Abbeyfield Society (The)

Cunningham House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Cunningham House is a residential care home providing personal care for to up to 54 people. The service provides support to older people. At the time of our inspection there were 40 people using the service, one of whom has a learning disability. Accommodation is provided across two connected areas, one of which specialises in providing care to people living with dementia.

People's experience of using this service and what we found
People were not always supported by enough staff and their care plans and risk assessments were not always up to date. Oral hygiene was poor, and food and fluid intake were not always documented accurately. People received their medicines safely.

People and their families were not always involved in their support plans. Care plans included people's likes and dislikes, but care provided did not always reflect people's preferences. There was little evidence of personalised activities for people.

There were issues with relationships among the staff teams. The manager was aware of this and had identified various other areas of improvement required. At the time of the inspection action taken had not yet been effective.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 29 December 2017).

Why we inspected
We received concerns in relation to staffing levels, people being woken up from 3am for personal care and left without food or fluids and medication errors. As a result, we undertook a focused inspection to review the key questions of safe, responsive and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Cunningham House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to risk assessments, poor oral hygiene and food and fluid documentation, staffing levels, people not receiving personalised care and the culture within the service at this inspection.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

At our last inspection we rated this key question good.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

At our last inspection we rated this key question good.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

At our last inspection we rated this key question good.

Cunningham House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors.

Service and service type
Cunningham House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Cunningham House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was not a registered manager in post. A new manager had been in post for two months and had submitted an application to register. We are currently assessing this application.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with one person about their experience of the service and four relatives. We spoke with twelve members of staff which included the home manager, senior operational manager, care, activities, kitchen, domestic and maintenance staff. We reviewed a range of records. This included four people's care plans and medication records. We looked at two staff files in relation to recruitment and staff supervision records relating to the management of the service. We spent time observing people and staff together to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

Assessing risk, safety monitoring and management

● People's care plans and risk assessments were not always up to date and some lacked detail. For example, one stated a person may show behaviours when moved but did not explain what was meant by behaviours or give guidance for staff on how to support the person. Following the inspection, the manager told us the behaviour was no longer an issue and the care plan needed to be updated.

● People living with dementia did not always have good support with oral hygiene needs. We found a lack of oral hygiene equipment. When people had toothbrushes, some had no toothpaste and despite people having already received personal care, toothbrushes had not been used.

● People's food and fluid charts had been completed in advance, some had identical times and volumes, and some were completed retrospectively. We observed a person's breakfast taken away uneaten and checked the record after, which stated three quarters of the food had been eaten. Therefore, we were not assured the records were accurate.

Information about risks to people were not always up to date. Oral hygiene was not managed well, and hydration and nutrition were not monitored effectively. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● People had personal emergency evacuation plans (PEEP) to ensure staff knew what support people needed in the event of an emergency.

Staffing and recruitment

● People on the unit for people living with dementia were supported to wash and dress by the night staff. Some of the people required support of two staff but with only three staff per night we were not assured care could always be provided safely. Staff told us for everyone to be up by 7.30 they were waking people up from 4am. One said, "On nights we are expected to do a lot…nothing is done [about it] because we are coping, but this is done by cutting corners, like starting at 4am."

● Staff told us the impact of there not being enough staff included not being able to spend enough time with people. One person told us, "There are not enough staff though, I sometimes have to wait a long time to use the toilet…there never seems enough staff at the moment." A relative said, "Numbers been down a bit recently. More would be better. Sometimes I can't find anyone but that is how it has always been."

● Staff told us they were aware of poor moving and handling practice, such as hoisting alone. One said, "That happens when we are short staffed."

● The manager told us night spot checks had been completed and discussions held with staff where they were told not to wake people up early. However, staff told us following this meeting when only one person was up and dressed, they were told they should have supported more people.

The service did not always provide enough staff to support people to stay safe. Staff were to provide care and support in a timescale that made them feel stretched and focus on completing tasks rather than on person-centred care and support. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

● Staff recruitment and induction training processes promoted safety, including those for agency staff. Agency staff familiar with the service were used.

Systems and processes to safeguard people from the risk of abuse
● Staff had training on how to recognise and report abuse and they knew how to apply it. One gave examples of safeguarding concerns and told us, "Process must be followed in order to protect the resident." However, all staff had completed the same course, safeguarding awareness, meaning staff may not have been trained to the level required for their roles. Following the inspection, the manager told us a new course was being launched which would be refreshed annually and they planned to have safeguarding as a regular topic in team meetings. There were plans for some staff to complete advanced safeguarding training.
● The manager was aware of their responsibility to raise safeguarding concerns to the local authority. They made referrals as required and were in the process of training the heads of care to complete in their absence.

Using medicines safely
● We observed a member of staff interrupted when they were administering medication to open the front door or attend to people in their rooms. This was not best practice. However, the member of staff always locked the medication trolley.
● Staff followed effective processes to assess and provide the support people needed to take their medicines safely. This included where there were difficulties in communicating, when medicines were given covertly, and when assessing risks of people taking medicines themselves.
● People were supported by staff who followed systems and processes to prescribe, administer, record and store medicines safely. Staff had received training and had their competency checked.

Preventing and controlling infection
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises. We found some equipment which had not been cleaned thoroughly and slings appeared to be used for more than one person. We raised this with managers, and they had identified this as a concern. We saw new documents had been created to record cleaning of each piece of equipment, including the slings which were also to be labelled or replaced as required.
● We were somewhat assured that the provider was supporting people living at the service to minimise the spread of infection. We found some creams in people's rooms without a date opened on or without lids. This meant there was a risk the cream had been contaminated and could cause infection if used on broken skin.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.
● The service supported visits in line with current guidance.

Learning lessons when things go wrong
● Staff had raised concerns relating to the times people were woken up in the mornings. The safeguarding team had visited as a result of this recently, but we found this was still the case when we visited.
● Some staff told us they were aware of occasions where unsafe moving and handling practice had been used. These had not been reported as incidents and the manager said this had not been identified as a concern. However, we saw information displayed on the staff noticeboard where lessons learned relating to

an occasion where a person who required two staff was supported by one.
● Staff recorded incidents on a monthly tracker form which described what had happened with the outcome and actions taken, such as referrals to other professionals. Staff described a distressed reaction incident which had been referred to the mental health team and we saw this had been logged on the monthly tracker.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Requires Improvement

Is the service responsive?

Our findings

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

● People did not always receive care that reflected their preferences. In the area of the service supporting people living with dementia most people were assisted to wash and dress by 7.30am. Whilst some people were described as early risers, we saw one person's plan stated they liked to sleep in. A member of staff told us, "The night staff start early getting people up around 5.30am…they get them up early because they go to bed early."

● We observed staff offering drinks to people. One staff poured the wrong drink in error and tried to make the person have it instead when they did not want it. However, another staff member interrupted and suggested an alternative which the person accepted.

● People and their families were not involved in care plan reviews. One relative we asked said, "Not automatically. I had cause to phone them and asked if had been updated and they said it had."

People were not always involved in decisions about their care, treatment and support. Their care was often task-focused and not person-centred. This was a breach of regulation 9 (person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● All families we spoke with told us they were informed if something happened, "They phone me if there is a problem, always. They are very quick to do that if (relative) is going to hospital, changes to medication or any incidents."

● Care plans we reviewed included information about people's likes, interests and what was important to them. There was information on how people liked to take their medication and one person was able to administer their own with minimal staff support.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

● People's care plans did not always describe their communication needs fully. One care plan stated a person could communicate verbally, but sometimes would not. It was unclear what staff were to do on these occasions; the care plan stated for staff to observe for signs of pain, discomfort etc but did not give guidance on what these signs may be, and a pain scale was not used.

● We were told people's communication needs were part of their initial assessment and information could be provided in a range of formats. One care plan we reviewed stated picture cards could be used to aid communication. There were none in their room and we could not find any in the ground floor of the dementia unit. Following the inspection, we were told these were available in residents' rooms and provided with examples. However, given that we could not find them we were not assured they were used by staff.

● The activity planner for each unit was displayed in picture format.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● An activity co-ordinator provided support with activities in one area of the service in the morning and another area in the afternoon. This was not ideal as people tended to fall asleep after lunch, but we were told there was a second activities co-ordinator employed and a third was being recruited. The activity planner included games, puzzles, quizzes, films and music. These were all group activities and there was little evidence of personalised options for individual people.

● People living with dementia were not involved in activities during our inspection. All but two people were in their rooms, mostly sleeping. Two were sitting in front of the TV in the lounge with no staff present. There was a sensory room, but staff told us this was not used.

● We asked people's families how their relatives tended to spend their day. One said, "Variable. Have found them sitting in the communal area and there has been entertainment, but [relative] doesn't really know what is going on…do their best to involve them." Another told us, "(Staff) don't spend much time with [relative] that I am aware of. Just go in and check on (them) and turn (them)."

● We saw from people's daily logs that some events had occurred including a Hawaiian themed day and jubilee celebrations which staff supported people to join in. One member of staff described activities including arts and crafts, board games, colouring books. They told us, "I like to have chat with them, go through some of their old photos." A ball game had been successful, "All engaged with that really well… made me realise we need to interact more."

Improving care quality in response to complaints or concerns

● We reviewed the complaints log which showed three complaints had been received since June 2021. It lacked detail as to what action had been taken and whether any learning had been shared with staff.

● The manager told us they investigated all complaints, including those raised informally. Families confirmed they had met with the manager to discuss their concerns.

● People, and those important to them, could raise concerns and complaints easily and staff supported them to do so. The complaints procedure was provided when people first moved into the service and leaflets were available. One relative told us, "Can't imagine I'd have to but would start with the manager. I'd write and would visit if didn't hear back."

End of life care and support

● Staff received training in end of life care to enable them to be responsive to people's changing needs at the end of their life. They were able to give examples of how they supported people such as providing mouthcare or adapting the environment so a person could see out of the window.

● In the plans we reviewed, there was nothing documented relating to people's religious, cultural and spiritual requirements.

Requires Improvement

Is the service well-led?

Our findings

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Staff described issues with the culture within the service. One told us the relationship between the area supporting people living with dementia and the residential area felt like 'us and them'. There were also issues between the day and night staff, relating to the workload expected of the night staff. One told us, "I don't agree with it, tried to put my foot down but it causes a rift between the day and night staff."

● Some staff felt their colleagues were not very supportive. They told us some staff were not happy about changes being made by the new manager but thought the changes were needed. One said, "I feel like [manager] has been a positive change and is really trying hard to get things in order."

Managers and staff did not share an understanding of the risks and issues facing the service and staff did not always feel they were treated equitably. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The manager was aware of the issues among the team and we saw this had been raised at team meetings. Action taken included moving staff to work in different areas of the service to make them feel more like one team. However, these actions were yet to be effective.

● Some staff were happy. One told us, "I like the team, works nicely together, feels like a family" and described their manager as "Great, very supportive. Always at the end of the phone." Another said, "I love it here. I love all the residents and get on really well with the team."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The manager was new to the service. They had identified some issues via audit and addressed them in team meetings and supervisions, but we found this had not yet been effective. For example, oral hygiene had been documented as an area to improve in July 2022, but we found evidence during our inspection of people not being supported.

● The manager had logged numerous issues in the service development plan. In July 2022, entries included nutrition documentation, IPC improvements such as cleanliness in the residential bathroom and slings and the need for more activities. These remained an issue at the time of our inspection.

● We asked the manager if there were any concerns relating to moving and handling. Two staff told us they were aware of people not being supported safely but had not reported it. The manager told us there had been an issue with a member of staff which was being addressed. We saw lessons learned relating to this displayed.

● Staff did not deliver good quality support consistently. Our observations during the inspection were mixed; there were a couple of occasions where care staff were a bit abrupt and lacked warmth when speaking to people. One person told us, "Most staff are nice, but you get the odd one who could be nicer." However, we also observed one member of staff speak kindly with full consideration of a person's dignity when speaking with them in a communal lounge.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The manager told us staff were expected to update families if there was a change in their relative's needs or at least monthly. Feedback from families suggested this was not always the case. One relative said, "I've had very little contact but take it as no news is good news." Another said, "In general they do call me up and say this is happening. Haven't heard from them in a while. They would generally call me."

● People's care plans did not evidence involvement of people and their families in reviews. Relatives tended to be contacted if there was a change. A person deteriorated during our inspection and staff told us they would call the family.

● Surveys for feedback on the service had been issued to staff and people who used the service. The resident survey was completed between January and March 2022 and whilst scores showed a positive response, it had only been completed by 14 people. The response rate for the staff survey completed in March 2022 was also low at 33.33%.

● Team meetings were held by department. Additional 'flash meetings' were held if there was something specific to address promptly.

Continuous learning and improving care

● The manager described their priorities for the service as improving documentation and care planning. They had also identified staff needed more support and knowledge in some areas, but they were new to the service and not fully aware of all the resources available from the provider relating to training and audits.

● Staff had not received training in dementia. Referrals were made to the crisis team as required but we were not assured the provider was keeping up with developments in dementia care. Following the inspection, the manager added dementia training to their improvement plan and had identified courses including dementia and the environment and behaviours that challenge for staff to complete.

● There was a portal for incidents to be logged. We were told these were reviewed by head office who generated a report for the manager where themes were identified, and an action plan was to be created. We requested an example of this but did not receive it.

● The housekeeping and maintenance manager had identified various improvements which needed to be made to the environment which was being worked through.

Working in partnership with others; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● People's records showed the service worked with other professionals. Details of visits from district nurses, chiropodists and the Speech and Language Therapy (SALT) team were documented.

● Multidisciplinary Team (MDT) meetings attended by GPs, mental health team, district nurses and matron were held every Tuesday. Details of discussions were recorded in each person's file.

● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC), of important events that happen in the service. The provider was aware of their responsibilities to submit relevant notification appropriately to CQC.

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 People were not always involved in decisions about their care, treatment and support. Their care was often task-focused and not person-centred.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Information about risks to people were not always up to date. Oral hygiene was not managed well, and hydration and nutrition were not monitored effectively.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Managers and staff did not share an understanding of the risks and issues facing the service and staff did not always feel they were treated equitably.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The service did not always provide enough staff to support people to stay safe. Staff were to provide care and support in a timescale that made them feel stretched and focus on completing tasks rather than on person-centred care and support.