Bupa Care Homes (GL) Limited

# Cleveland House Care Home

## Inspection report

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10 January 2017

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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 of Cleveland House took place on 4 and 10 January 2017. We previously inspected the service on 4 and 11 May 2016, at that time we found the registered provider was not meeting the regulations relating to person centred care, consent, safe care and treatment, nutrition and hydration needs, governance and staffing. We rated them as inadequate and placed the home in special measures. The purpose of this inspection was to see if significant improvements had been made and to review the quality of the service currently being provided for people.

Cleveland House provides support to people with both nursing and residential care needs. The home has a maximum occupancy of 45 people, on the day of our inspection 34 people were resident at the home.

The service did not have a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe and staff were aware of their responsibilities in keeping people safe from the risk of harm or abuse. However, where people required staff support due to immobility, not all aspects of their support were robustly assessed. Risk assessments lacked detail regarding equipment and the method staff were to deploy to keep people safe.

Action had been taken to ensure bed rails were used appropriately and the clinical lead nurse was able to tell us about strategies used by staff to reduce people's falls risk. However, a robust analysis of falls was not in place.

There were systems in place to protect people in the event of a fire. This included fire training for staff and regular checks on the fire detection and methods of escape. Maintenance checks were completed for aspects of the environment and equipment to reduce the risk of harm to people or staff.

A number of pre-employment checks had been completed on potential candidates to reduce the risk of employing staff who may not be suited to supporting vulnerable adults. Some of the evidence to support these checks had had not been filed at the home, but a senior manager emailed outstanding documentation to us after the inspection.

People told us there were enough staff and we saw people's needs were met by staff in a timely manner but staff lacked time to spend with people other than when they were completing a care related task.

Not all aspects of medicines management were robust. When people were prescribed a cream, this was kept in their bedroom but the records staff were to complete to evidence the cream had been applied as prescribed were not consistently completed. Staffs competency to administer people's medicines was

assessed and checks were made at the ends of each medicine round to reduce the risk of errors.

There was a programme of induction for new staff and this was followed by regular refresher training. A lack of staff knowledge highlighted in our previous report had been addressed through training but these topics were not included in the registered provider's rolling refresher programme.
Staff told us they received supervision but at the time of the inspection the records did not support this being completed at regular intervals.

All the staff we spoke with expressed an understanding of the Mental Capacity Act 2005 (MCA) and people's right to make choices and decisions about their daily lives. Peoples care plans contained evidence of capacity assessments and where people were deprived of their liberty, an application to the local authority had been made. This was to ensure a people's rights were protected.

People were offered a choice of food and drinks and told us the food was good. People were weighed at regular intervals, weight loss was highlighted and action taken to address this.

Staff were caring and kind, they spoke with people in a caring and inclusive manner. People told us staff respected their privacy and dignity. People were not nursed in bed unless they wished to remain in bed or there was a clinical reason for that decision if they lacked the capacity to decide for themselves. There were plans in place to improve the care planning documentation in regard to people's wishes as they entered the final stages of their lives.

The home had a new activities coordinator and they were introducing a programme which included one to one and group activities. For example, singalongs, crafts, gardening, chair exercises and group discussions as well as external entertainers coming to the home.

Information within people's care plans was recorded consistently throughout their care plan. Records were person centred and recorded people's likes and preferences, staff also recorded the care they provided to people on a daily basis throughout their shift.

Where people had raised a complaint, we saw this had been investigated and a response had been sent to them. The registered provider had a system in place to ensure, where people were unhappy with the outcome to their complaint, this was escalated to a more senior person to review.

We received positive feedback about improvements at the home. We saw evidence action had been taken by the registered provider to improve the quality and safety of the service people received. A number of audits had been undertaken to assess and monitor the quality of the service but it was not always evident actions had been addressed. During our inspection we found evidence of some improvement, however as evidenced within the main body of the report, there remains a number of areas where there is a need for further work to ensure the safety and well-being of the people who live at Cleveland House.

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.

People told us Cleveland House was a safe place to live.

Not all aspects of people's care and support was thoroughly risk assessed. Falls were not analysed for patterns or trends.

Recruitment practices were safe although not all the required documentation was available for review on the day of the inspection.

Staff did not have time to engage with people other than through a task related activity.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

New staff completed a programme of induction. There was a periodic programme to refresh training but this did not address all topics.

There was a programme of supervision but this was not yet consistent.

Staff respected people's right to make decisions and where people lacked capacity decision specific capacity assessments and evidence of best interests decisions were recorded.

People spoke positively about the meals served at the home.

### Is the service caring?

**Good**

The service was caring.

Staff were caring and kind.

Staff took steps to maintain people's dignity, privacy and their levels of independence.

Plans were in place to improve the quality of end of life care

planning.

## Is the service responsive?

Good

The service was responsive.

People spoke positively about the activities provided at the home.

People's care records were person centred and reflected their care and support needs.

Where a complaint was received, this was investigated and feedback was provided to the complainant.

## Is the service well-led?

Requires Improvement

Not all aspects of the service were well led.

There was a manager in post but they were not yet registered with the commission.

Since the last inspection a number of improvements had been made to the service, although there remained some areas which still needed attention.

A variety of audits were completed on a regular basis but these did not always evidence action had been taken to address highlighted issues.

# Cleveland House Care Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 4 January 2017 and was unannounced. The inspection team consisted of two adult social care inspectors 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. The expert by experience on this occasion had experience of working in health and social care. One inspector also visited the home again on 10 January 2017, this visit was announced.

The registered provider had been asked during December 2016, to complete a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. Prior to the inspection we reviewed all the information we had about the service including statutory notifications and other intelligence. We also contacted the local authority commissioning and contracts department, safeguarding, infection control, the fire and police service, environmental health, the Clinical Commissioning Group, and Healthwatch to assist us in planning the inspection. We reviewed all the information we had been provided with from third parties to fully inform our approach to inspecting this service.

We used a number of different methods to help us understand the experiences of people who lived in the home. We spent time in the lounge and dining room areas observing the care and support people received. We spoke with seven people who were living in the home and four visiting relatives. We also spoke with the clinical lead nurse, the lead carer, a senior care, three care staff and four staff from the catering and housekeeping team, the maintenance person and the activity organiser. During the two days of the inspection we also spoke with one of BUPA's training staff and two senior managers from BUPA's service

recovery team. We reviewed five staff recruitment files, five people's care records and a variety of documents which related to the management of the home.

Requires Improvement

# Is the service safe?

## Our findings

Our inspection on 4 and 11 May 2016 found the registered person was not meeting the regulations as people's care and treatment was not provided in a safe way, medicines were not managed safely and there were insufficient staff on duty to meet people's needs. We said the service was not safe and rated this domain as inadequate, although on this inspection we found a number of improvements had been made.

People we spoke with told us Cleveland House was a good, friendly and safe place to live. One person said, "I feel safe with the carers and other residents, the door security is good", another person told us, "I feel safe." A relative we spoke with said, "I feel safe with (person) living here."

Each of the staff we spoke with told us they received regular training in safeguarding vulnerable people from the risk of harm or abuse. Staff were aware of the different types of abuse and their responsibility in reporting any concerns to a more senior member of staff. Staff were confident senior staff would respond to any worries they had, one staff member said, "If there was an issue I would be ok to go and tell them (senior staff)." Both the clinical lead nurse and lead carer were aware of the actions they should take to deal with any allegations of abuse including notifying the local authority safeguarding team. This showed staff were aware of how to raise concerns about harm or abuse and recognised their responsibly in safeguarding people who lived at the home.

During our inspection we observed staff supporting people to transfer using a hoist; we saw this was done safely. We reviewed the risk assessments for one person who was immobile and reliant upon staff for all transfers, including support to access the bath or shower. The moving and handling risk assessment lacked detail regarding the specific equipment staff were to use or how to use it safely to reduce the risk of harm to the person when bathing or showering. The risk assessment simply recorded 'bathing, two staff, bathing hoist'. The person also used a wheel chair and specialist chair. There was no risk assessment for the wheelchair and the risk assessment for the specialist chair was generic and not person or equipment specific. For example, staff had recorded 'ensure (person) is repositioned correctly' but there were no instructions as to what the correct position should be. Having this level of detail reduces the risk of harm to the person and the staff supporting them.

These examples demonstrate a continuing breach of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people were identified as being at risk of developing pressure sores, a risk assessment was in place and we saw specialist mattresses and seating cushions were in use. Records in people's bedrooms detailed the time staff had supported people to change position and the position they had been moved to. We reviewed the care plans for two people and saw staff had repositioned them at regular intervals and these times corresponded to the instructions in their care plans. This showed care and support was planned and delivered in a way that reduced risks to people's safety and welfare.

Some people at the home required the use of bed safety rails to reduce the risk of them falling out of bed.

One of the staff we spoke with said bed rails were used as a last option to keep people safe. The clinical lead nurse told us when they had commenced employment at the home a significant number of people had bed rails in place. They said following assessment it was clear that some people did not require them and they were removed, for other people, alternative safety methods were implemented, for example, a low bed. Three of the people whose care plans we reviewed, required the use of bed rails and we saw risk assessments had been completed regarding this aspect of their care.

Staff were aware of the action to take in the event of a person having fallen, this included calling for the nurse to assess the person, deciding whether to assist them from the floor or request an ambulance as well as recording the accident. Care staff told us they would remain with the person to reassure them and reduce any anxiety. The clinical lead nurse told us about strategies to reduce the risk of people falling or suffering an injury as a result of a fall. This included sensor mats, changing the layout of their room, better foot wear and crash mats. This showed hazards were assessed in order to reduce the risk of harm to people.

We looked at how accidents and incidents were recorded and analysed. A senior manager explained these were logged on BUPA's online reporting system this was then reviewed by the quality and compliance team and a monthly report was sent to the senior management team. We reviewed the monthly quality report and saw this provided an overview of the number of accidents per month but no further breakdown was evident, for example, times or locations of falls. Following the inspection we contacted a senior manager who was present on the day of the inspection, to ask about this this. They told us there was a monthly falls analysis system but it had not been completed for Cleveland House. Analysing accidents and incidents can identify patterns or trends to be identified, enabling action to be taken to reduce the risk of future occurrences.

These examples demonstrate a continuing breach of Regulations 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One of the staff we spoke told us they had attended a fire drill, they also said part of their induction training had included instruction as to how to use the fire evacuation slings which were to assist staff in moving people from their bedrooms. A record of staff's attendance at fire drills was kept and this was also recorded on the training matrix. Regular checks were completed by the maintenance person on the fire system including the alarm, emergency lights and exits. The maintenance person showed us the fire emergency file which contained a business continuity plan, a map of the building, essential numbers including staff and other BUPA homes in the local area. The file also contained people's personal emergency evacuation plan (PEEP), this is a document which details the safety plan, for example, equipment and staff support for a named individual in the event the premises have to be evacuated. This was recently dated and the maintenance person confirmed it was updated on a weekly basis. This showed us the home had plans in place in the event of an emergency situation.

We saw a number of internal maintenance checks which were completed on, for example, water temperatures, wheelchairs, bedrails and window restrictors. We also saw evidence external contractors were used to service and maintain equipment, for example the gas and electrical safety and moving and handling equipment. This showed there was a system in place to ensure the premises and equipment were suitably maintained.

Safe recruitment practices were in place. We asked one member of staff about the recruitment procedure. They told us they had attended the home for an interview and they had then had to wait for the references and Disclosure and Barring Service DBS check to be returned prior to them commencing work at the home. DBS checks return information from the Police National Database about any convictions, cautions, warnings

or reprimands and help employers make safe recruitment decisions and help to prevent unsuitable people from working with vulnerable groups. We looked at five staff recruitment files and saw application forms had been completed; references and DBS checks had been obtained. Not all of this information was readily available on the day of the inspection but outstanding documents were emailed to us following the inspection to evidence they had been received.

We asked people if there were enough staff on duty to meet their needs, comments included, "There are enough staff for what I want doing", "There are enough staff but sometimes they get a bit rushed", "No, very busy, staff rarely have time to come and talk to me" and "Not very quick to answer the bell, can be twenty minutes." A relative said, "I think there are enough staff." Another relative said, "I have no concerns about the staffing."

The staff team consisted of the manager, clinical lead, lead carer, nurses and care staff, supported by catering and housekeeping staff, a maintenance person and activities co-ordinator. When we spoke with staff they told us they were busy but the work load was not unreasonable although they lacked time to chat with people. One staff member said people at the home now needed more care but the number of staff had not increased to cover the greater workload. Staff comments included; "Its ok, we do the best we can" and "There is a lot to do but I never feel stressed." Another staff member told us one extra staff on duty would enable staff to, "Provide that extra bit of attention, such as put (people's) make up on."

We asked one of the senior managers how staffing at the home was decided. They told us each person's dependency score was reviewed annually unless a change in their needs necessitated this being done sooner. They said the scores then formulated the number of staff hours required at the home each week but the dependency tool did not take account of the size and physical layout of the building. The senior manager said they were aware of this and the clinical lead had also brought this to their attention.

In the two days we spent at the home, we observed staff to be consistently busy although staff did not appear anxious or worried about their workload. We observed people's needs were met by staff in a timely manner, but we did not see nurse and care staff have opportunity to engage with people other than through a task related activity.

The lead carer told us the time it took staff to respond to a person's call bell was monitored and recorded. They said they checked the report on a regular basis and where they noted a call response time of over eight minutes, they looked into the reasons for this. They told us they had recently had to look at one incident but upon investigation it was due to staff attending the shift handover, they said staff had now been instructed to attend to call bells and reassure the person that staff would respond to their needs as soon as the handover was completed.

People did not raise any concerns about the management of their medicines. One person said, "My medication, my pills, are always right and on time", another person told us "They give me my tablets there are never any mistakes." A relative told us. "There were some problems with the meds at the start, it's all sorted out now."

We observed nurses administer people's medicines safely, locking the trolley and securing all medicines prior to administering individual's medicines and speaking with people as they supported them to take their medicines.

A monitored dosage system (MDS) was used for the majority of medicines while others were supplied in boxes or bottles. We checked four individual boxed medicines and found the stock tallied with the number

of recorded administrations. We also checked one medicine which was stored in the controlled drugs cupboard. The stock tallied and each entry was completed and checked by two staff. We also saw the controlled drugs stock was checked weekly to ensure all the stock was accounted for.

When people were prescribed a cream, for example moisturising lotions, the clinical lead said these were kept in people's bedrooms along with a medicines administration record (MAR). We looked at these records for three people and saw one person was prescribed a cream twice daily but staff had not signed the MAR since 31 December 2016. The other two people's MAR had not been replaced after their completion on 25 December 2016. This meant there was no clear record staff were administering people's creams in line with the instructions of the prescribing health care professional.

This also demonstrates a continuing breach of Regulation 12 and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The clinical lead nurse said their competency to administer people's medicines had been assessed by the manager when they commenced employment and that part of their role was to assess the competency of the nursing team. They said medicines competency would then be assessed annually unless there was a need to assess it more frequently. When we looked at their personnel file we saw evidence of their competency assessment, the assessor had written 'high standard of practice throughout'. This showed people received their medicines from staff who had the appropriate knowledge and skills.

A check was completed at the end of each medicine round by the nurse, this included checking for missing signatures and ensuring adequate stock was available for people. The clinical lead said since the check had been introduced, safe, effective medicines management at the home had improved.

During our inspection we found the home to be clean, tidy and no malodours were noted. The housekeeper told us domestic staff were on duty each day and their duties included a programme of steam cleaning to maintain cleanliness at the home. They told us they completed regular checks of pressure mattresses and cushions and showed us the guidelines they followed to ensure the checks were robust. We saw evidence a number of pressure cushions had been condemned during 2016 and new ones purchased. We also noted in October 2016 they had recorded that two mattress covers needed replacing and we saw from the records in November 2016 this had been done. This meant there were systems in place to protect people from the risk of infection.

Requires Improvement

# Is the service effective?

## Our findings

Our inspection on 4 and 11 May 2016 found the registered person was not meeting the regulations regarding consent, nutrition and hydration and staff lacked knowledge of key aspects of people's care. We said the service was not effective and rated this domain as inadequate. On this inspection we found improvements had been made.

People we spoke with responded positively about the training of the staff, one person said, "Yes all the things I need for moving, all the equipment and the skills are in place". A relative said, "They know exactly what they are doing for this type of care."

The lead carer told us all nursing and care staff attended a handover at the beginning of their shift. They said the handovers had improved and now worked well. This was echoed when we spoke with other staff. A brief written record was maintained of the handovers and we reviewed a random sample from December 2016, the content included; admissions and departures to the home, changes to people's needs and visits from other healthcare professionals. Handovers help to ensure staff have up to date information about the people they are supporting and enable relevant information to be shared among staff.

New staff completed a programme of induction, this included face to face training and, where appropriate, practical training, for example, moving and handling. We reviewed the personnel files for four staff who had been employed for less than twelve months and saw evidence in two of the files of the induction programme they had competed. There was no evidence of induction in the other two files although when we spoke with one of them, they were able to tell us about the induction programme they had completed prior to commencing work in the home. We also saw evidence they had competed the relevant training when we reviewed the staff training spreadsheet provided by the staff trainer. The records of induction we saw evidenced the content of each induction day and were signed as completed by both the candidate and the trainer.

The clinical lead nurse also confirmed they had received a comprehensive induction and they were now receiving support with mastering the management systems within the home. They said they had spent time with a clinical lead nurse who was based at another home and this had been beneficial in helping them learn more about their role and responsibilities. This demonstrated new employees were supported in their role.

Staff we spoke with who had worked at the home for a longer period of time told us that refresher training consisted of mainly online training although there was a practical element to the moving and handling training. They also said face to face training would be provided for staff if this was felt to be appropriate. During the inspection we spoke with a trainer, employed by BUPA, they told us that following the last inspection they had provided a number of training sessions to staff, such as pressure care, nutrition and hydration and record keeping. The clinical lead nurse said they had spent a lot of time on the floor, observing and supporting staff in their duties. They explained this had provided opportunity to improve staff knowledge and skills.

We looked at the training summary chart which recorded staff training compliance was 89.5% on 1 December 2016, although, of the 39 course listed 13 courses showed a compliance rate of less than 85%. This included food hygiene, fire safety, infection control and risk culture and incident management. We also reviewed the training matrix and noted that not all topics required a refresher. For example, pressure area care, nutrition and hydration and topics related to the care of people living with dementia. Although we did not evidence poor practice by staff and staff were knowledgeable about key aspects of their role, for example, signs a person may be developing a pressure sore, at our previous inspection on 4 and 11 May 2016 we identified staff lacked knowledge in regard to these topics. Ensuring staff receive thorough training and regular updates mean staff have up to date skills and knowledge to enable them to meet people's needs in line with current standards of good practice.

Staff told us they received supervision. The lead carer told us they had received supervision with a previous member of staff based at the home but they had not yet had supervision with the current manager. The housekeeper and cook said the home manager did their supervision but they were responsible for completing the supervisions for their teams. When we looked at staff personnel files we saw evidence of supervision but this did not always appear regular. For example, over a two year period, one staff member had only received three supervisions and there was no record of supervision for a member of staff who had been employed at the home since September 2016. However, when we spoke with them, they told us they had had supervision with a senior nurse. Ensuring staff receive regular management supervision to monitor their performance and development needs helps to ensure they have the skills and competencies to meet people's needs.

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.

Each of the staff we spoke with understood people's right to make decisions and understood some people may be able to make simple decisions but not more complex ones. When staff spoke with us they told us how they supported people to make choices and decisions. For example, one staff member told us how they showed a person a choice of clothes to enable them to decide what they wanted to wear.

We reviewed the care plan for three people whose capacity was variable. We saw evidence of a capacity assessment and of the involvement, where appropriate, of their family in the decision making process regarding key aspects of their care. Following this process demonstrates openness and transparency in providing services for people who lack capacity as prescribed in the Mental Capacity Act 2005.

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 MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS) as described in MCA. We reviewed a file where correspondence relating to DoLS applications and authorisations was kept. One person who lived at the home was subject to a DoLS authorisation and there were 11 further applications which had been submitted to the local authority for their assessment. This showed that although some people had been deprived of their liberty, the provider had requested DoLS authorisations from the local authority in order for this to be lawful and to ensure a person's rights were protected and was awaiting the outcome of other applications.

People told us the food was good and they had plenty to eat and drink. One person said, "The food is very good, plenty of it, enough to eat and there are choices". A relative told us, "The food seems to be adequate,

if I bring some in it's not because it's inadequate".

We observed lunchtime on the first day of our inspection. The dining room was clean, bright ,well decorated and welcoming with background music of a suitable era. The tables had tablecloths, place settings, napkins and a centre piece. The staff, including the cook, were all involved and interacted with people in the dining room, encouraging people to eat and asking if they were happy with the food. One person required staff to cut their food up and another person needed staff support to eat, this support was offered in a timely and appropriate manner. As people were seated at the tables they were given a choice of fruit juice and at the end of the meal tea and coffee were served. The menus were displayed on the wall, but people were verbally given a choice of two different main courses and a choice of dessert. The food looked good and the portion size appeared suitable. We overheard one person say to a member of staff, "The cauliflower cheese was very tasty and nice."

At our last inspection we were concerned about a lack of consistency in monitoring people's weight. On this visit we found people were weighed at regular intervals. The clinical lead nurse showed us a matrix on which they recorded the monthly weights of each person who was living at the home. Where people had lost a specific amount of weight with either a one or three month timeframe, this was highlighted on the matrix. There was also a second tracker which recorded action taken with individuals to address any issues. For example, the weight recorded in one person's care plan noted they had lost weight between April and July 2016; this information was also recorded on the tracker. Weights recorded since this date evidenced they were no longer losing weight, their weight had stabilised and they had since re-gained some of the weight they had lost. This evidenced systems were now in place to address concerns regarding people losing weight.

People felt that there was good access to other health care professionals, "They sort you out with dentists and things and would refer you on if needed. Another person said, "A doctor comes now and again to check things." A relative said, "There is good access to other services." We saw evidence in peoples care plans of referrals to and the involvement of other health care professionals, for example, doctors, speech and language therapist and other specialist community staff. This showed people received additional support when required for meeting their care and treatment needs.

Good

# Is the service caring?

## Our findings

Our inspection on 4 and 11 May 2016 found the registered person was not meeting the regulations regarding person centred care. We said the service was not always caring and rated this domain as requires improvement. On this inspection we found improvements had been made.

People spoke positively about the staff and their experience at Cleveland House. Comments included, "They are nice and know what I can do", "They are nice and caring and get to know you and what you like." A relative said, "The staff are very personable very supportive of relatives as well as residents." A relative emailed the Care Quality Commission (CQC) directly to praise the staff at the home, their email included 'Our thanks to all the staff at Cleveland House for the care they gave and the love they showed (name of person). We are especially grateful to your team of carers who selflessly made (name of person)'s stay at Cleveland easier for them and us to bear'.

Interactions between staff and people who lived at the home were friendly, caring, inclusive and professional. Staff spoke with people while supporting them with physical tasks such as using a hoist or transferring in a wheelchair. At lunchtime we observed a new resident being brought to the dining room for the first time by staff. The staff member introduced the person to the other people who were seated around the table before they left them at the table. We noted a member of staff saw the sun was shining in a person's eyes, so they adjusted the curtains accordingly. People were clean and appropriately dressed. A staff member said, "I sometimes pull people (staff) up on things, like messy hair or people wearing skirts and no tights. Treat them like your own mum and dad."

We spoke with a member of staff who was not employed in a caring role, they told us they chatted with people as they completed their work in the home. They said if someone rang their bell and they were close by, they would respond to see what the person wanted and if it was something they could assist with, such as organising a cup of tea or picking something up for them they would do this for them.

We asked the lead carer and clinical lead nurse how they ensured staff were kind and caring in their approach to people. They told us they observed staff and worked with them on the floors. They also said staff told them if there were concerns about the attitude or conduct of other staff and this enabled them to take action to address the matter.

At our last inspection we were concerned about the number of people who were being nursed in bed and staff had no clear understanding of why this was. On this inspection, although we saw some people were nursed in bed, we found this was either through choice or to maintain their safety or wellbeing. We spoke with one relative who told us the registered provider had purchased a chair which would enable their relative to sit out of bed during the day. They said staff now got their relative out of bed about three times per week, they were satisfied with this and felt it met the needs of their relative. We spoke with another person who was still in bed and they told us very clearly that they wished to remain in their bed. Staff told us about one person who was consistently nursed in bed and lacked the capacity to make that choice independently. Staff told us this was due to the person's physical disability and was to keep them safe, the

reason for this was also recorded in their care plan. Following the inspection a senior manager emailed a copy of an occupational therapy report dated June 2016, which recorded this person was not safe to sit out of bed and should be nursed in bed. This document had not been in the care plan at the time of the inspection as it had been archived.

Staff told us how they encouraged people to make choices, for example, what time they got up, the clothes they wore and where they wanted to spend their time. The lead carer told us, "People can choose where to eat each meal. People can get up when they want depending upon how they feel." When we asked one person about their life at the home they responded, "I can choose when to get up and go to bed, I like getting up early so they get me up first. There are no restrictions on me I can come and go as I want."

People told us staff respected their privacy and dignity, one person said, "They treat me with respect." Another person said, "They always knock on the door." Staff were able to tell us how they maintained people's privacy and dignity, for example, closing doors and curtains. The lead carer said, "We get carers to think about what they would want." People were supported to retain their levels of independence. One staff member said, "We get people to do all they can for themselves, give them a flannel to wash their hands and face. Encourage people to walk and not use the wheelchair." Encouraging people to be as independent as possible can improve people's quality of life.

At the previous inspection it was not always clear from people's care plans whether they had expressed any end of life care wishes. There was a section in peoples care plans to record their end of life wishes but the content in the care plans we reviewed was minimal. The clinical lead nurse showed us a care plan booklet which was designed to be implemented when a person entered the final stages of their life, we saw this provided opportunity for their wishes to be recorded alongside a summary of their care and support needs. They showed us a booklet which had recently been completed and we saw that although some sections had been completed there were still large gaps on the document, they said they were aware this was an aspect of people's care that still needed to be addressed. They said they had begun to take action to improve this aspect of peoples care and end of life training had been organised for staff in March 2017.

We asked how staff knew which people had a Do not Resuscitate (DNACPR) instruction in place. The clinical lead nurse showed us the symbol which was placed the care files of people who had this instruction in place. They said using the symbol ensured this was clear to staff but respected people's privacy and dignity.

Following the inspection we were contacted directly by the relative of a person who had recently received end of life care at the home. They told us about the quality of the care their loved one had received and how staff had ensured the person was always clean and comfortable. They also told us how staff had explained to them what would happen as their relatives health deteriorated and what could be done to alleviate any distressing symptoms. This showed people were receiving end of life care from staff who were kind and caring.

Good

# Is the service responsive?

## Our findings

Our inspection on 4 and 11 May 2016 found the registered person was not meeting the regulations regarding person centred care, in relation to the provision of activities for people, and, record keeping. We rated this domain as inadequate. On this inspection we found improvements had been made.

The majority of the people we spoke with were positive about the planned activities. Peoples comments included; "They get me involved in social activities like the gardening club", "There are enough activities", "There are enough activities for me", one person said, "There could be more activities." One relative commented, "I haven't seen any of the activities", however, another relative said, "I think there is enough going on."

The activity coordinator told us they had been in post for four months and they had introduced a full programme for people. A monthly program was placed in peoples rooms and was on display at various places around the home. The activity coordinator said they tried to actively involve everybody but they knew some people did not want to or were unable to take part in group activities therefore they visited them in their rooms and had one to one interactions. One to one activities included chatting and singing, while larger group activities included singalongs to CDs, crafts, gardening, chair exercises and group discussions. People also took part in national days such as Halloween and bonfire night and there were external entertainers, for example, choirs, singers and a pantomime group.

Each of the care plans we reviewed had a document 'my day, my life, my portrait'. The clinical lead nurse said this provided staff with an overview of peoples care and support needs. We checked two care plans and found the information on this document reflected the content of the rest of their more detailed care planning documentation. Care plans were person centred and detailed individual's needs, likes, preferences and abilities. For example, one care plan referred to the person needing to use a beaker with a spout, when we saw them they were drinking from an appropriate beaker. Their care plan also recorded they were able to wash their hands, face and brush their teeth independently. Another care plan noted the person had dentures but 'often refuses to wear them'. This level of detail helps staff to know what is important to the people they care for.

Daily logs were completed by staff throughout the day and provided a synopsis of people's care and support. This included support provided by staff with personal care, diet and fluid intake and if they had declined aspects of their care. This ensured there was a record of the care and support people had received each day.

One person had a percutaneous endoscopic gastrostomy (PEG) feeding tube in place. Their care plan detailed their feeding regime and their daily intake was recorded on an enteral feeding chart. However, their care plan lacked detail in regard to the actions the nursing staff needed to take on regular basis to reduce the risk of complications. Not having this information means there is a risk not all staff are aware of the tasks to be performed to ensure good PEG care.

None of the people we spoke with said they were involved in the planning or review of their care plan. One person said, "My care plan is here somewhere I don't talk about it." However, the majority of the relatives did feel involved, one relative said, "Very much so, there is a review meeting once a month, about two hours to review the care." Another relative told us there was a 'resident of the day', they said this was a nominated day of the month when their family members care plan was reviewed, and they said they were part of that process. We spoke with the clinical lead nurse and they explained each person had a nominated day each month when all aspects of their care and documentation were reviewed. Regular reviews help in monitoring whether care records are up to date and reflect people's current needs, enabling action to be taken to address any identified shortfalls.

People told us they did not know the complaints procedure but no one felt this was a problem as they had no complaint to raise. One person said, "I haven't made a complaint, not yet I haven't." One person told us they had raised a concern and they were satisfied with how it had been dealt with. A relative told us, "I have no issues but I would just go to the office and get things sorted."

We looked at the complaints file and saw there were four complaints recorded since the last inspection. There was a record of the action taken by the registered provider including their response to the complainant. A senior manager present during the inspection told us any complaints were logged on the registered provider's online management system. They explained this guided staff as to timescales for responding to complaints and provided letter templates to be used for the stages of the complaints process. They also added that in the event the complainant was dissatisfied with the outcome of their complaint, then the matter was escalated to a more senior manager within the organisation for them to review. This showed there was an effective complaints system in place.

Requires Improvement

# Is the service well-led?

## Our findings

Our inspection on 4 and 11 May 2016 found the registered person was not meeting the regulations regarding good governance. We rated this domain as inadequate. On this inspection we found a number of improvements had been made.

We asked people about the management of the home, comments included; "I don't speak to the manager I don't know who she is", "It is well managed", "It's well run" and, "I don't know, things just happen." When we spoke with relatives they said, "It's well run from what I have seen", "Yes, well run a good team hierarchy" and, "It's well managed now there is a marked difference since the last CQC report".

One of the senior managers present during the inspection explained that when the home was placed in Special Measures a service recovery team had been placed at the home by the registered provider to support staff and improve the quality of the service people were receiving. There had been a number of management changes during 2016 and the present manager who was not able to be present on the days of our inspection, was not yet registered with CQC. The clinical lead nurse and the lead carer had both been deployed to the service to support with the programme of improvement at Cleveland House.

Staff we spoke were positive about the management at the home, one staff member said, "(Name of manager) is very approachable and nice. (Name of lead carer) is brilliant you can talk to her about anything." Another staff member said, "I am happy with the management, I feel supported." We asked the lead carer what their vision for the home was, they said, "We want to provide safe, happy care. We want them to have a good quality of life". They also said the home was getting back onto an 'even keel' following the last inspection and feedback from people and relatives was positive

Three of the staff at the home told us about a daily meeting held for all 'heads of' for example, the cook, carer lead and lead nurse. They said this was a brief, 10 minute meeting, held daily, where key information pertinent to the running of the home and the welfare of people living at the home was shared.

There were a number of systems and processes to audit the service provided to people at the home. An audit had been completed by a senior manager in the service recovery team, on 28 and 29 December 2016. We saw this recorded the findings of the audit and recorded a final score. We saw an action plan had been devised following this detailing the key areas the service recovery team needed to focus on including timescales for completion.

A planner was on the office wall which provided staff with information regarding the audits which were to be completed and their frequency. This included a daily walk around check, a weekly clinical risk meeting and four unannounced night visits. We saw the manager had completed an unannounced night visit on 2 December 2016 and their findings were recorded in the audit file. Audits of people's medicines and care plans were also completed at regular intervals. Although we found the audits were thorough, they did not consistently evidence that issues identified had been acted upon or that the auditor had checked to see if the identified actions had been addressed. Issues that were identified but not recorded as actioned were not

routinely carried forward to the next audit. We brought this to the attention of the senior manager on the day of our inspection.

Due to the relatively short time frame since the last inspection, we were unable to evidence the improvements were truly embedded and standards of care delivery were consistently maintained. Future inspection will seek to evidence a sustained and consistent high level of quality has been achieved and that systems of governance are reflective, transparent and robust.

During this inspection we found a number of improvements had been made since our last inspection relating to relating to person centred care, consent, safe care and treatment, nutrition and hydration needs and staffing. However, as evidenced within this report there were still a number of areas where improvements were needed, for example, assessing risk, training, end of life documentation and auditing. These findings demonstrate a continuing breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us there were regular meetings held at the home. Copies of meeting minutes were retained and these evidenced meetings were held with staff at regular intervals. Topics included training, teamwork and areas for improvement. Meetings provide an opportunity to disseminate information to staff.

One of the relatives told us they had attended a relatives' meeting. We saw minutes of a relatives' meeting held in June 2016 and this included discussion regarding the findings from the May 2016 CQC inspection. The lead carer told us a further meeting had been planned for December 2016 but this had been cancelled due to the home having an outbreak of the winter vomiting bug. We saw there was a poster in the reception area informing people that a manager's surgery was to commence in January 2017.

Under the Care Quality Commission (Registration) Regulations 2009 registered providers have a duty to submit a statutory notification to the Care Quality Commission (CQC) regarding a range of incidents. Prior to the inspection we saw evidence the registered provider submitted these notifications in a timely manner. During our inspection we did not identify any issues which the registered provider had failed to notify us about.

There is a requirement for the registered provider to display ratings of their most recent inspection. We saw a poster displaying the ratings from the previous inspection was on display within the home and the rating, along with a link to the CQC report was also available on the registered provider's website.

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 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Risk assessments did not address all aspects of peoples care and support.<br><br>Not all aspects of medicines management were robust. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems and processes were not operated effectively to ensure regulatory compliance. The service provided was not robustly assessed and monitored to ensure its quality and safety for people and staff. |