Croftwood Care (Cheshire) Limited

Crossways Residential Care Home

Inspection report

Station Road
Lostock Gralam
Northwich
Cheshire
CW9 7PN

Tel: 0160645559
Website: www.minstercaregroup.co.uk

Date of inspection visit:
30 August 2018
03 September 2018

Date of publication:
26 September 2018

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

We carried out an unannounced inspection of Crossways on 30th August 2018.

Crossways is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Crossways is registered to accommodate 39 people. At the time of our visit, 32 people were living there.

This care service is owned by Croftwood Care (Cheshire) Limited. The registered provider was registered with us in December 2016. This was the first inspection of the service since the registered provider changed.

They are registered to provide personal and respite care for up to 39 adults. A passenger lift and staircases provide access to all levels. The home is purpose built and situated in the village of Lostock Gralam, about three miles from Northwich town centre. Parking is available to the side of the building.

The service had a registered manager who was registered with us in August 2018. 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. The manager was present during the days of our visit.

We have made a recommendation in relation to the decoration of the premises to assist people who are living with dementia. We have also made a further recommendation in relation to them providing information in a format that is accessible for all people who use the service.

Activities were not always structured. This was because the activities co-ordinator employed by the registered provider had started a period of temporary absence. The registered manager recognised this and took steps subsequent to our visit to remedy this. As a result people had received a regular activities programme.

Arrangements were in place for the reporting of safeguarding incidents.

The management of medication was robust. Medication was appropriately stored and subject to regular audits.

Staffing levels were appropriate to the needs of people. Staff were available to assist people at all times.

The premises were clean and hygienic. Equipment used by people were checked and serviced regularly to ensure that they were safe to use.

Risks faced by people in respect of health needs such as pressure ulcers, falls and malnutrition were in place and reviewed regularly. Where people had experienced weight loss, a clear plan of action was in place to protect people's health.

Recruitment of staff was robust. This ensured that vulnerable people were supported by suitable staff.

Accidents and incidents were recorded to ensure that patterns and trends could be identified to prevent re-occurrence.

Staff received the training they needed to perform their role. This training covered mandatory health and safety topics as well as training inked to the specific needs of the people they supported.

Staff received supervision on a one to one basis as well as through staff meetings.

A structured induction process was in place. The care certificate was used for those who had no previous experience of care.

The registered provider was operating within the principles of the Mental Capacity Act 2005. Appropriate safeguards had been applied for and granted to ensure that people were safe.

People had their health needs promoted and had access to health professionals in order to ensure they kept healthy.

Staff adopted a caring and patient approach to people they supported. The privacy of people was promoted at all times.

People had the opportunity to personalise their rooms as they wished to which reflected their interests.

Care plans were person centred and included the personal preferences of people. Care plans were reviewed and audited on a regular basis.

A complaints procedure was in place. This gave people the information they needed if they wished to raise concerns.

A registered manager was in place. This person demonstrated a detailed awareness of the specific needs of people who used the service.

A range of audits were in place. These were completed monthly and enabled the registered manager and registered provider to monitor the quality of support provided within Crossways.

The views of people who used the service and their families were obtained. Residents/relatives meetings were held on a regular basis.

The registered provider always informed us of any incidents that adversely affected the wellbeing of people who used the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us that they felt safe living at Crossways.

Medication management was safe.

The premises were clean and hygienic.

Is the service effective?

Good

The service was effective.

Signage and decoration did not consistently take the needs of people living with dementia into account although the registered manager had identified this.

The registered provider was working within the principles of the Mental Capacity Act 2005.

Staff received the training they required to perform their role.

The nutritional needs of people were met.

Is the service caring?

Good

The service was caring.

People were treated in a respectful and dignified manner.

People's sensitive information was kept secure at all times.

People were encouraged to personalise their own living space.

Is the service responsive?

Good

The service was responsive.

Recent activities had not always been structured but the registered manager had subsequently taken steps to address this.

Care plans were person centred and were reviewed regularly.

A robust complaints procedure was in place.

Is the service well-led?

Good

The service was well led.

The registered manager demonstrated knowledge about the individuals needs of people who used the service.

Effective audits were in place to measure the quality of care provided at Crossways.

The registered manager was aware of the need to notify CQC of any adverse incidents.

Crossways Residential 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.

The inspection took place on the 30th August 2018.

The inspection team consisted of one Adult Social Care Inspector.

Before our visit, we reviewed all the information we had in relation to the service. This included notifications, comments, concerns and safeguarding information. Our visit involved looking at eight care plans, training records, policies and procedures, medication systems and various audits relating to the quality of the service. In addition to this we spoke to five people who used the service and three relatives. We also spoke to the registered manager, the Area Manager and three members of staff. We spoke with members of the local authority commissioning team who had no concerns about the service.

As part of our inspection, we ask registered providers to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We had not requested a PIR be completed and returned to us.

We checked to see if there had been a recent visit from Healthwatch. Healthwatch is an independent consumer champion created to gather and represent the views of the public. Healthwatch visited Crossways in February 2018 and did not identify any concerns.

Good

Is the service safe?

Our findings

The premises were well maintained. We noted that a sluice room on an upper floor had been left unlocked. This room contained some cleaning products that could pose a hazard to people who used the service. We drew this to the attention of the registered manager who immediately ensured the door was locked and placed a notice on the door alerting staff to keep the door locked at all times. Our tour of the premises noted some required minor repairs needed in two toilet areas. These were raised with the registered manager who again ensured remedial action was taken. The building was in a good state of repair. Maintenance staff were employed who kept a record of required repairs and completed records once they had been achieved.

The registered manager undertook regular environmental audits of the building with details of action required and completed. All gas and electrical systems had been checked to ensure that they were safe and this extended to fire-fighting equipment, fire-detection systems, water temperatures and risks of legionella.

Other equipment had been checked and serviced. These included portable hoists and portable electrical appliances.

The premises were clean and hygienic. The registered provider employed domestic staff who attended to their tasks during our visit. Domestic staff used personal protective equipment (PPE) such as disposable gloves and aprons. There were sufficient stocks of PPE available for staff to use. All bathrooms and towels had soap dispensers and paper towels available to ensure good hygiene practice. One person's room was being subject to a deep clean during our visit. A relative told us that the building was always clean and hygienic. Standards of infection control within the service were assessed and analysed by the registered manager on a monthly basis through audits.

Staff were able to outline the types of abuse that could potentially occur. Not all staff demonstrated a thorough knowledge of the action they would take and some responses indicated that if an allegation of abuse occurred; action by staff may compromise any subsequent police investigation. We fed this back to the registered manager who told is they would address this. Staff were aware of the reporting process on how any allegations could be raised with the registered manager and were confident that appropriate action would be taken. Staff were aware of the whistleblowing process. They were aware of how any concerns they had could be made known to others within the organisation as well as external agencies such as CQC.

The registered manager recorded all low level safeguarding concerns to the local authority on a monthly basis. Low level concerns are those incidents that do not meet the threshold for more formal investigation. People told us that they felt safe with the staff team and told us that they trusted them. This view was echoed by relatives who said that their relations were safe in the care of the staff team.

The recruitment processes were found to be robust. Information in recruitment files of staff who had come to work at Crossways recently included an application form, interview notes and references. Further checks included a Disclosure and Barring Service check (known as a DBS) and this confirmed that people had not

received any past convictions that would mean they were not suitable to support people who used the service. Information was also available confirming the identity of each member of staff. Other information was available for those staff who had been offered a position in principle dependent on satisfactory checks. These records demonstrated a systematic approach to carrying our checks to ensure people were suitable to work there.

Medication was stored in lockable facilities which in turn were stored within medication rooms. These were secure when not in use. People had been prescribed controlled medications. These are medicines that are subject to legal controls. A register of the stocks of controlled medications was in place and this tallied with stocks held. Some medicines required to be stored at a lower temperature to ensure that they were effective. A refrigerator was available to ensure this and the temperature of this was taken on a regular basis.

Medication administration records were appropriately signed with details included of when medication was received. A system of disposing of unwanted medication was also in place. A clear process for the ordering of medication was in place to ensure that people always received their prescribed medication. Some people received medication as required (known as PRN). Clear instructions were in place outlining the circumstances when such medication should be given. For those individuals who were not always able to express pain or discomfort due to their limitation in expressive communication, assessment records were in place to assist staff as to when painkiller, for example, should be appropriately offered.

Staff received training in medication and had their competency to do this, checked. This was done through the supervision process and took place earlier on in 2018. People told us that "I always get my tablets when I need them" and "they never miss giving me my tablets."

Staff rotas were available. These clearly outlined people who were on duty during the day and night. The registered provider employed a management team of care team leaders and senior care assistants as well as care assistants. Other ancillary staff were employed in the kitchen so that care staff could concentrate solely on their role of supporting people. People who used the service told us "yes there are always someone around" and "there is always someone there to help me. They are brilliant". Staff told us that they considered that there were sufficient staff employed to safely support people.

The risks faced by people during their care were clearly outlined. The susceptibility of people developing pressure ulcers had been identified through appropriate scoring systems. When people were assessed as being at a high risk of developing these, equipment had been introduced to ensure that their skin remained intact. Where redness of skin had developed; a body map chart had been completed detailing the nature of the mark and the action taken to prevent further deterioration.

Risks to people's nutrition was recognised and assessed. Those who were at risk of malnutrition were always referred to other health professionals such as doctors or dieticians. Care plans demonstrated that positive outcomes had been achieved with people who had been at risk, increased their weight through staff intervention.

The risk people faced from falls was well documented. This meant people who were at high risk of falls had been identified and where accidents or incidents involving falls had occurred, patterns and trends had been identified and equipment brought in to prevent future re-occurrence. This demonstrated that reflective practice following incidents had taken place. All incidents had been appropriately recorded.

Good

Is the service effective?

Our findings

.Some people who used the service were living with dementia. Signage was available in parts of the building such as toilets and bathrooms to assist in orientating people but these were not always consistently present and were present in text as opposed to helpful symbols. The decoration of the building also was not always dementia friendly. Adaptations such as contrasting handrails and doors were not in place to assist people living with dementia. The registered manager acknowledged this.

We recommend that the registered provider refers to good practice guidelines in relation to the environmental considerations for those people living with dementia.

The design of the building was such that many lounge areas were located throughout the building. This meant that people had access to more popular areas that they could sit and socialise or other comfortable areas where they could spend time alone. A garden area was available and was being used during our visit. This was well maintained providing seats for people to use. An internal courtyard was also available.

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 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 are called the Deprivation of Liberty Safeguards (DoLS).

The registered provider was operating within the principles of the Mental Capacity Act. Staff had received training in this and were able to outline how this process impacted on the everyday lives of people who used the service. Capacity assessments were in place with a clear process in determining if people had the capacity to make decisions affecting their lives. Where people were assessed as lacking capacity, a series of best interest meetings were held including significant others focussing on an aspect of care that potentially restricted a person's liberty. This was done in an inclusive manner with a view to protect the interests of the person. Where applicable, deprivation of liberty orders had been applied for and granted. Most orders were related to the need to restrict people accessing the local community unescorted as this potentially put vulnerable people at risk. All deprivation of liberty applications and orders were included in a log which enabled the registered manager to determine what orders had been granted and whether the order was due to renewal.

We looked at how the nutritional needs of people were met. People told us that they were happy with the food provided. They told us that they always received a choice in the menu and that the food was cooked to a good standard with sufficient portions served.

All meals were prepared in a clean well-equipped kitchen. The kitchen had received a five star rating following a food hygiene inspection earlier this year. Five stars is the maximum award for food hygiene standards. Before entering the kitchen, we were asked to wear protective clothing to ensure food hygiene was maintained. Food stocks were sufficient to cater for people who used the service and were stored appropriately in freezers and refrigerators whose temperatures were regularly checked.

Kitchen staff had information about the dietary needs of people as well as how their meals should be presented to enabled them to eat independently and safely. Information was in place relating to those who had diabetes or required low fat meals.

We observed breakfast and lunch. People at breakfast ate at their own pace and were not hurried. Meals were served in a dining room although some people preferred to eat in their own rooms in line with their personal choice. Staff attended to people in an attentive manner, offering them a choice of cold drinks and ensuring that everyone was served their meals in a timely manner. We saw one person being prompted to eat their food with staff sitting next to them assisting them appropriately. Another person was asked if they wished their meal to be cut up by staff. When they agreed, staff did this and reinforced to the person what food was available on their plate. People were prompted and encouraged to eat. One person had not wished to have any breakfast and staff were mindful of this encouraging the person to eat given that they had not chosen to eat that day.

A menu was available. The registered manager had devised a summer menu in consultation with people who used the service and their relatives. The choice of food available for that day were put on display within the dining room with alternatives in place. Each person chose their preferred meal in advance and these choices were recorded. The registered manager told that increasingly staff showed two meals on offer to people so that they could make an informed choice. Drinks were available to people throughout the day.

The nutritional needs of people were further reinforced by the regular monitoring of people's weights. In some instances where the risk of malnutrition was greater for some people; their weights were monitored more frequently (usually weekly) with referrals made to other health professionals in order to promote good nutrition. All weights were monitored closely by the registered manager with positive outcomes as August 2018 had shown that no weight loss had been experienced by any individuals living at Crossways.

Records demonstrated that the health of people was promoted. All people were registered with a doctor and the registered manager stated that they received good support from the local GP practice. People told us that they felt well and that when their health was affected that the staff team immediately sought medical help for them. People were able to receive other ongoing health treatment such as ensuring that their eyes were tested and that foot care was available to them. In those situations were people required the input of District Nursing services; again records confirmed the involvement of these agencies.

Staff confirmed that they received regular supervision. This was either through one to one meetings with their line manager or through staff meetings. A supervision schedule was in place. Supervision sessions included annual appraisals, personal professional development and practice-based supervision such as competency to administer and manager medication.

Training records and staff interviews confirmed that staff received regular training. As well as training in mandatory health and safety topics; training had been provided in those subjects linked to the individual needs of people such as dementia awareness and diabetes. Training had been provided to staff in respect of safeguarding and the Mental Capacity Act 2005. A training matrix was available to enable the registered manager to identify the numbers of staff who had received training and what refresher training was needed.

In respect of refresher training, the registered manager had sought to place staff onto Care Certificate training. Ordinarily this is used for people who are new to care, however, it was recognised by the registered manager that topics within this process would enable refresher training to take place as well as staff to re-visit value-based training to support them in their role. The Care Certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. It's made up of the 15 minimum standards that should be covered if people are 'new to care' and should form part of a robust induction programme.

People told us that they thought the staff team "knew what they were doing" and that they "had confidence in the staff team to support them".

A structured induction process was in place. This included initial training and a period of shadowing. Two members of staff had been relatively recently recruited to the service confirmed that they had received induction into their roles and that this had prepared them well for position they were undertaking. Again, the care certificate was used in the induction process.

Good

Is the service caring?

Our findings

People who used the service and their relatives consistently told us that they felt cared for and were treated in a dignified manner. One relative outlined how staff had "gone the extra mile" to ensure that personal items had been included in their relations bedroom to enabled them to feel settled and at home.

We looked at recent comments that had been made on the internet. People had written "Crossways is caring and professional in its care of the elderly" and our relation receives excellent care." Others commented "The care and consideration my relative gets is excellent and has been since they arrived". The service had received written compliments. These included comments such as "staff are dedicated and friendly" and "many thanks for your friendship"

Interactions observed during the inspection were respectful and friendly. Staff spent time talking to people and offered them choice to make decisions, for example, where they wished to sit at lunch. The wider wishes of people were gained through regular resident meetings which provided evidence that people were consulted about aspects of the service. Care plans recorded the preferred names of people and these were used in interaction with them. Staff promoted the privacy of people who used the service by knocking on bedroom doors before they were invited to enter and by supporting people with personal care in their rooms behind closed doors. People who required assistance with mobility were always supported in a patient and unhurried manner.

Staff gave us practical examples of how they would take people's privacy into account. This related in particular to when people were being supported with personal care and demonstrated that privacy was embedded within care practice.

Staff told us that the most positive part of their work was the feeling that they were making a positive difference to people in their lives and that the service felt like an extended family and a "home form home".

Sensitive information was kept secure at all times. All confidential records were secured in an office in a lockable cupboard which was secured when no one was in the room. We did not see any confidential information on display or available to others not connected with the person's support. All staff had signed a confidentiality policy to confirm their understanding of keeping sensitive information secure.

The wishes of people when considering coming to the end of their lives had been taken into account. These included specific arrangements they wanted in place to meet their wishes or their religious needs. Other arrangements had been put into place as to whether people wished to be resuscitated and these were reflected in DNAR (do not attempt resuscitation) forms available for some people who wished this to be the case.

Bedrooms had been personalised in line with people's tastes. People we spoke with were happy with their bedrooms and in many cases, people had filled their rooms with personal items such as photographs or furniture in order for them to impress their identity on their living space.

Good

Is the service responsive?

Our findings

We checked whether the service was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand and any communication support that they need. We looked on the information that was provided to people to ensure that people had equal opportunity to access important information. Activity boards were available but these were in written form. It was not certain whether this form of information was suitable to all people who used the service and whether it met their communication needs. The same applied to menus. The meals on offer during the days of the visit were on display but were in written form. Menus were not presented in pictorial form. The registered manager had introduced a system of offering two alternative meals to people to assist them to make a choice.

We recommend that the registered provider refers to good practice guidelines in relation to the Accessible Information Standard so that people are provided with information in a format appropriate to their communication needs.

We looked at the activity programme for people. Events had taken place and these included in house activities, visits from hairdressers and in-house entertainers. Visits had also been made by members of the local church. While activities continued, they did not appear to be structured and we did not see any activities being held on the days of our visits.

The registered manager explained that while an activities co-ordinator was employed by the service, they had recently commenced a period of absence. The registered manager was aware of this had arrangements had been made to recruit a new activities co-ordinator so that activities could be structured once again. People who used the service had been consulted and informed about the situation at the last residents meeting and we saw evidence that this consultation had taken place.

Prior to people coming to use the service, an assessment of needs was completed by the staff team. This was used in conjunction with any other assessments gained from the local authority or other agencies. Assessments included all aspects of the needs people had in their daily lives to be supported successfully. Details included their medical needs, social interests and communication needs. Information included risks that people had faced from falls, malnutrition and pressure ulcers.

Once completed, assessments were translated into care plans. Each person using the service at the time of our visit had a care plan. All care plans were person centred and included details of the support they required in all aspects of their daily lives where applicable. In some cases, people were independent in certain daily routines and were encouraged to continue with these. The person-centred nature of care plans was reflected in details of the individual preferences, likes and dislikes of people and ways in which they wished to be supported. For example, detailed instructions for staff were in place in how people preferred to take their medication.

Separate parts of care plans included the social history of people. This related to their interests and their previous employment and other significant experiences that they had had. This was included in a "this is me" document. All care plans had been re-devised earlier in 2018 and demonstrated a person-centred approach tailored to the individual needs of people.
A complaints process was in place. This outlined the timescales for investigation of any concerns raised. People told us that they did not have any complaints and had not needed to make any in the past. They told us that if they did, they felt confident that the registered manager would address any concerns. One complaint had been recorded within the service's complaints log. This was appropriately responded to and dealt with.

Arrangements were in place for those identified as being at the end of their lives. One person had been identified as being at this stage and we saw evidence that the staff team had made appropriate arrangements to ensure that the person would be supported appropriately. We saw evidence of the staff team liaising with the local medical centre updating them about the person's condition. In addition to this, the final wishes of the person had been recorded. This recording of the last wishes of all people had been recorded.

Good

Is the service well-led?

Our findings

People who used the service were complimentary about the staff team and the care that was delivered to them. One relative commented "the service is well run. The manager is efficient but cares about the people who live here". Other comments included "My relation always speaks highly of the management here" and "it is a very well-run service". They told us that they had the opportunity to make comments about the support provided and that they were "listened to".

Staff confirmed that they found the registered manager to be supportive and approachable. The registered manager sought to adopt an "open door policy" enabling staff, people who used the service and relatives to speak with the registered manager at any time. The registered manager demonstrated an awareness of the needs of all individuals who used the service. The registered manager also maintained a presence within the service during our visit.

A range of quality assurance checks were in place to ensure that the needs of people were being met. These included regular and detailed audits of the environment, infection control, care plans and medication. A representative of the registered provider visited on a monthly basis to check the quality of support within the service and this person was present during the first day of our visit. The registered manager told us that they received good support from the registered provider. Other audits included details of accidents that had occurred and weight loss that had been experiences by people. The registered manager was able to demonstrate that where weight loss, for example, had occurred, there was a clear plan of action taken in order to ensure that people weights could be improved. The same approach was used to those people who had experienced a fall or an accident. Again, there was clear evidence that action had been taken to ensure that there was no re-occurrence. In respect of weight loss, the registered manager had found that no -one within the service had experienced weight loss in August 2018.

Other checks included unannounced visits from the registered manager at night to ensure staff were supported and that people who used the service were having their needs met. All audits forms the basis of a monthly report submitted by the registered manager indicating whether key clinical indicators had been met. Where points of action were required, these were recorded.

The views of all connected with the service were encouraged by the registered manager. Staff meetings were held on a regular basis and this was reinforced with individual supervision sessions. The views of people and their families were gained through surveys. One relative confirmed that they had recently received a questionnaire form the service. In addition to this, the registered providers website enabled people to comment on their experiences. We checked this and found that recent comments had been included on the website and that these had been positive.

The registered provider demonstrated that they co-operated with other agencies. Information in care plans and daily records indicated that the staff team sought to liaise with medical services, for example, to ensure that people's needs were met.

Our records demonstrated that the registered provider always informed CQC of those events which adversely affected the well being of those who used the service. While this was the first inspection of Crossways since a new registered provider had taken over the management of the service; the registered manager was aware of the requirement to display the rating made following this visit.