff did not always follow the advice regarding giving medicines with food or on an empty stomach, which means the medicines may not work effectively or a person may experience unwanted side effects. In accordance with good practice guidance, two people signed handwritten additions to the MARs. The care home did not have topical medicine administration records (TMARs) for all the prescribed creams, gels and ointments. The TMARs which were in place did not always have a completed body map showing where to apply the topical medicine. It was therefore not possible to say if people received topical medicines as prescribed.

Nursing staff had completed medicines administration competency assessments in the past six months, although we did not see evidence of this for one nurse. This was subsequently rectified following our inspection. There was a system for reporting and investigating medicine errors. Staff said they knew how to report incidents, but they could not think of any examples of shared learning from recent incidents.

The care home liaised regularly with the dispensing pharmacy and GP surgeries to discuss medicine management. The managers did weekly and monthly medicine audits. There was evidence the audits were identifying areas for improvement and action was taken to make the improvements.

We looked at the storage arrangements for thickener which is used to thicken fluids for people at risk of choking. We saw these items were not securely stored in people's rooms and risk assessments were not in place to cover this. We made the clinical services manager aware and they told us they would put in place risk assessments and review the storage arrangements.

During our inspection we observed staff assisting people to move on several occasions and found the quality of care provided was variable. On the first day of our inspection, we observed two members of staff assisting one person from a wheelchair to a chair. The staff members did not apply the brakes to the wheelchair and they held the person under their arms. The same person was transferred from their chair to a wheelchair later in the morning and on this occasion staff didn't encourage the person to push themselves up using the chair arms. One staff member held on to the waistband of the person's trousers and used this as a lever to pull them up, whilst the other staff member placed their hands under the person's arm. This meant both the person being assisted and staff were at risk of injury due to this unsafe moving and handling practice. We discussed our concerns with the regional support manager and regional director for recovery. On day two we saw another person was appropriately assisted from an armchair, although a staff member noted a cushion should have been in the seat to shorten the distance to standing.

We did however, witness other occasions over the two days of our inspection when people were supported safely by staff members who assisted them to move through good communication and following moving and handling care plans.

We saw risks assessments were in place which were specific to each person and took into account the associated risk and measures to minimise levels of risk. The clinical services manager told us they had recently reviewed a person's care in line with increased falls and put a sensor mat in their room to reduce the risk of harm when they were alone in their room.

We concluded there was a continuing breach of Regulation 12 (b)(g)(Safe Care and Treatment) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 as the systems used to demonstrate the safe administration of medicines were not robust and people were at risk of injury due to unsafe moving and handling practice.

The regional support manager told us lessons had been learned by ensuring new home manager's only carried out their induction with services operated by the registered provider which the Care Quality Commission had rated overall as Good. During the daily meeting for department heads, staff discussed any learning opportunities from the previous day. This meant the service looked for areas where they could improve and learn lessons.

We looked at three staff files and checked whether safe recruitment processes had been followed. We saw examples of interview records, verification of identification and background checks with the Disclosure and Barring Service (DBS). The DBS assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people.

We saw references for two staff members had been taken, although the third file did not contain a last employer reference. The referee had been contacted after the original request for reference and had offered to provide a verbal reference, but had since failed to return a written reference. We found the staff member had started their employment without this check having been completed. We saw the same staff member had positive references from their two previous employers. We discussed this with the regional support manager who was able to demonstrate this had been requested again on the second day of our inspection.

We saw checks had been made with the Nursing and Midwifery Council to ensure nursing staff did not have any restrictions placed on their practice.

Is the service effective?

Our findings

At our last inspection we rated this key question as inadequate. The home was not fully compliant with the Mental Capacity Act (2005). People's nutritional and hydration need were not always managed effectively. Staff had received some training, supervision and appraisals to support them in their role, but this was not always up to date and in line with the registered provider's policies. At this inspection we saw some improvements had been made.

We checked to see if the service was compliant with the Mental Capacity Act 2005 (MCA). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards or DoLS. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Information in people's care plans about their mental capacity was not always consistent. One person's care file included a capacity assessment for their involvement in planning their care; this concluded the person had capacity. However, during the inspection we noted the person's access to unsupervised fluids was restricted on the advice of a healthcare professional and there was no evidence the person's capacity to consent or refuse to this restriction had been assessed.

A second person's care file contained mental capacity assessments and best interest documentation for decisions made, including for where the person lived and the use of bedrails to keep them safe. The care file of a third person living with dementia contained capacity assessments and best interest decisions for where the person lived and for the taking of their photograph. We noted the person did not have capacity assessments for their involvement in care planning or the administration of their medicines, which staff managed for them.

People's care files contained evidence DoLS had been applied for, if required, and we saw evidence people's relatives or friends had been asked to produce evidence of any Lasting Power of Attorney if this had been granted. During the inspection we noted people were provided with choices by staff, and staff we spoke with could demonstrate a good working knowledge of the legislation and how it affected the people they supported. This meant people were supported in accordance with the MCA, but this was not always reflected in their care records.

We asked one person about the personal care they received from staff. They told us, "They're all nice and they make it very private and always ask me before they do anything". With the exception of one instance,

we saw staff explaining to people what they were doing and asking for their consent prior to supporting their needs. One staff member who had helped a person to get ready brought a bag with several pairs of glasses in and encouraged the person to choose a pair before offering to clean them.

A staff member told us they worked with health professionals such as opticians, chiropodists, social workers and district nurses to meet people's needs.

People we spoke with told us they had access to healthcare services when they needed this. They told us, for example, when they needed a GP to visit them, staff responded quickly. People's care records showed they had been seen by a variety of healthcare professionals to help meet their wider health needs. This included community nurses, GPs, speech and language therapists, dieticians and specialist nurses. One person's care records showed the service had raised concerns about the person's health and was working with their GP to monitor a potential new medical condition. A second person had detailed care plans relating to a complex health condition; staff had liaised with a specialist nurse and used information from them about the condition to inform the care plans put in place. During the morning handover and at the heads of department meetings, we found health appointments were discussed amongst the staff team to ensure staff knew who would be visiting the home or if people needed support to attend an external appointment. This showed service worked well with other healthcare professionals to meet people's needs.

Care records we looked at showed people had access to a range of healthcare appointments.

We saw the registered provider's policies included equality, diversity and inclusion, complaints and safeguarding. Having up to date policies helps to ensure staff are following current, up to date guidelines.

People we spoke with told us they felt staff were sufficiently trained and competent in their roles. One person told us, "Staff know what they are doing." Another person said, "I am sure they do, they are very knowledgeable."

Staff we spoke with were satisfied they received a suitable induction which adequately prepared them for their role. One staff member said, "It was brilliant, it covered everything. I had several days shadowing."

We looked at ongoing support for staff through a programme of supervision and appraisal and found this required improvement as supervision did not consistently happen every two months as per the registered provider's supervision policy. The regional support manager told us, "Appraisals are still work ongoing." We asked one staff member about the supervision they received and they told us, "You get a chance to say if you've got something on your mind. It's a good thing."

We met briefly with the new home manager for the home who told us once they were in post, they wanted to have a supervision with each member of staff to get to know them.

We looked at staff training records and found the average completion rate across mandatory and non-mandatory subjects was 90%. Staff training needs were reviewed on a weekly basis by the home manager and care manager who booked training where this was needed. The heads of department meetings we attended were used to discuss scheduled training which in March 2018 included, for example, nutrition and hydration, falls prevention, basic life support, catheterisation, skin integrity and wound management.

We looked at people's nutritional and hydration needs and found these were being met.

People we spoke with were complimentary about the food they were offered and they told us they were

given choice. One person said, "On the whole the food is excellent, and you get a choice for dinner." Another person told us, "We have a menu and if there's nothing I like, they try bring me something else. We get a good choice every meal and the menu is on the table at lunchtime, so you know what there is and it's always nice."

Kitchen staff had sufficient knowledge of people's dietary needs and the records we looked at showed this was documented. At lunchtime we found staff who assisted people in their own room with meals demonstrated lots of interaction with people which made the experience pleasant. However, the service in the dining room appeared strained and task oriented. People who didn't require assistance were served first as other people had to wait for a staff member to become free. One person in the lounge kept calling out for their food and a staff member twice said, "It's coming love." We recommend the registered provider reviews these arrangements to ensure people do not experience avoidable delays in receiving their meals.

We found there was no water, juice or snacks laid out for people in the lounges and when we asked a staff member how people could access fluids, they told us, "They ask." However, we looked in people's rooms and found they had access to drinks and we also observed a drinks trolley was taken round mid-morning and mid-afternoon with a choice of hot and cold drinks, milk shake and snacks including fruit and scones. This meant in communal areas, people either had to ask for fluids or rely on staff to provide them if they had communication difficulties.

One person told us the tea trolley which used to go around on an evening had stopped without explanation. We were told this used to also serve toast and biscuits. The management team were unaware of this and told us they would look into this following our inspection.

Is the service caring?

Our findings

At our last inspection we saw people did not always receive dignified care in accordance with their preferences, information was not securely stored and end of life care wishes were not considered and acted upon.

During this inspection we found not all staff interactions with people were positive as privacy and dignity was not consistently respected. On the morning of the first day of our inspection, we overheard one staff member in the dining room pointing at a person and telling them, "Now you sip that drink." We observed one staff member entering a person's room without knocking and without any explanation. They proceeded to hang clean clothes in the cupboard. We saw a child who was visiting a relative with their family was introduced to everyone in the lounge by a staff member with the exception of one person who had communication difficulties.

At lunchtime we overheard two staff members talking to each other. One member of staff commented, "[Person]'s a monkey". This was in reference to a person who was kicking another person at the dining table.

On the first day of our inspection a staff member was kind and respectful as they assisted one person with a drink. We saw they asked the person if they would like a drink and then waited before placing the beaker to the person's mouth. They watched to ensure the person had swallowed before giving them another drink. As this staff member was serving drinks from a trolley at the time, they said they would return shortly afterwards. Around ten minutes later another staff member entered the lounge and approached the same person from behind and placed the beaker in the person's mouth without making their presence known. We saw the person physically jumped and blinked as they were unaware of what the staff member was doing.

At lunchtime, we saw one person had their back to the table and the staff member assisting them did not talk with the person as they were chatting with another member of staff. The staff member did not check the person had swallowed their food in between mouthfuls. The staff member also left the person twice to answer the nurse call bell and there was again no interaction when the staff member returned. We discussed how staff reacted to this person in detail with the management team. We saw concerns had been identified in the quality manager's home visit sheet dated two weeks prior to our inspection regarding staff not engaging with people at mealtimes.

We concluded this was a breach of regulation was in breach of Regulation 10 (Dignity and respect) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people were not treated with dignity and respect.

We also saw some examples where people's privacy and dignity was respected and we found staff were able to provide appropriate answers when we asked how they supported people to maintain their privacy and dignity.

People we spoke with were complimentary about the care provided by staff. People's comments included,

"It is lovely here. I am very happy, It feels like home and staff chat to you", "I'm happily settled here", "Staff knock on the door to come in", "It's very good, I've not found a fault, staff show respect", "Yes, they are kind and helpful. I like the staff, they are very good and when I ask for anything they look after you. They are all friendly people. I'm happy and settled" and "If there's something I don't like, they rectify it and they're always changing my bed clothes and see I've fresh water and the ladies that clean look after my flowers."

One relative told us, "The staff are very friendly and ask me what [relative] needs. The staff are caring and do what I ask, especially around videos as I bring them in for [relative] and they (staff) make sure they have them on." Another relative said, "Staff do show empathy and compassion."

People and relatives we spoke with told us family and friends were able to visit the care home without restriction. One relative said, "It's very safe. It's a lovely place and I'm made to feel welcome. They always offer me coffee when I visit. It's very relaxed and comfortable."

Staff we spoke with recognised the importance of supporting people to remain as independent as possible. One staff member said, "We don't want to take away people's independence. It's a balance." Another staff member said, "If I'm helping them to get dressed, I encourage them to do up the buttons or put clothes on. I give them as much chance to do what they can for themselves. We can't take that away even though it may take longer."

We saw a number of positive interactions when staff demonstrated kindness and compassion. For example, we saw a staff member noticed a person's spectacles were dirty and they offered to clean them for the person. Another staff member saw a person was falling asleep and their head was tilting to one side. The staff member offered them a pillow to support them. One person who was sat in a chair told a staff member they were feeling cold. The staff member immediately went to find a blanket for them.

We saw a compliment on display which stated 'With grateful thanks for all the kind and compassionate care provided by the staff at Cleveland House'. A further compliment dated February 2018 read 'Staff were on hand showing real compassion and respect'.

People we spoke with were unsure about having involvement in their care planning. Relatives told us they were aware of review meetings taking place and some had been involved in initial care planning, although one relative said the timing of reviews was not flexible to ensure they could be involved. We passed this feedback on to the management team.

We discussed with the management team their approach to respecting issues of equality, diversity and human rights. They said they supported people to practice their faith and gave examples of how the care given supported these beliefs. For example, on a monthly basis a religious meeting took place. We also spoke about the need for people to have their sexuality recognised and supported. When we spoke with the management team, we found that although they understood the importance of non-discriminatory approaches to care, they were unaware of the assumptions they may be making about aspects of peoples identity related to the protected characteristics of the Equality Act 2010, sexual orientation for example. This meant the registered provider could not be sure they had embedded a cultural approach in the home which upheld all peoples' right to equality and diversity of care.

The registered provider supported people to access advocacy services where people did not have family members or friends to act on their behalf.

Peoples' personal records were stored confidentially in a locked room.

Is the service responsive?

Our findings

At the last inspection in August 2017 we identified a breach of Regulation 17 relating to good governance as people's care plans were not always an accurate and contemporaneous record of their care needs; we also found they contained contradictory information.

At this inspection we reviewed four people's care plans and found that whilst there had been some improvement, various issues remained. Each person's care plan followed a standard layout, with care plans for aspects of care such as continence, eating and drinking, mental health and mobility. One person we reviewed had a complex medical condition. We saw their care plans made reference to how this affected them, and there was a separate stand-alone care plan for the condition based upon information from a specialist nurse. A second person with various medical conditions also had separate care plans for them, which gave guidance to staff on how to meet the person's needs.

A third person with a complex medical condition did not have a separate care plan for this, even though it affected their mobility and ability to eat and drink. Their care plans also contained some contradictory information, for example, in the person's skin care plan it described the person as immobile, but went on to say they could change their own position in bed and in their chair to relieve pressure.

We also reviewed people's daily records which staff used to evidence they supported people in accordance with their care plans. All four of the people we followed up needed assistance to reposition in bed, and/or when seated in a chair to help reduce their risk of pressure ulcers. One person's skin care plan said they needed help to move when in a chair; we found repositioning charts for this person were not in place. We found significant gaps in the repositioning charts of the other three people, mostly between early evening and the early hours of the morning. Records showed none of the four people had a pressure ulcer at the time of this inspection, suggesting they were receiving the support they needed, but staff were not documenting this.

Staff we spoke with could describe the care needs of people at the home, for example, how to support them to move or to eat and drink safely. This meant that whilst improvements had been made and people's care was person-centred, some issues with record-keeping and consistency remained.

We asked the regional support manager how the Accessible Information Standard (AIS) had been implemented at Cleveland House. The AIS came into force in 2016 with the aim of ensuring people with disabilities, impairments or sensory loss receive information in a format they can understand, plus any communication support they need when receiving healthcare services. The regional support manager was able to share examples of how people's specific communication needs were being met.

We found people's care plans contained person-centred detail regarding their communication needs. For example, one person's communication care plan described their visual impairment and how their medical condition impacted upon their ability to understand and respond to verbal communication. It also provided detail about the person's facial expressions. This meant the principles of the standard were followed within

people's care plans.

The home manager had introduced charts to ensure pressure mattress settings were recorded on a daily basis. We saw these charts, but noted this was a recent initiative which meant the registered provider could not demonstrate this was embedded practice.

None of the people using the service were receiving end of life care at the time of this inspection, so we asked staff what good end of life care involved. One care worker told us, "You need to give them more TLC (tender loving care) and be there for them. They need that extra care", and a second care worker said, "Dignity in dying is important. Support is slower, quieter. It's about what they want."

At the last inspection we found people's care plans did not always include their end of life wishes and preferences. At this inspection we found some effort had been made to complete people's 'future decisions' care plans, and this had either involved them or their relatives. However, we found most were not detailed. One person's future decisions care plan noted the person had not wished to discuss the issue when asked. This meant there had been some improvement in the recording of people's end of life wishes, but more could be done to make them person-centred.

We asked people about the activities provision at Cleveland House Care Home. One person said, "They always ask me, but I prefer to go back to my room, but I do like dominoes and if they do a quiz in the lounge, I like that. They sometimes do exercises in the seats too." Another person said, "Staff will come and talk. I don't feel lonely, time goes fairly quickly." One relative told us, "I don't think (people) are restricted, but outside space could be made better use of as they don't really go out to get fresh air". We briefly spoke with the new home manager who told us they wanted to make better use of the gardens surrounding the home.

People told us staff communication of activities needed to be improved as they were not always aware of what was happening, when and where. One person told us, "It's hit and miss. In passing, staff tell you of activities." We discussed this with the management team who told us they would look at this.

A changeover at the end of March 2018 had been made to the activities provision which meant members of the kitchen team had taken on the responsibility for coordinating and delivering the activities programme. On day one of our inspection, we looked at the activities planner and saw this related to the period from 5 to 11 March 2018 which was the week before our inspection. On day two we saw the planner had been updated to reflect activities had been scheduled to include, for example, music and movement, coffee and catch up, dominoes, bingo and baking. On the first day of our inspection we observed a small number of people participated in an art activity. On the second day of our inspection, crafts were taking place in the morning and a reminiscence session took place in the afternoon.

People we spoke with consistently gave us positive feedback about the previous activities coordinator and noted they were no longer in this role. People felt the activities provision had slipped since the change, although we noted the handover in responsibility for the activities provision had recently taken place.

We spoke with one of the staff members delivering activities and found they had not received any training to do this. They told us they enjoyed doing the activities and watched what other staff had done and learned from them.

We saw examples of other activities such as a choir sing-a-long planned for March 2018 and another sing-along event booked for the same month. Minutes of meetings with people and relatives included evidence of how people were consulted so trips and activities were prioritised around what people wanted.

People we spoke with told us they knew how to complain if they were dissatisfied. One person said, "Yes, I know how to do it. I would speak to the staff first and if I'm not happy I would go to see the manager."

We looked at the management of complaints and saw this required improvement. We found the record of one complaint was missing which meant we were unable to check the terms of reference to ensure all points had been addressed. We spoke with the regional support manager regarding the response to this complainant dated October 2016 which referred to the dependency tool used to calculate the number of staff needed on shift. The response stated 'This tool is recognised by CQC'. The regional support manager acknowledged the Care Quality Commission does not endorse such tools and they told us all complaint responses since this date require senior management approval before being sent. We found records of other complaints and responses were on file and satisfactory responses were sent within timescales identified in the registered provider's complaints policy.

The service used assistive technology to support people such as motion sensors and pressure mats. Cleveland House had wi-fi installed two months before our inspection meaning people could use this to access the internet. The regional support manager told us people had access to Sky television and one person used an interactive voice controlled audio device to play music.

Is the service well-led?

Our findings

At the last inspection we found that the service was in breach of Regulation 17 Good Governance and rated the service as inadequate. We found numerous failures in the leadership and governance of the service which impacted on the delivery of care. Good governance structures and mechanisms in the service ensure that quality is reviewed. The regional support manager said they felt the culture in the home was starting to change. They described problems they had experienced with staff sickness prior to the last inspection and how this had impacted on quality as staffing numbers had remained low. They said that management had since tackled this issue and as a result morale was much improved. One staff member told us, "There's been a lot of changes for the better since they've (home manager) been here. It was spiralling before that. Staff morale was so low, it seems to have settled now. Things seem calmer." Another staff member said, "I'm finding it a happy place to work."

At the time of our inspection, a registered manager was not in post. The management team consisted of a home manager who oversaw a clinical services manager and a care manager. Also supporting the home towards improvement were regional support managers and a quality manager, overseen by the regional director for recovery. The regional director told us the new home manager was undergoing their induction at another home operated by the registered provider and they were expected to start at Cleveland House Care Home in mid-April 2018.

As part of the inspection we reviewed staffs response time to call bells. One relative we spoke with told us, "They (staff) take their time to come. (Relative) needs the commode quickly and often soils the incontinence pad." The care manager told us they carried out an analysis of call bell response times and highlighted any incidents where it had taken five or more minutes for a staff member to respond. They also said they investigated the reasons for the delay, which they had identified on occasions was due to staff assisting people first, before turning the call bell off. We looked at the call bell response times for the period covering 20 to 25 March 2018 and found a high number of instances where people had waited over five minutes and this had not been identified in the care manager's analysis. This meant the process was not robust as the actual number of instances where people had to wait more than five minutes was not accurately reflected. We raised our concern with the regional support manager and regional director.

The new home manager told us they wanted to investigate all such incidents and create an action plan to improve performance.

We looked at a range of audits which covered, for example, health and safety, care plans, 'first impressions' and infection control. Whilst these were carried out regularly, they were not fully effective. We looked at the quarterly health and safety audit dated March 2018 and found there was no specific action plan related to who was responsible for a specific action, when it would be completed by, together with sign off to show it had been completed. Infection control audits carried out in November 2017 and January 2018 did not have dates recorded against the actions. The homes' quality assurance and health and safety committee meeting minutes dated March 2018 stated there were no actions from the previous meeting minutes. We looked at the previous meeting minutes and found this referred to several points which had not been followed up.

We looked at staff interaction with one person in particular and have made reference to this against the 'caring' key question of our inspection report. We found leadership in the home had not acted to review this aspect of quality of care supported the development of staff to ensure staff consistently understood how to support people appropriately regardless of their ability.

We concluded these examples demonstrated a continuing breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as systems used to assess, monitor and improve the service were not sufficiently robust.

In the reception area we saw a 'You said, we did' notice dated 06/03/18. This showed people had asked for more permanent staff. The notice stated 'We have recruited 20%+ permanent employees'. There was information on display inviting people and visitors to comment on the service provided. One relative said, "Occasionally, they send a questionnaire round and if they don't tell me what that has resulted in I just knock on the door and ask." This meant the registered provider invited feedback and responded to the information shared with them.

We reviewed a sample of accidents and incidents which were recorded on a system the registered provider had started using in September 2017. We found basic recording of incidents and little in the way of in-depth analysis through investigation with outcomes. The regional director for recovery told us they had asked their home managers to fill these forms out with as much detail as possible. They told us they were automatically alerted to specific accidents and incidents if these were classified as serious. Following our inspection, the regional director for recovery sent us an analysis which demonstrated the system provided a breakdown of accidents and incidents by categorising these and looking at the time they occurred. This meant the information could be used to introduce measures to lower risks to people.

After our last inspection the provider put in place a home improvement plan. This was an action plan to address the shortfalls which our last inspection had highlighted. The action plan clearly stated all of the concerns from the previous inspection. When we checked to see if the actions documented had been carried out there was clear evidence to support this. There were various meetings which oversaw aspects of the improvement plan. The improvement plan was still a work in progress, but we saw the plan was regularly reviewed and updated. Actions were being undertaken against all aspects of the plan. All actions listed were rated for progress under a traffic light system. We saw no actions were rated as red. It was clear from the audit information and from the case records that care plans and documentation had improved. This meant that this aspect of the improvement plan was effective. A 'Daily clinical walk round' was completed to ensure quality was constantly under review. We saw evidence checks were completed each day.

We saw a 'residents charter' which stated the philosophy of the home was to encourage people, relatives or advocates, visitors and staff to influence the way the service was shaped through them being involved. We saw the service had held three meetings with people and relatives since November 2017. The meeting minutes highlighted information was shared with people about the management changes to the service, recent monitoring visits from the local authority and updates about the homes regulatory position with the CQC. Staff meetings had also taken place with different teams in the home in November 2017 and February 2018. This meant there were structures in place where people and staff were informed of key changes or issues in respect of the running of the home.

We asked people and relatives if they were familiar with the home manager and found a mix of people who were able to identify them and those who could not. One relative told us, "I'm very happy with him as he's approachable." However, another relative noted the home manager spent a lot of time in the office, which

meant they did not have a presence in the home. We asked staff for feedback about the home manager. One staff member said, "They are really good. They're really approachable." However, they also commented, "He's always in the office." Another staff member said, "He does manage from the office." However, they also told us the home manager had given people the 'tools' to carry out their roles more effectively. They added, "He's given us more of an insight into our roles."

The care manager had been appointed as infection control lead in November 2017. A night shift rota for cleaning had been introduced to include items such as chairs and hoists which is harder to do during the day when these items are more likely to be needed. They provided examples of areas of practice which had improved and noted two senior care workers had also been given the roles of infection control champion.

The care manager told us the role of chart champion was introduced three weeks before our inspection. This was allocated to different staff on a daily basis. Their responsibility was to prompt staff who had missed filling in a chart. The care manager said, "I have seen some improvements in the charts."

We saw the home manager had completed checks on a night time to ensure safe care was being provided. These had been completed in January and March 2018.

We attended both the morning staff handover and a further meeting called '10 at 10' which was attended by department heads. This meeting was an initiative introduced since our last inspection to help the service identify for example, clinical risks, appointments, building maintenance, people's feedback, residents of the day and activities.

We saw there had been a recent user survey from December 2017 which seven people had completed. This showed 86% felt happy and content with the home, 83% felt listened to by staff, 100% said that they felt safe and secure, 86% felt they were treated with dignity and respect. In four out of six domains people fed back that they were 100% satisfied with aspects of care at the home to include food, activities, their bedrooms and communal spaces. This meant the provider was gathering information about people's experience of using the service.

We looked at how Cleveland House worked in partnership with other agencies and found they had good links with the local palliative care team. However, in other respects we found there was limited evidence of working in partnership with the local community. We recommended the registered provider looks to develop these links.

The regional director for recovery completed a monthly home review in January 2018 which looked at care plans, medicines, kitchen, activities, laundry and maintenance. At the time, they rated the home overall as amber which demonstrated improvements were needed.

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 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	Service users were not treated with dignity and respect.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The systems used to demonstrate the safe administration of medicines were not robust.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems to assess, monitor and improve the service were not sufficiently robust.