Active Lives Care Ltd

Cumnor Hill House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 18 April 2017. Cumnor Hill House is a purpose built care home providing personal and nursing care for up to 72 people. The home registered with the Care Quality Commission in June 2016 and this was the first inspection. At the time of our inspection there were 40 people using the service.

There was no registered manager in post. 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. However, there was an interim home manager in post and the provider had recruited a new manager who had applied to register with the Care Quality Commission as the registered manager.

Medicines were not always managed safely. People did not always receive their medicines as prescribed and medicines were not always administered in line with the provider's policy.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. However, care records did not support this practice. We have made a recommendation in relation to the Mental Capacity Act 2005.

Systems for monitoring and improving the service were not always effective. Auditing systems had not identified the issues we found during the inspection. Incidents were not always investigated to identify actions needed to reduce the risk of further events.

There was a relaxed, cheerful atmosphere throughout the inspection. People and staff laughed together and clearly enjoyed each other's company. There was a person-centred culture that valued people as individuals and involved them in the running of the service. The provider took opportunities to obtain feedback about the service to guide improvements.

During the inspection people's requests for support were met in a timely manner However, people and relatives were not confident there were always enough staff to meet people's needs.

The provider had recruitment processes in place that ensure people were supported by staff who were suitable to work with vulnerable adults. Staff were supported through regular supervisions and had access to development opportunities. Staff completed training to ensure they had the skills and knowledge to meet people's needs. Staff were clear about their responsibilities to report any concerns to senior staff and were confident to do so.

Risks to people were identified and where necessary management plans were in place to manage risks. Staff understood the importance of promoting people's independence. The service responded to people's

changing needs and where needed were supported to access health professionals.

People were supported by caring staff who treated them with dignity and respect. People were involved in developing their care plans to ensure their needs were met in a way they chose.

Nutritional needs were met and people were complimentary about the quality of the food they received. Friends and relatives were able to join people for meals at any time and received a warm welcome. The provider promoted the engagement of relatives and friends to encourage a sense of belonging for everyone.

There was a programme of activities available for people. The home manager had identified that improvements were still needed and had a plan in place to achieve the improvements.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not always managed safely.

Risks to people were identified and plans were in place to manage the risks.

The provider had safe recruitment procedures in place to ensure suitable staff were employed in the service.

Is the service effective?

Requires Improvement

The service was not always effective.

People's care records did not always reflect the principles of the Mental Capacity Act 205 (MCA).

People received food and drink to meet their nutritional needs.

Staff were supported through regular supervision. Staff had access to training and development to ensure they had the skills and knowledge to meet people's needs.

Is the service caring?

Good

The service was caring.

People were supported to maintain their independence.

Staff treated people with dignity and respect. Giving choices and respecting people's decisions.

People and their relatives were involved in the development of care plans and all decisions about their care.

Is the service responsive?

Good

The service was responsive.

People received personalised care that valued them as individuals.

People were encouraged to maintain relationships with family and friends.

There was a range of activities on offer and additional staff had been recruited to develop the activity programme.

Is the service well-led?

Requires Improvement

The service was not always well led.

Systems to monitor and improve the quality and safety of the service were not always effective.

There was a person centred culture that promoted the inclusion of people in the running of the service.

Staff were positive about working in the service and there was a strong culture that promoted good team working.

Cumnor Hill House

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 18 April 2017 and was unannounced.

The inspection was carried out by two inspectors, a specialist advisor who was nurse and an Expert by Experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we looked at information we held about the service. This included notifications the provider had submitted to CQC. A notification is information about important events which the provider is required to tell us about by law.

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.

During the inspection we observed staff practices and completed a Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us

We spoke with eight people and five visitors. We spoke with the home manager, the clinical lead, the operations manager, one nurse, two senior care workers, six care staff and the chef. We looked at 13 people's care records, five staff files and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

Medicines were not always managed safely. People did not always receive their medicines as prescribed. For example, one person's medicine administration record (MAR) was signed to confirm the person had received their medicine. However, we found the medicine was still in the monitored dosage system (MDS).

One person's care plan stated the person required thickened fluid. Thickening agent to thicken fluids is prescribed for individuals. We found staff were administering thickening agent prescribed for a different person.

Records relating to the administration of medicines were not always accurate and complete. For example, there was a gap on one person's MAR. The medicine for the specific time and date relating to the gap on the MAR was not in the MDS. We spoke to the senior care worker who advised they would follow the provider's medicine policy and report the error.

National Institute for Clinical Excellence (Nice) guidance 'Managing medicines in care homes' states MAR should "be completed as soon as possible after administration" and "make the record only when the resident has taken their prescribed medicine". This guidance was reflected in the service's medicines policy. However, we saw one nurse signing for medicines before observing people taking their medicines.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People felt safe. One person told us, "Yes really safe". Relatives were confident that people were safe. One relative told us, "Mother is absolutely safe, I have peace of mind. There are always people around".

Staff had completed training in safeguarding adults and understood their responsibilities to identify and report any concerns. Staff comments included; "Yes, I had safeguarding training. I'd go to a senior and report, they'd raise an alert and I'd see how I can keep the person safe" and "I'd report to the manager and escalate if needed; make sure the person was safe". However, staff in a supervisory role were not always clear about their responsibilities to raise a safeguarding alert if an incident occurred between two people using the service.

The manager had notified the local authority safeguarding team and CQC of some incidents. However, the manager was not aware of the local safeguarding adults board guidance in relation to the thresholds for raising safeguarding concerns and had not considered whether recent medicine errors met the threshold for reporting through to the local authority safeguarding team.

The manager used a dependency assessment to determine the staffing levels required to meet people's needs and rotas confirmed these staffing levels were met. However, relatives did not feel there were always enough staff to meet people's needs. One relative told us there were not always enough staff at weekends and people sat for long periods in the lounge with no staff present. During our inspection we had to

approach a member of the non-care staff team on two occasions in a communal area of the home as a person required some assistance and there were no care staff present.

Care staff told us staffing levels had improved and that no agency staff were used. However, some staff felt the staffing levels varied depending on the unit they were working on. One member of staff told us, "Three staff is fine for residential unit but for nursing we need more. Many people need hoisting there". We spoke to the home manager who advised us that staff could move between units to support each other at busy times.

During the inspection we saw call bells were answered promptly and people's requests for support were responded to in a timely manner.

People's care plans included risk assessments and where risks were identified there were plans in place to manage the risks. Risk assessments included risks associated with: medicines; moving and handling; behaviour; nutrition and falls. One person had experienced falls when they first moved to Cumnor Hill House. A risk assessment had been completed and the care plan detailed the support the person required to minimise the risk of falls. This included a bed that could be lowered close to the floor, to minimise the risk of injury should the person fall out of bed. The person also had a walking aid. We saw the specialised bed was in the person's room and the person was using their walking aid. Staff ensured the frame was within the person's reach at all times. The person had not experienced any falls in the previous six months.

The provider followed safe recruitment practices. Staff files included application forms, records of identification and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (DBS) to make sure staff were suitable to work with vulnerable people. The DBS check helps employers make safe recruitment decisions and prevents unsuitable people from working with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

People's care records did not always reflect the principles of the Mental Capacity Act 2005 (MCA). 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.

Information relating to people's capacity to consent to elements of their care was not always clear and in line with the principles of the act. For example, one person's mental capacity/cognition care plan stated, '[Person] can sometimes forget things. [Person] has capacity to make safe decisions'. However, a Deprivation of Liberty Safeguard (DoLS) had been applied for which stated, '[Person] is not free to leave and is requesting to go home, requires constant supervision and does not have capacity to make decisions. His diabetes is somewhat uncontrolled and likes to eat food constantly. We have key pad locks in place'. There were no mental capacity assessments completed in relation to any specific decisions or to support the application for the DoLS.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The manager had made several applications to the supervisory body for DoLS. However, there were no capacity assessments made to identify that people lacked capacity to consent to the restrictions on the DoLS application. Some people's care plans identified people had capacity to make decisions; however DoLS applications had been made. This meant we could not be sure people with capacity to consent were not being consulted about restrictions on their right to liberty.

We recommend that the provider refers to the codes of practice relating to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

People were supported by care staff on a day to day basis who understood the Mental Capacity Act 2005 (MCA). Staff had completed training in MCA and understood their responsibilities to protect people's rights in line with the principles of the act. Staff comments included: "Everybody should be judged as they have capacity unless proven otherwise. Our clients can still make their own decisions. People should be able to make their decisions even if we don't agree with them"; "Everybody has mental capacity unless proven otherwise. People's capacity fluctuates and we support them to make their own decisions" and "I assume someone has capacity unless proved otherwise. If they have not got capacity they can still make choices like what they would like for dinner, you can show them. It's also about knowing what they like and prefer. If you know they don't like fish and the choice is chicken or fish you could say, "I know you don't like fish, what about the chicken".

People and their relatives felt staff were well trained and competent in their roles. One relative told us, "There is a good mix of staff and they are well trained".

New staff completed an induction programme to ensure they were confident in their roles before working unsupervised. The induction included training, shadowing and competency assessments. Staff were positive about the induction they had received. Staff told us, "The induction was really good, it taught me to do the job, I hadn't done caring before" and "Training is brilliant, I shadowed too which was the main learning. Absolutely superb".

Staff completed training in topics that included: moving and handling; mental capacity; medicines; infection control and dementia. Staff were complimentary about the training and the development opportunities offered. One member of staff told us, "They are keen for me to progress. I am going to do a mentorship course, there is funding set aside for this. I am also going to do phlebotomy so I can take bloods".

Staff received regular supervision and were positive about the supervision process. Staff comments included: "I had one to one with [home manager], definitely a two way process. I had partially work, partially personal problems and she was very good" and "Had my probationary review with [home manager], how she saw me working with people and had input from other staff who worked with me, in a very supportive and constructive way".

People were complimentary about the food they received. Comments included; "[Food] phenomenal. They spoil me" and "The food is good. No complaints". Relatives were invited to join people at mealtimes. Relatives who had sampled the food were positive about the food offered.

People choose where they wanted to eat their meal. I heard staff asking people where they wanted to eat their lunch. Most people chose to eat in the dining room however one person requested their meal in their room and this was provided. One person told us "I have friends upstairs; sometimes I eat up there with them".

When people were being assisted to eat, support was given in a patient and sensitive manner. For example, one person was being assisted. The care worker sat at the same level as the person, chatted to the person throughout the meal, and did not rush them.

People had protocols in their care records to assess the risk of malnutrition and dehydration. Monthly weight charts were kept. Where people were losing weight their weight was recorded weekly and they were referred to health professionals for advice and guidance. For example, one person had lost weight over the previous four months. Staff had referred the person to the Speech and Language Therapy (SALT) and dietician and informed the GP. Care records documented the outcome of the professionals visit and care plans had been updated to reflect the advice.

Staff recorded what people ate and drank if they were at risk of malnutrition or dehydration. However, food charts were not always completed after the person had eaten. For example, there were no entries on the food charts on the day of the inspection. Staff were completing these at 4pm when they were filling in the daily records. Where food charts were completed they were not detailed. For example, they had entries such as 'porridge' or 'soup' they did not document how much of the offered food had actually been eaten. The food charts might not therefore be a true reflection of people's nutritional status. Following the inspection the registered manager advised us that records relating to people's nutritional intake were now stored in people's rooms and were completed in a timely manner.

People had access to a range of health professionals. People's care records showed people had been supported to access: G.P; District Nurse; SALT; diabetic nurse and hospital consultant services. Health professionals we spoke with told us staff referred people appropriately to services.

Good

Is the service caring?

Our findings

People were complimentary about the staff supporting them. Comments included: "Staff are attentive"; "Fabulous, I think it is wonderful; "Staff are very kind" and "Yes they definitely care. They care for me like I would care for myself". Relatives were confident people were well cared for. Relative's comments included; "The staff will do anything, nothing is a problem. Staff are sufficiently tactile to be supportive but not intrusive" and "Excellent care, without a shadow of a doubt".

Staff were kind and caring in their approach to the people they supported. One member of staff told us, "I always imagine the person is my Grandma or Mum, always treat them as if they are your family". Another member of staff said, "We genuinely love our residents".

We saw many caring interactions between staff and the people they were supporting. Staff took time to speak with people and gave them time to express their needs and preferences. People were supported with their personal care discretely and their choices were respected. One person had declined support to have a shave. A member of the care staff said to the person, "Just call me later when you want a shave. I'll pop back later in case you forget".

People were treated with dignity and respect. One person told us, "They always respect privacy and knock on doors". Staff understood the importance of protecting people's dignity and privacy. One member of staff told us, "We always knock on the door, curtains drawn, especially from the garden side. I always shut the windows so if people walk by they can't hear if we ask people if they have had their bowels open".

People's choices were respected. For example, one person preferred a female care worker to assist them with their personal care and this was recorded in their care plan. The person told us, "I do prefer a lady and I always get one. We have a charming gentleman here but he doesn't help with personal care". Staff talked with and about people in a respectful way and knew people's preferences. One member of staff told us, "It's important to not force what you want. They are human beings; it's important for them to have and make their own choices".

Staff understood the importance of promoting people's independence. We don't want to take people's independence away, so I'd give someone a flannel so people can wash their face". We saw staff encouraging people to maintain their independence. For example, one member of staff used verbal encouragement to support a person to stand up from their chair, the member of staff checked the person was a comfortable and was steady on their feet with their mobility aid and then walked alongside team to ensure they were confident walking.

People were involved in their care and in the development of their care plan. Care plans detailed how people wished their care needs to be met. We saw that where people were not able to state how they wished their needs to be met, relatives and representatives were involved in developing the care plans.

People's personal information was stored securely. Staff understood the importance of maintaining

confidentiality and respected people's personal information.

Good

Is the service responsive?

Our findings

People's needs were assessed prior to them moving into Cumnor Hill House. This information was used to develop personalised care plans. Care plans included a document called 'This is your life' which detailed information about people's life histories, what was important to them, their likes and dislikes. For example, one person's care plan stated the person "Likes to look well presented. Very fashion conscious". We saw the person was well dressed and was wearing jewellery and make up.

The information in people's care plans enabled staff to get to know people well. Staff were able to provide support that was meaningful and treated people as individuals. For example, one person's life history stated they had been a florist. The person told us staff had arranged some flower arranging activities at the service. They said "I have done some flower arranging here, I love it". Another person could become anxious when they could not remember if they had received visitors. The person had a diary containing photographs taken of them with their visitor on the day the visit occurred. We saw staff looking at the diary with the person and talking to them about the visits.

Care plans gave clear guidance to staff about how people's needs should be met. For example, one person's care plan detailed the support a person required in relation to their mobility and skin condition. The care plan detailed the person required a pressure cushion when sitting. We saw the person sitting on the cushion and staff ensured they had it to sit on when they went to a different unit of the home.

One person's care plan identified the person could present with behaviour that could be seen as challenging to themselves or others. The care plan detailed the person did not enjoy verbal communication and could become frustrated. We saw staff supporting the person in a calm manner, using minimal verbal communication. It was clear staff knew the person well and how to support them to remain calm.

People were not always positive about the activities provided in the service. One person told us, "Activities are not so good, we don't go out". However, one relative told us, "Activities is a work in progress, it will be delivered".

There was a comprehensive diary of events displayed in the home and we saw displays that showed some of the activities people had enjoyed. For example there was a display of Easter arts and crafts people had made. Other activities people had enjoyed included: flamenco dancers; reflexology; manicures and an on-site hairdresser.

People were supported to maintain relationships that were important to them. Relatives and friends were able to join people for meals at any time. On the day of the inspection one person was dining with friends, staff were aware this was a special occasion for the person and took time to welcome the visitors. There was a dining area available for special occasions. One relative told us they had recently used the area to celebrate a special birthday. The relative said, "It was excellent".

The registered person told us the service held many events in the evenings. The registered person said, "This

is to encourage families to be in the service and encourage a sense of belonging".

On the day of the inspection the activity coordinator was not on duty and responsibility for activities was with staff on duty. We saw people sat in various areas of the service, interacting with each other and staff. People were reading newspapers and enjoying chatting.

We spoke to the manager who told us they had recruited additional staff to provide activities. The manager was aware this was an area for development and had a clear plan to train and develop staff understanding of activities.

There was an extensive, attractive garden people were able to enjoy. We saw people walking and enjoying the garden. The service also had a minibus to enable trips out.

There were monthly meetings arranged for people and relatives. People told us they felt the meetings were a positive event and had given people a voice enabling them to raise issues. No one we spoke with had any issues they had wished to raise at the meetings.

The provider had a complaints policy and procedure which was made available to people and their relatives when they moved into the service. People felt confident to raise concerns. We saw that complaints had been dealt with in line with the complaints policy and had been resolved to the satisfaction of the complainant.

Requires Improvement

Is the service well-led?

Our findings

Systems for monitoring and improving the quality of the service were not always effective. There were a range of audits carried out; however audits had not identified the issues we found during the inspection. For example, a medicines audit had been completed the day before our inspection and had not found the issues found by the inspection team. Additionally, where the audit asked if "no more than 1 medicine error occurred in the last year" the auditor recorded "To check". Despite this action point the audit outcome identified; "Audit complete, good systems in place" and that there was "No action needed". However, records showed there had been four medicine errors reported since the service opened. This meant the audit was not effective.

Where audits had identified areas for improvement there was not always a clear action plan identifying how improvements would be made and when the actions would be completed. For example, a provider audit carried out on 10 February 2017 identified that weekly outings must be arranged. There was no information as to how this was to be arranged and when it would be actioned. At the time of our inspection weekly outings were not taking place.

Systems for monitoring accidents and incidents were not always effective. Records relating to accidents and incidents did not always identify actions taken as result of an incident to minimise the risk of a reoccurrence. For example, there had been four medicine errors. The records relating to the errors did not include details of any investigation carried out and any action taken to reduce the risk of further incidents. We spoke to the manager and clinical lead about the medicine errors. They told us staff would have completed reflective accounts and a competency assessment completed. On the day of our inspection we saw that only two reflective accounts had been completed by staff and two competency assessments had been completed. We asked the manager for this information who was unable to find the remaining two records. Following our inspection the manager sent to us two further reflective accounts held with staff. However, we found medicines were not always managed safely therefore the action taken in response to these errors was not effective.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a home manager in post who told us they were leaving the service. A new manager had been recruited and had visited the service to meet people, relatives and staff. People and their relatives were positive about the home manager and felt they had made a number of improvements in the service. One person told us they thought the home was well managed and that the management had "empowered the staff".

Staff were positive about working at the service and the management team. Staff comments included: "I've loved this job since my first day"; "I feel supported, we can be open and honest, the management considers both workers and clients. They are fair" and "[Home manager] is brilliant and [clinical lead] is excellent.

The manager promoted a personalised culture which encouraged people to be involved in all aspects of the home. For example, two people had been involved in interviewing new staff. The manager had used their feedback to make recruitment decisions. The people who had been involved in the recruitment had enjoyed the experience and were keen to be involved in the future.

There was a positive atmosphere throughout the inspection with a strong emphasis on team working. Comments from people and relatives included: "Staff work as teams and are very supportive of each other"; "Staff muck in together and help each other out" and "Staff support each other, there is no hierarchy and they all seem happy".

Staff were complimentary about the culture in the service promoting good team work. One member of staff told us, "Brilliant team, work is brilliant, everyone works well together". There were regular team meetings that gave staff an opportunity to provide feedback and suggestions for improvement.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure safe care and treatment was provided in a safe way to service users as medicines were not always managed safely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to monitor and improve the quality of the service were not always effective. Systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users were not always effective.