Care UK Community Partnerships Ltd

Cumberland

Inspection report

The Cumberland
67 Whitford Gardens
Mitcham
Surrey
CR4 4AA

Tel: 02086461551
Website: www.cumberlandmitcham.co.uk

Date of inspection visit:
23 May 2017
24 May 2017

Date of publication:
27 June 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Cumberland is a care home which provides nursing and personal care for up to 56 adults. The service specialises in supporting older people living with dementia. The service is divided into two distinct units called Turner and Reynolds. At the time of our inspection there were 48 people using the service.

At the last Care Quality Commission (CQC) inspection in March 2015, the overall rating for this service was 'Good'. At this inspection we found the service remained 'Good'. The service demonstrated they continued to meet regulations and fundamental standards.

People continued to be safe at Cumberland. There were robust procedures in place to safeguard people from harm and abuse. Staff were familiar with how to recognise and report abuse. The provider assessed and managed risks to people's safety in a way that considered their individual needs. There were enough staff to keep people safe and recruitment procedures were designed to prevent people from being cared for by unsuitable staff. The premises and equipment were safe for people to use because staff routinely carried out health and safety checks. Medicines were managed safely and people received them as prescribed.

Staff received appropriate training and support to ensure they had the knowledge and skills needed to perform their roles effectively. People were supported to eat and drink enough to meet their dietary needs. They also received the support they needed to stay healthy and to access community healthcare services.

Staff were caring and treated people with dignity and respect and ensured people's privacy was maintained particularly when being supported with their personal care needs. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

People received personalised support that was responsive to their individual needs. Each person had an up to date, personalised care plan, which set out how their care and support needs should be met by staff. This meant people were supported by staff who knew them well and understood their needs, preferences and interests. Staff encouraged people to actively participate in leisure activities, pursue their social interests and to maintain relationships with people that mattered to them.

The registered manager continued to provide good leadership and the management team led by example. The service had an open and transparent culture. People felt comfortable raising any issues they might have about the home with staff. The service had arrangements in place to deal with people's concerns and complaints appropriately. The provider also routinely gathered feedback from people living in the home, their relatives and staff. This feedback alongside the provider's own audits and quality checks was used to continually assess, monitor and improve the quality of the service they provided.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Cumberland

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 was a comprehensive inspection, which took place because we carry out comprehensive inspections of services rated 'Good' approximately every two years. The inspection took place on 23 and 24 May 2017 and was unannounced. It was carried out by an inspector and an expert by experience. Our expert by experience was a person who had personal experience of caring for someone who is living with dementia and uses this type of adult social care service.

Before the inspection, the provider completed 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. Prior to our visit we reviewed the information we held about the service. This included reports from previous inspections and statutory notifications submitted by the provider. Statutory notifications contain information providers are required to send to us by law about significant events that take place within services.

During our inspection we spoke with four people who lived at the home and ten visitors including, seven relatives and three community health care professionals that included, a psychologist, a palliative care nurse and a member of the London Borough of Sutton and Merton's challenging behaviour team. We also met various members of staff who worked for Care UK including, the registered manager, the area manager, the deputy manager, five nurses, six care workers, two activities (lifestyle) coordinators, the cook, and the maintenance person.

We also observed the way staff interacted with people and performed their duties. During lunch we 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.

In addition, we looked at care plans for six people who lived at the home, five staff files and a range of other

documents that related to the overall governance and management of the home.

Good

Is the service safe?

Our findings

People told us Cumberland was safe. A relative said, "The home is safe with security and the staff always being around." All the people who participated in the provider's March 2017 satisfaction survey stated the home was a safe place to live. People continued to be protected from the risk of abuse or harm. Since our last inspection all staff had received refresher training in safeguarding adults at risk. This helped them to stay alert to signs of abuse or harm and the appropriate action that should be taken to safeguard people. We looked at documentation where there had been safeguarding concerns about people and saw the provider had taken appropriate action, which they followed up, to ensure people remained safe and to prevent reoccurrence.

Measures were in place to reduce identified risks to people's health, safety and welfare. Senior staff routinely assessed and reviewed risks to people due to their specific health care needs. They had put in place risk management plans for staff to follow to reduce these risks and keep people safe. This included eating and drinking, mobility and the safe use of moving and handling equipment, such as mobile hoists and skin care. Our observations and discussions showed staff understood the risks people faced and took action to minimise them. For example, we saw one to one staff support was always provided to several people identified as being at risk of falling if they stood up unaccompanied. We also observed a member of staff reassure a person who had become anxious by take their time to calmly talk to this individual. Staff told us they had received training in responding to behaviour that challenged, including aggressive behaviour. This helped staff deal with incidents of challenging behaviour consistently and ensure the safety of people, staff and any others present.

Managers followed up the occurrence of any such incidents involving people living in the home and developed action plans to help prevent them from happening again. Examples included seeking advice from relevant community health and social care professionals, such as the local authority's challenging behaviour team who the registered manager met with at monthly intervals, and reviewing people's risk management plans so staff knew how to support people safely. The registered manager gave us several examples of situations where they had used incident reporting to identify trends and patterns to develop an action plan which had resulted in a significant decrease in the number of incidents related to people's behaviour that challenged the service and falls.

The home continued to be safe and hygienically clean for people. Staff demonstrated good awareness of their role and responsibilities in relation to infection control and hygiene. Arrangements were in place to deal with foreseeable emergencies. People had personal emergency evacuation plans which explained the help individuals would need to safely leave the building. Appropriate numbers of staff were trained in first aid. Staff demonstrated a good understanding of their fire safety role and responsibility and told us they received on-going fire safety training.

The environment was well maintained which contributed to people's safety. Maintenance records showed service and equipment checks were regularly carried out at the home by suitably qualified professionals in relation to the home's fire extinguishers, fire alarms, emergency lighting, portable electrical equipment,

water hygiene, and gas and heating systems. We observed the environment was kept free of obstacles and hazards which enabled people to move safely and freely around the home and garden. We saw chemicals and substances hazardous to health were safely stored in locked cupboards when they were not in use. We also observed staff checking the temperature of hot water used in baths during our inspection, which records indicated never exceeded a safe 43 degrees Celsius.

The provider's recruitment process helped protect people from the risk of employing unsuitable staff. The provider maintained recruitment procedures that enabled them to check the suitability and fitness of staff they had employed. Records showed the provider carried out criminal records checks at three yearly intervals on all existing staff, to assess their on-going suitability.

There were enough staff to support people. Relatives told us there were enough staff working in the home. Typical feedback included, "There are enough staff working here. I always see them around", "There are enough staff as far as I can see" and "Plenty of staff about whenever I visit my [family member], which is quite often at the moment."

The registered manager told us the service should normally have four nurses working on the units during the day, but this had fallen to two nurses at the time of our inspection due to unexpected staff absenteeism. However, we saw the registered manager and the deputy manager who were both qualified nurses often worked as part of the team to cover these staff shortfalls during peak periods of activity, such as mealtimes for example. Throughout our inspection staff were highly visible in communal areas, which meant people could alert staff whenever they needed them. There were also numerous examples of staff attending immediately to people's requests for a drink or assistance to stand and we saw one-to-one staffing was in place for three people identified in their care plan as needing this additional support to mitigate known risks of harm. The services staff rota was planned in advance and took account of the level of care and support people required in the home.

Medicines were managed, stored, given to people as prescribed and disposed of safely. People's care plans contained detailed information regarding their medicines and how they needed and preferred these to be administered. We looked at medicines administration records (MARs) which should be completed by staff each time medicines were given. There were no gaps or omissions which indicated people received their medicines as prescribed. Our checks of stocks and balances of people's medicines confirmed these had been given as indicated on people's MAR sheets. Staff received training in the safe management of medicines and their competency to handle medicines safely was assessed annually.

Good

Is the service effective?

Our findings

People were cared for by staff who were well trained and supported by senior staff. People's relatives told us staff were competent. One relative said, "The staff are specially trained to look after people with Alzheimer's and challenging behaviour", and another remarked, "The staff are highly skilled and trained. They all do a really good job."

Since our last inspection records showed staff had either completed their mandatory induction training or refreshed their existing knowledge and skills in topics relevant to their roles. This helped staff keep their competencies up to date in various subjects that included dementia awareness, moving and handling, fire safety, food hygiene and infection control. Staff spoke positively about the training they had received, which they said was on-going. One member of staff told us, "Care UK are very good at making sure we receive all the training we need to do our jobs properly." Another member of staff said, "Recently I completed a course to update my fire safety and moving and handling training, which I found helpful."

Staff continued to be supported through regular meetings with their line managers. Staff had regular one-to-one meetings with their manager or senior staff which included bi-annual supervision and work performance appraisals. In addition, managers, nurses and care workers regularly attended group meetings with their fellow co-workers. Staff told us these individual and group meetings gave them sufficient opportunities to discuss their work and training needs. Staff also told us they felt supported by senior staff.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's consent and ability to make specific decisions had been assessed and recorded in their records. Where people lacked capacity, their relatives or representatives and relevant healthcare professionals were involved to make sure decisions were made in their best interests. Staff had received training in MCA and DoLS and understood their responsibilities under the Act. The registered manager had assessed where a person may be deprived of their liberty. People living at Cumberland needed constant supervision to keep them safe and were unable to access the community unaccompanied. DoLS applications made to deprive people of their liberty had been authorised by the appropriate body. Records showed the provider was complying with the conditions applied to the authorisation.

People were supported to have enough to eat and drink. People we spoke with and over ninety percent of those that had participated in the provider's most recent satisfaction survey typically described the food

they were offered at the home as 'good'. One person told us, "The food is pretty good here", while another person said, "I do enjoy the food. I chose to have the chicken for my lunch today, which I'm looking forward too." Another person's relative commented about the food, "My [family member] really enjoys the meals here and there is always plenty of drinks available, especially on hot days."

We saw care plans included information about people's food preferences and the risks associated with them eating and drinking, for example where people needed a soft or pureed diet. We observed staff offering people drinks throughout the day and jugs full of water or juice were available in peoples' bedrooms. People's nutrition and hydration was provided in a way that met their specific needs, which included providing thickened fluids and soft diets. The cook was clearly aware of people's special dietary requirements and gave us some good examples of the preferred meals some of the people who lived at the home preferred to regularly eat, which included omelettes and various Caribbean style dishes. Staff also gave us good examples of how they offered people different foods to find out what they did like to eat if someone living with dementia was losing weight.

People were supported to maintain good health. A relative told us, "Doctors visit when needed." In addition, a community health professional said that staff always listened to what they had to say and implemented their professional advice about how best to meet people's health care needs. Staff ensured people attended scheduled appointments and check-ups such as with their GP or consultant overseeing their specialist health needs. People's individual health action plans set out for staff how their specific healthcare needs should be met. Staff maintained records about people's healthcare appointments, the outcomes and any actions that were needed to support people with these effectively. Staff were knowledgeable about recognising signs and symptoms that a person's health was deteriorating. A care worker gave us a good example of how they had recently liaised with the nurse in charge of the shift because they were concerned about a person's rapid weight loss.

Good

Is the service caring?

Our findings

At our last inspection it was observed during lunch that some staff had very little interaction with people they were assisting to eat their meal. In addition, a few relatives told us some of the staff could be quite abrupt at times. These issues were discussed with the registered manager at the time.

At this inspection we observed positive interactions between staff and the people living in the home and their relatives. For example, people looked at ease and comfortable in staff's presence, responding positively to their questions and requests for assistance. Staff also gave people their full attention during conversations and spoke to people in a kind and considerate way. During lunch we saw staff frequently checked if people were enjoying their meal or needed a drink and provided encouragement. Staff described the food before supporting people to eat it and assisted them in a dignified manner.

People told us they were happy living at Cumberland and typically described the staff who worked there as 'kind'. One person said, "It's nice here. It's my home", while another person commented, "I am happy living here and I'm taken care of by the staff." People's relatives were equally complimentary about the home. Typical comments included, "I am happy with this care home. Very satisfied with everything and my [family member] is happy because their care needs are being met", "This care home is wonderful. My [family member] is so much better here than at home" and "I would recommend this care home to anyone."

People's privacy and dignity were respected and maintained. The majority of people who participated in the service's March 2017 satisfaction survey said staffed treated them with kindness, dignity and respect. We saw staff did not enter people's rooms without first knocking to seek permission to enter and kept doors to people's bedrooms and communal bathrooms closed when supporting people with their personal care. In addition, during lunch we observed staff always offered people seconds, and only cleared plates away when people had finished their meal.

People were supported to make decisions about their own care and support. People told us staff supported them to be involved in planning the care they received at the home. One person said, "Staff make sure I am always involved in decisions about my care." Another person's relative explained, "I was very much involved in helping the staff develop my [family members] care plan." We saw people were well cared for and appropriately dressed in clean well maintained clothes. People could make choices which were individual to them and these were respected by staff. Staff knew what people liked to do and what their preferred routines were. For example, we saw staff respect a person's decision to have a late breakfast late one morning, which staff confirmed this individual often chose to do instead of having a hot meal at lunchtime. Staff clearly knew people well and were able to tell us about their food preferences, social interests and backgrounds.

Staff understood and responded to people's diverse cultural and spiritual needs in an appropriate way. Information about people's spiritual needs were included in their care plan. It was clear from comments made by staff that they were fully aware of the culturally diverse dietary preferences of people who lived in the home. Religious leaders from various faiths regularly visited the home to support people to meet their

spiritual needs and wishes.

Although most people living in the home were dependent on the care and support they received from staff with day-to-day activities and tasks, staff still encouraged people to be as independent as they could be. For example, we saw people could move freely around the home. We also observed people who were unable to use traditional cups and plates had their needs assessed and where appropriate, had been given a plate guard or special crockery which enabled them to drink and eat with minimal assistance from staff.

When people were nearing the end of their life, they received compassionate and supportive care. Staff told us they asked people for their preferences in regards to their end of life care and documented their wishes in their care plan. This included conversations with people, and their relatives, about their decision as to whether to be resuscitated and whether they wanted to be hospitalised for additional treatment and in what circumstances. Staff confirmed they had received end of life care training. A community palliative care nurse spoke positively about the end of life care support staff provided people in the home.

Good

Is the service responsive?

Our findings

People's needs were assessed and care and treatment was planned and delivered in line with their individual care plan. A relative told us, "I've seen my [family members] care plan and I'm happy it's reflective of their care and how staff need to support them, including what their likes and dislikes are". Care plans were kept up to date and contained personalised information about people's social interests, food preferences and how personal care and support was to be provided. For example, people's daily routine set out for staff when people liked to wake up, how they wished to be supported with getting washed and dressed and when and where they would like to eat their meals.

Care plans were personalised and centred on people's needs, strengths and choices. There was detailed information about what was important to the person. People's life histories and the names of family members and friends who were important to them were recorded in their care plan.

Care plans were reviewed monthly, or sooner if there had been changes to people's needs. Where changes were identified and plans were updated, information about this was shared with all staff.

People remained active and participated in a variety of social and recreational activities that met their social and physical needs. One person told us, "I do like feeding the birds in the garden as this is something I've done for as long as I can remember." We observed the lifestyle coordinators initiate numerous leisure activities in various communal areas during our inspection that included, a game of bingo, skittles, music and movement and bird feeding in the garden, which people who chose to participate in them seemed to enjoy. The lifestyle coordinators gave us several good examples of new activities they had introduced, which had included gentle exercise classes, dancing, sing-alongs and reminiscences quizzes. The service has its own designated rooms for hairdressing and a well-equipped sensory room. The lead lifestyle coordinator also told us they had attended a course on providing appropriate social activities for people living with dementia.

It was also evident from care plans we looked at and comments we received from the activities coordinator they ensured people who liked to spend time on their own also had opportunities to engage socially with staff in their bedroom. They explained the rationale behind this was to mitigate the risk of these individuals becoming socially isolated.

The provider continued to maintain appropriate arrangements for dealing with people's complaints or concerns if these should arise. People and their relatives told us they felt able to raise any concerns they might have about the home directly with the provider. One person said, "I am confident to raise a complaint. I was unhappy here, but as soon as I told the staff what was bothering me, my concerns were dealt with straight away." A relative also told us, "I have complained to the manager about the care my [family member] received in the past, and to their credit my complaint was addressed quickly." The provider had a robust complaints procedure that was designed to ensure people's complaints were dealt with in a prompt and fair manner. The complaints procedure was openly displayed in the home and explained what people should do if they wished to make a complaint or were unhappy about the service they received. The

provider had a positive approach to using complaints and concerns to improve the quality of the service. Complaints were dealt with by the provider's management team. The complaints records showed that complaints lodged at the service had been taken seriously, investigated and where required action taken and lessons learnt.

Good

Is the service well-led?

Our findings

The registered manager had been in day-to-day charge of Cumberland for many years and knew the people who lived there well. Cumberland had an effective management structure in place. Several people and their relatives told us the home was 'managed well'. One relative said, "I have got a lot of time for the manager who I think is always professional and very good at his job." The registered manager was supported by a deputy manager and members of staff had designated roles in areas such as dementia awareness and medicines management. The staff team were caring and dedicated to meeting the needs of the people using the service. The service promoted and supported people's contact with their families.

The registered manager demonstrated a good understanding of their role and responsibilities particularly with regard to legal obligations to meet CQC registration requirements and for submitting statutory notifications of incidents and events involving people living at the home.

The registered manager and staff also worked closely with the local authority, the clinical commissioning group (CCG), and the acute and community healthcare services to review joint working arrangements and share information and learning around local issues and best practice in care delivery. For example, the services management regularly met with members of the local authority's challenging behaviour team and community palliative care nurses to discuss and seek advice from these specialist professionals about how best to support people living in the home whose behaviour might challenge or who needed end of life care.

The provider valued and listened to the views of staff working in the home. Staff spoke favourably about the registered manager and their leadership style. One member of staff told us, "The manager is very supportive of us. He's always helpful." Another said, "I think the manager and the deputy work well together as a team and I find the deputy manager is a good listener and always approachable." Staff meetings were held monthly and staff said they were able to contribute their ideas. Records of these meetings showed discussions regularly took place which kept staff up to date about people's care and support and developments in the home. Staff also shared information through daily shift handovers and a communication book.

The provider promoted an open and inclusive culture which welcomed and took into account the views and suggestions of people living in the home and their relatives. One relative said, "Communication with management is good here and they do listen to us. I always attend the relatives meeting every three months where the management ask us for our views." Another relative told us, "I often attend the relatives meetings and the staff generally tell us what you want to know". The provider used a range of methods to gather people's views which included a suggestions box, quarterly relatives meetings and an annual stakeholder satisfaction survey. We saw the 12 people who had participated in the provider's most recent survey in March 2017 were satisfied with the overall standard of care they or their family members received at Cumberland.

The provider had established good governance systems to monitor and review the quality of care they delivered. This included regular daily, weekly, monthly and annual audits completed by managers and

senior staff who worked at the home, as well as quarterly quality monitoring visits undertaken by the provider's regional governance manager. We saw audits had been conducted in areas including care plans and risk assessments, medicines management, food hygiene and nutrition, staff training and supervision, health and safety, and accidents and incidents. For example, we saw the provider used an electronic system to monitor staff training which automatically flagged up when staff training needed to be refreshed.

Through the aforementioned governance systems the registered manager had identified several issues which they had begun to address. For example, the registered manager explained how they had helped the reduce the number of falls in the home by introducing regular falls analysis meetings where all the relevant staff, including community health nurses, could discuss how best to support people where patterns in incidents of them falling had been identified.