Mr Charles Otter

Cranhill Nursing Home

Inspection report

Weston Road
Bath
Somerset
BA1 2YA

Tel: 01225422321

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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 undertook this unannounced inspection on 13 and 15 November 2018. The last comprehensive inspection of the service was carried out in August 2017, and a focussed inspection was carried out in February 2018.

At the last comprehensive inspection, we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Shortfalls related to safeguarding people and obtaining their consent, staff training and insufficient staff to support people. Audits did not always identify shortfalls found during the inspection. Following the last comprehensive inspection, we asked the provider to make improvements to the service. At this inspection, we found that improvements had been made.

Cranhill is a 'nursing home'. People in nursing homes receive accommodation and nursing care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Cranhill Nursing Home provides care for up to 31 people. At the time of our inspection there were 19 people living there. The communal areas of the service were all on the ground floor. Bedrooms were available on all floors and an elevator and stair lifts enabled people to access each floor. Some bedrooms were en-suite, and some were large enough to enable couples to share a room.

A registered manager was in post at the time of our inspection. 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.

People were supported by adequate numbers of staff to meet their needs, however agency staff supported shortfalls in staffing numbers. At the time of the inspection, the provider was trying to recruit to fill vacant posts. The provider followed effective procedures to ensure prospective staff were suitable to work in the service, and checks were also carried out on staff who had worked at the service for many years.

Staff were trained in a range of relevant subjects, although some training records required reviewing and updating. Staff usually received regular supervision and appraisals, and the staff we spoke with were positive about the service.

Care records were clear, although some needed more detailed information about people's needs and preferences. Individual risk assessments were in place, although some of these also needed checking for consistency. Care plans were reviewed regularly to ensure they continued to meet people's needs. Relatives told us that they were consulted with and informed about people's care.

Systems and processes were in place to protect people from the risk of harm. Staff had received training and told us about their responsibilities in making sure the service was safe. The principles of the Mental Capacity Act 2005 were being followed and the provider had made safeguarding referrals to the local authority

appropriately.

People's medicines were administered as prescribed and managed safely by suitably trained staff.

Policies, procedures and checks were in place to manage health and safety. This included the management of incidents and accidents.

A wide range of audits and monitoring tools were in place. This included regular checks of pressure mattress settings, call bell responses, health and safety, medicines and falls. Shortfalls and themes had been identified and action plans put in place to continually monitor and improve the quality of 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 were supported by staff, systems and processes which kept them safe.

People's medicines were managed safely.

Risks to people were assessed and monitored to ensure people were safe.

Is the service effective?

Good

The service was effective.

Staff received training and supervision to ensure they provided effective care for people. There were some gaps, but the provider planned to address these.

Staff supported people's choices and the service was following the principles of the Mental Capacity Act.

People were supported to stay healthy and well. The service made appropriate and timely referrals to relevant health professionals when required.

Is the service caring?

Good

The service was caring.

Staff demonstrated respect for people who used the service in the way they interacted with and spoke about people.

People and their relatives were confident in the abilities of staff, and told us that they were kind and patient.

Staff had a good understanding of people's needs and preferences, and were compassionate and caring.

Is the service responsive?

Good

The service was responsive.

Care records were clear, although some care plans required more information and updating.

People received care and support that was personal to them, and this was usually provided by staff who knew them well.

People and their relatives felt able to make a complaint, and were confident that any concerns would be fully investigated.

Is the service well-led?

Good

The service was well-led.

Systems to monitor and review safety and the quality of care were in place and effective.

The provider was open and receptive to feedback and was keen to improve the service.

People, relatives and staff spoke positively about the manager.

Cranhill Nursing 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 13 and 15 November 2018. The first day was unannounced. The inspection was carried out by an inspector, a bank inspector 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 who was part of this inspection team had expertise in the care of older people and people who are living with dementia. The bank inspector on this inspection team was a nurse.

Prior to the inspection, the provider completed a Provider Information Return (PIR). This is a form which gives key information about the service, what the service does well and any improvements they plan to make. We also looked at the notifications we had received from the service. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We reviewed other information to help inform us about the level of risk for this service. We considered this information to help us to make a judgement about the service.

During the inspection we spoke with nine people living at the service and four family members or friends. We contacted another relative after the inspection by telephone. We spoke with four members of staff as well as the registered manager, deputy manager and quality assurance consultant. We also spoke with two health and social care professionals who were involved with the service.

We looked at seven care records and the medicines administration records for everyone living at the service. We looked at four staff files, and staff training records. We also looked at a range of records and documents including meeting minutes, policies, audits and environmental reports.

Good

Is the service safe?

Our findings

People told us that they felt safe living in the home. A relative said, "[They are] secure here. First class."

Systems and policies were in place to protect people from harm and to support staff. Staff had received safeguarding training, and staff we spoke with felt there were no concerns at the service. They felt confident about reporting their concerns, and described the actions they would take if they witnessed abuse or had any concerns. The registered manager was aware of their responsibilities and shared safeguarding concerns appropriately.

People's care plans contained risk assessments relating to individual needs including moving and handling, falls, nutrition and pressure care. Information guided staff about how to manage risks to ensure people remained safe. For example, people who had been assessed as being at risk of developing pressure ulcers had been provided with appropriate pressure relieving equipment, such as air mattresses and cushions. Air mattresses had been set at an inflation pressure appropriate to the person's weight, and records showed this was checked at least four times a day by the nurses.

Environmental risks were assessed. For example, steps and stairs, electrical equipment, windows, hot water and hazardous substances such as cleaning fluids. Specific risks and control measures around the building were regularly assessed. This included, checks of window restrictors, radiator guards and regular water temperature checks. These all helped to keep people safe and servicing and repairs were carried out as required.

Health and safety information was displayed at the service, including fire and other emergency procedures. A contingency plan was in place which provided guidance for staff on what to do in different emergency situations. Systems were in place to keep people safe in the event of an emergency. For example, in the event of a fire each person had an emergency evacuation plan that detailed their needs.

Accidents and incidents were recorded and investigated, including those which had affected staff. The registered manager regularly reviewed records to check for trends or specific concerns. This supported the service to learn from accidents and incidents and take steps to improve safety for people where required.

Medicines were managed safely. Nurses were responsible for the administration of medicines, and those who worked regularly at the service had received training in medicines management and had their competency to give medicines regularly assessed. We observed part of a medicines round. The staff member was organised and aware of the needs and preferences of people.

Medicines administration records (MARs) were accurate and clear. These records showed that people were receiving their medicines correctly and at the right time. Each MAR had a photograph of the person, and detailed their medicines preferences, as well as any allergies and their date of birth. People had separate MARs in place for topical medications such as creams. These included a body map of where the cream

should be applied. The topical MARs were kept separately and were completed consistently by care staff when a cream was administered. People who had 'as and when needed' (PRN) medicines had protocols in place and records confirmed that these PRN medicines were administered safely.

There were safe systems for ordering, receiving, storing and disposing of medicines. This included medicines which required additional security. Records showed that medicines which required additional security were regularly checked and were signed by two staff members.

There were secure, locked cupboards for storing medicines. An appropriate fridge for storing medicines was available and temperatures were checked and recorded daily. This ensured that medicines were stored safely and as directed.

Regular checks of medicines were completed, and appropriate records were kept for the receipt and return of medicines to the pharmacy. A list of 'household remedies' had been agreed with and signed by a GP. Household remedies are non-prescription medicines which are used for simple complaints.

Monthly medicine audits were carried out which monitored stock checks, the ordering and receipt of medicines, administration recording, storage, controlled medicines and medicines disposal. The audit carried out in the month before our inspection showed a very high overall compliance rating.

Safe recruitment and selection procedures were in place. Staff files had pre-employment and other checks in place that confirmed staff were suitable to work with vulnerable people. One person's file, who had been recruited recently, had some missing information. We highlighted this during our inspection. All files checked had Disclosure and Barring Services (DBS) checks detailed. A DBS check allows employers to confirm whether the applicant has any past convictions that may mean they are unsuitable to work in this kind of service. Staff who had been employed for many years had completed declarations which provided an update about any police cautions, charges or convictions.

Staffing levels met the identified needs of people who lived at the service. There were vacant posts at the service, but the provider was actively recruiting to these. They had reduced the number of people living at the service so that the reduced staff team could manage safely. Agency staff were used, but these were usually staff who had worked at the service before. Staff told us that they felt there were enough staff to meet people's needs. However, people said, "I am looked after well, but they are short staffed," "Staff have no time to talk," and also noted, "The staff change a lot."

During the inspection staff responded to call bells quickly. Call bell response times were reviewed on a weekly and monthly basis. These checks and audits showed that in the majority of cases, people were responded to in a timely way.

People said that they found the service to be clean and tidy. We found this to be the case during our inspection. One person described it as, "clean and pleasant. It doesn't smell. Good attention to detail." Infection control systems, cleaning schedules and personal protective equipment were all available and in use. Local audits monitored standards to ensure safe and effective practices were in place.

Good

Is the service effective?

Our findings

At our last comprehensive inspection, we found records relating to people's health care needs were not always complete, accurate and up to date. At this inspection we found that improvements had been made, although ongoing work was still required. For example, staff were continuing to review and personalise records. A staff member said, "Within this year, everything has evolved. The record keeping has improved, and I think we have addressed what was required." People's daily care charts were being completed to confirm personal care had been provided to people, and checks on pressure relieving air mattresses were being carried out four times per day, and regularly audited. This showed improvements had been made since the last comprehensive inspection.

Staff were positive about the training that they received. They told us that they felt equipped to carry out their role. New staff received an induction and orientation when they started working at the service. Staff's competence in their role was regularly checked by management who worked alongside staff. Competency in medicines was specifically checked. This meant checks ensured that staff had the skills and abilities to care for people effectively.

Staff usually received supervision and had formal appraisals of their work. Supervision is where staff meet with a senior staff member to discuss work or any other issues affecting the people who use the service. A staff member said, "The manager is supportive," and another added that they felt able to raise issues or ideas informally at any time.

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 to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. People were not being restricted unnecessarily, appropriate assessments and decisions had been carried out, and applications submitted to supervisory bodies as needed. Records were kept to track the status of all DoLS applications, although these needed to be updated. We highlighted this to the registered manager during the inspection.

People were asked for their consent. For example, we observed during our inspection people being given choice and control about day to day matters such as food, clothing and their daily routines. We spoke with a person in their room who told us that they preferred to stay in their room most of the time, adding, "I prefer

to avoid activities." When talking about meals, one person told us, "I get a choice, but they know what I like." We observed that a lot of people chose to have meals in their rooms, which meant that mealtimes took longer and placed greater demands on staff.

Most people told us that they enjoyed the food they received. One person said, "The food is good," however, another person told us the food, "lacks flavour." A relative told us that their family member loved the food. People told us that they had enough to eat and drink, and that they could have alternative meals if they didn't like or want what was on the menu.

People's nutritional needs were met by the service. Nutritional assessments were carried out and staff, including kitchen staff, knew about the needs of people who were at risk. Where risks had been identified, people had care plans and regular monitoring were in place. One person told us that they needed large handles on their fork to eat independently. These were provided in the dining room. Records of food and drink taken by people were kept, and these mostly indicated that people were offered regular food and drinks. One person's records had some gaps. We spoke with the person, who confirmed that they were being offered enough to eat and drink.

A one-page summary sheet in each person's room provided information for staff about individual's needs and preferences. This supported staff to deliver personalised care which was effective. People told us that staff knew them well, but noted that they preferred to be cared for by permanent staff. One person said, "There are more agency staff. I can't chat to agency, it's much more difficult. The main staff know my routine."

People had access to healthcare services and received regular reviews. The service worked with a range of health professionals to meet people's needs. This included regular contact with GPs, mental health staff, opticians, dentist and podiatrists. A health professional told us that they were confident that the service sought assistance to best meet people's complex needs, stating, "They are asking the question 'are we meeting their needs?'" This showed that people were supported to be healthy and well and other professionals were involved as required

There were some limitations to the adaptation and design of the building because of its age and listed status. For example, there were steep steps leading to some bedrooms. People in these rooms could manage the steps, and hand rails and signage was in place. The communal lounge and dining areas were spacious and pleasant, and some bedrooms were very large. Many people chose to spend time in their bedrooms, and these were personalised. A plan was being developed to improve the accessibility and use of the garden.

Good

Is the service caring?

Our findings

People told us that they were supported by staff who were kind and caring. One person said, "Staff are kindly and helpful, I respect them, and another said, "I am happy here. I get on well with staff." One relative said, "The staff are so tolerant. They're mature and experienced." Staff we spoke with were motivated and positive about their role. They told us that they enjoyed working at the service. One staff member said, "I really love coming to work here."

Staff provided person centred care that met people's needs. During the inspection, staff interacted with people in a patient and compassionate way. There were many positive interactions between staff and people who lived at the service. For example, one person told us about an incident where their wedding ring fell off their finger. They said, "Staff were so kind, they looked all around for it, and found it."

There were positive relationships between staff and people who lived at the service. People appeared to be comfortable around staff, and staff were positive about the people they cared for. One person said, "The staff chat to me while I get washed and dressed," and another person added, "They do their best, they are very good natured." A member of staff spoke with sensitivity about a person who had recently died, telling us about how they had felt, and adding that, "The staff team and the matron were lovely. Just lovely." There were regular services of memorial and thanksgiving for people who had died at the service.

Staff respected people's privacy and dignity. Staff gave us examples of how they did this, such as describing how they supported people with personal care. One staff member explained that they would close doors and curtains, cover the person and ensure they were comfortable when washing. Staff knocked on people's doors and asked if they could come in to carry out specific tasks.

During our inspection, staff regularly checked on the people who preferred to stay in their rooms.

People's relatives told us that they were always made to feel welcome, and that they did not feel unnecessarily restricted when visiting. Relatives also told us that communication was good. Family members told us that they had been involved in care plan development and review. One relative told us, "If I need to talk with staff, they're always available, time never seems to be an issue."

The service had a folder of compliments and cards received from people and their relatives. One card stated, "I just wanted to say thank you for looking after [Name] so well. I know he felt safe and cared for and was treated with kindness." The message on another card read, "Thank you for all the care you have given [Name] in [their] last days. [They] couldn't have asked for any more kindness and all the family appreciate what you have done."

Personal information was recorded in people's care files, and staff told us that they could access these at any time. Information was kept securely, and staff understood the principles of protecting people's confidentiality.

Good

Is the service responsive?

Our findings

At our last inspection we found that care plans were not person centred and did not involve people or their relatives. At this inspection we found some improvements had been made.

Relatives told us that they were involved in care planning and reviews, and some people had signed their own care plans or review forms. Care plans were regularly reviewed and were up to date.

Information in areas of some people's care record was brief. For example, some people's personal histories or end of life plans were not completed in the main care record. We saw that staff knew people and their individual care needs well. However, having more detail in care records would reflect the knowledge of staff and enhance the care being delivered in practice. Other information within care records sometimes conflicted. For example, one person's plan had contradictory information about the walking aids that they needed. We raised this with the management team during our inspection, who planned to review the care records.

The registered manager had completed a detailed care review form with some people. This recorded the views and preferences of the person and the views of the staff member, then outlined an individual care agreement about areas such as personal care, risk assessments, advanced care planning and activities. The registered manager was reviewing the use of these forms, and planned to discuss their continued development with the quality consultant.

People and relatives told us that the service provided care that met their needs. One person told us, "If you wanted anything you can ask." Staff told us that they received information about changes to people's needs through handover and staff meetings. When we spoke with a staff member, they showed that they knew people well, and could tell us about the actions they would take in specific situations.

We received positive feedback about end of life care from relatives. They told us that this was personalised, caring and responsive. Some people had detailed end of life care plans in place, but this was not consistently the case. We highlighted this to the registered manager during our inspection, who stated that they would review people's end of life plans.

An activities co-ordinator had been appointed since the last inspection. They had established a varied group activities plan, and also spent time with people individually each day. During our inspection we observed activities such as a coffee morning, bingo and exercise group. There had recently been activities to mark Remembrance Sunday, and different religious leaders came to the service regularly. Staff and people told us that the activities available reflected people's preferences, and staff respected that a number of people did not wish to join in with group activities. People told us that they were supported to enjoy individual activities such as reading, watercolour painting, listening to 'talking newspapers' and radio, going out for walks and visits from a person's dog.

Resident's meetings were held every 2-3 months. Notes from recent meetings confirmed that topics such as

food preferences, activities, learning from incidents and staffing updates had been discussed. People who did not wish to attend the meeting were asked for their comments before the meeting. Minutes and action plans aimed to ensure the service continued to review and improve the quality of care.

The service carried out surveys on a regular basis. People and their relatives gave feedback and the rated their experience as mostly 'good' or 'very good.' For example, eight people responded to the question, "How do you rate the quality of the care?" Four people reported 'good', and four stated 'very good'.

There had been five complaints made in the last 12 months. These had been investigated, and there were details of outcomes and lessons learned. Where relevant, information was shared with people and staff. A complaints policy was available, and a copy was also in the visitor's information folder. People told us that they would talk to staff if they had any worries or concerns. Relatives told us that they knew how to complain and said that they would feel comfortable raising concerns with a staff member or the registered manager. Staff told us that they felt able to raise concerns or complaints, and a whistleblowing policy was available.

Good

Is the service well-led?

Our findings

The registered manager and deputy manager were present during our inspection. They delivered clinical care and support to people. Staff told us that senior staff or managers were always available, and staff felt that they were supported to provide a quality service. One staff member said, "The manager is definitely supportive." One person said, "I have a high regard for matron,". Another person added, "Matron comes up [to my room] and she does care." Relatives told us they knew who the registered manager was and said they were happy to approach staff at any time. A relative said, "Matron has her finger on the pulse. She's always around and I can talk to her."

People who used the service told us, "Staff are wonderful, core staff have been here years, but there's more and more agency staff. They (agency staff) are not always trained as well as they might be." Most people that we spoke with told us that they preferred receiving care from permanent staff who knew them, rather than agency staff. Permanent staff told us that they found working with agency staff challenging, although one staff member noted that the registered manager tried to ensure the same agency staff were used when needed.

Staff told us that they enjoyed their jobs and that they mostly felt supported and valued. Some staff told us that they would have liked to receive feedback from the registered manager when they raised concerns about working relationships with other staff. However, staff were positive in their approach and said they worked well as a team for the benefit of the people they cared for. One staff member said, "It's a great team here. I really fit in." The staff we spoke with were confident in their roles and well-motivated.

Systems were in place to monitor the quality of the service and ensure people received the care and support they needed and wanted. A quality assurance consultant had been employed by the provider to support the development of quality assurance and monitoring systems. There were regular audits of care plans, health and safety issues, falls, medicines, pressure care and the environment. Some audits had been developed recently, but they were effective, highlighted shortfalls, and were regularly monitored. Where shortfalls were found, action had been taken or was planned to address issues. For example, the frequency of emergency lighting checks had been changed following recommendations from a health and safety audit.

There were regular staff meetings, and minutes were available. These demonstrated that matters such as best practice in dignity and respect, infection control issues and lessons learned from incidents had been discussed.

The registered manager had established networks with other organisations, and attended local forums. This supported them to keep up to date with local and national issues and developments.

The registered manager was aware of their responsibilities and had notified the Care Quality Commission of events that had occurred within the service as required. They had been open and transparent following incidents, and had spoken with people and contacted families as necessary.

The rating from the last CQC inspection was on display at the service and on the provider's website. The provider is required to display their latest CQC inspection rating so that people, visitors and those seeking information about the service can be informed of our judgments.