Cumbria Care

Applethwaite Green

Inspection report

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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?	Requires Improvement

Overall summary

This unannounced inspection took place on 12th March 2015. We last inspected Applethwaite Green in December 2013. At that inspection we found the service was meeting all the regulations that we assessed.

Applethwaite Green is situated in a residential area of Windermere but in walking distance of local amenities. It provides accommodation up to 28 older people living in three units. The home offers accommodation in single bedrooms and there are suitable shared areas with each unit having its own small kitchen, lounge and dining area. One of the units provides care for people who are living with dementia. There were 25 people living at the home at the time of our inspection.

The service had a registered manager in post. 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 and associated Regulations about how the service is run.

We have made a recommendation about ensuring information relating to people's needs is clearly shared at all levels of staff in the home.

Summary of findings

The service was not being well managed in respect of effectiveness of the quality monitoring systems used to assess practices and improve aspects of the service where needed.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in relation to effectively monitoring and improving the quality of the service people received.

These regulations correspond to 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

We spoke with people who lived at Applethwaite Green in their own rooms and in the communal areas on the units. People living in the home told us that staff were available to help them when they needed this. Everyone we spoke with told us that they felt safe and happy living at the home.

We saw that the staff on duty approached people in a friendly and respectful way and using their preferred names.

People were able to see their friends and families as they wanted and go out into the community with support. There were no restrictions on when people could visit the home. All the visitors we spoke with told us that staff made welcome in the home.

The registered provider had systems in place to make sure people living there were protected from abuse and avoidable harm. They also had safe systems for recruitment to make sure the staff taken on were suited to working there.

Safe systems were in place for the recruitment of new staff and for the induction and on going training and development of staff working there. The staff we spoke with were aware of their responsibility to protect people from harm or abuse. They knew the action to take if they were concerned about the safety or welfare of an individual.

The environment of the home was welcoming and the communal areas were decorated and arranged to make them homely and relaxing. The home was being maintained and we found that all areas were clean and free from lingering unpleasant odours.

Where people were living with dementia there was highly visible signage to show people what different areas of the home were for. This was to support and promote people's independence. The home had moving and handling equipment and aids to meet people's mobility needs and to promote their independence

Medicines were stored safely and records were kept of medicines received and disposed of so all of them could be accounted for.

People knew how they could complain about the service they received and were confident that action would be taken in response to any concerns they raised.

The service followed the requirements of the Mental Capacity Act 2005 Code of practice and Deprivation of Liberty Safeguards. This helped to protect the rights of people who were not able to make important decisions.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was safe.

Staff had been recruited safely with appropriate pre-employment checks. The staff we spoke with knew how to recognise and report abuse.

There were sufficient staff to provide the support people needed, at the time they required it.

Medicines were stored safely and records were kept of medicines received and disposed of so all could be accounted for.

Good

Is the service effective?
The service was effective.

People had a choice of meals and drinks. People who needed

additional support to eat and drink received this help in a patient and kind way.

People's rights were being protected because the Mental Capacity Act 2005 Code of practice and Deprivation of Liberty Safeguards were being followed and applied in practice.

Good

Is the service caring?
This service was caring.

People told us that they were being well cared for and we saw that the staff

were supportive, respectful and that they treated people with empathy and understanding.

The staff took appropriate action to protect people's dignity and privacy and took time to speak with people and gave them the time to express themselves.

Staff demonstrated good knowledge about the people they were supporting and their likes and dislikes.

Good

Is the service responsive?
The service was responsive.

People made choices about their daily lives in the home and were provided with a range of organised activities if they wanted to take part.

Support was provided to follow their own interests and faiths and to maintain relationships with friends and relatives and local community contact.

There was a system in place to receive and handle complaints or concerns raised

Good

Summary of findings

Is the service well-led?

The service was not well-led.

This was because the registered provider had not made sure that all aspects of service provision and record keeping were being regularly monitored for quality assurance and to maintain improvements.

There was a registered manager employed in the home. The staff were well supported by the registered manager and there were systems in place for staff to discuss their practice and to report concerns.

The registered provider had formal and informal systems to gather the views of people who used the service.

Requires Improvement

Applethwaite Green

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 checked 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 12th March 2015 and was unannounced. The inspection was carried out by an adult social care lead inspector.

During the inspection we spoke with 10 people who lived in the home, two relatives, five care staff, domestic staff, the supervisor on duty and the registered manager. We observed care and support in communal areas and spoke to people alone and in groups, in private and communal areas.

We also spent time looking at records, which included looking at seven people's care plans and risk assessments to help us see how their care was being planned with them and delivered. We also looked at the staff rotas for the previous two months, staff training and supervision records and records relating to the maintenance and the management of the service and records regarding how quality was being monitored.

As part of the inspection we also looked at records and care plans relating to the use of medicines.

Before our inspection we reviewed the information we held about the service. We looked at the information we held about notifications sent to us about incidents affecting the service and people living there. We looked at the information we held on safeguarding referrals, concerns raised with us and applications the manager had made under Deprivation of Liberty Safeguards (DoLS).

Is the service safe?

Our findings

Everyone we spoke with told us that people were safe and happy living at the home. People who lived in the home said, "I'm very happy here, there is always someone about so I know I will be looked after". A relative we spoke with told us, "I would not want them anywhere else; I can go home and not worry about anything". They told us that they had not had any concerns about the safety or welfare of their relatives.

People living in the home told us that staff were available to help them when they needed this. We were told that "There's always staff about" and "I have my bell to ring if I want help or a cup of tea".

There was one staff vacancy and the rotas showed some staff were on long term sick leave. This was being covered by temporary staff posts.

We saw that in addition to the supervisor and registered manager there were five care staff on duty. We saw there were two care staff during the day on the unit where the people living with dementia lived and one care worker on each of the other units. There was a 'floater' working between the two upstairs units during the morning shift. A 'floater' is a support worker who helps out where needed. We saw that the floater was helping staff where two carers were needed to assist people. We could see that where one person had been assessed as requiring additional support the 'floater' was being used to give them additional support. We saw that staff were present on all the units during handover periods to support and monitor people on their unit.

Staff on the units 'talked us through' how the 'floater' worked with them to make sure people always had two staff members to support those using hoists. By being available across the units the floater provided help where needed to meet people's needs. Staff said they found the system worked well unless someone called in sick at short notice.

The registered manager did not have formal tools to monitor the staffing levels or the effect on staff of changes in people's dependency. Such tools would be good practice as they assist in formally assessing staffing needs when people's care needs increased or changed

There were sufficient domestic staff in the home to keep it clean and enough catering staff employed to provide a good range of meals.

The registered provider had systems in place to help make sure people living there were protected from abuse and avoidable harm. The staff we spoke with told us that they had completed training in recognising and reporting abuse. Those we spoke with could tell us of what might be abuse and how to report it. All were confident that any allegation of abuse would be taken seriously and action would be taken. One staff member told us "I have never seen anything that worried me" They told us they would feel confident telling the manager about anything that saw that did worry them.

Training records indicated that staff had received this training. Some staff were approaching the time this needed renewing under the organisations' policies and procedures. The manager was aware who needed an update on safeguarding adults and had arranged for this to be provided.

We could see from the minutes of a recent 'resident's meeting' that safeguarding people was also discussed and people had been asked about what they understood by the term. We could see examples were discussed for people to be aware, such as having your bell placed out of reach by staff or being told you could not have a cup of tea when you wanted one. People living there had found this information useful as some at the meeting had not realised this was seen as abuse.

We spent time with people in all the communal areas of the home and observed breakfast and lunchtime meals. We saw that those who could not easily tell us their views were at ease and relaxed with the staff that were supporting them on the unit. We saw that the staff on duty approached people in a friendly and respectful way and using their preferred names.

As part of this inspection we looked at how medicines were managed in the home. We also looked at how medicines were stored. Refrigerator temperatures where medicines were stored. The records showed that medicines requiring refrigeration were stored within the recommended temperature ranges. However the room where other

Is the service safe?

medicines were stored did not have the temperature monitored to help prevent any deterioration of the medicines. We raised this with the registered manager and they addressed this.

We noted that where handwritten changes had been made to administration charts they were not always being checked and countersigned by another staff member. This 'double check' helps to prevent mistakes where information has been added. We discussed this with the manager and could see it had previously been with supervisory staff at their supervisions and at their supervisor's meetings to help make sure all supervisors knew what was required for good practice.

We looked at the handling of medicines liable to misuse, called controlled drugs. These were being stored, administered and recorded correctly. Medicines storage was neat and tidy which made it easy to find people's medicines. We saw that the staff administering the medicines had received appropriate training to do so and that they gave people the time and the appropriate support needed to take their medicines.

We looked at care plans for seven people in some detail and saw that these had been reviewed and updated so that people continued to receive appropriate care. There were risk assessments in place that identified actual and potential risks and the control measures in place to minimise them. This included risks associated with the use of equipment people used in the home, such as bath aids and bed rails.

The risk assessments we saw had been also been reviewed so that risks could be managed and people received appropriate support to stay safe. Where a risk was identified we could see that action had been taken to minimise this. For example, providing the right pressure relieving mattresses and gel cushions when sitting. People's care plans included risk assessments for skin and pressure care, falls, moving and handling, mobility and nutrition. Where possible people were being supported to make their own daily choices and take part in activities outside the home as well as within.

There were contingency plans in place to manage foreseeable emergencies and people had individual emergency plans in place. This was to help make sure that there was information on how to support people if the home needed to be evacuated.

The registered provider for the service had systems in place to ensure staff were only employed if they were suitable and safe to work in a care environment. We looked at the records of three new staff that had been recruited since our last inspection. We saw that the checks and information required by law had been obtained before the staff were offered employment in the home.

We found that the home was clean and tidy and was being maintained. Records indicated that the mobility equipment in use had been serviced and maintained under contract agreements and that people had been assessed for its safe use.

Is the service effective?

Our findings

The staff team working in the home that were able to tell us about the needs and personal preferences of the people they were supporting. Staff were able to tell us about how they cared for people to help ensure they received effective care and support. We were told "I like living here, I like the girls, and they know me and understand I am slow". People living there also told us that they enjoyed their meals in the home saying "It's good food" and that there was always a choice.

Relatives we spoke with told us, "The care has been really good here, the staff really know [relative], they are all top notch". They told us that the staff, "Watch out for weight loss and give drinks to build [relative] up" and also "I have great confidence in the staff".

We spent time with people in the dining areas of the home as they had their breakfast and midday meal. We saw that people had what they wanted for breakfast and could have cooked breakfasts if they let the cook know. People were dressed and sat at the breakfast tables as they wanted. It was relaxed and there was lively conversation and friendly banter between staff and people living there. Staff were chatting with people about what they were doing that day.

Lunch was also a calm and social time. People who required support with eating received this in a patient and respectful way with staff helping and prompting people with their meals.

All of the care plans we looked at contained a nutritional assessment and a weekly or monthly check on people's weight for monitoring. People who were at risk of losing weight and becoming malnourished had management plans in place. We could see these were being given meals with a higher calorific value and also fortified drinks prescribed by their doctors. If people found it difficult to eat or swallow we saw that advice was sought from the dietician or the speech and language therapist (SALT).There was also information on specific dietary needs such as diabetic diets and soft and pureed meals as well as where people had dietary intolerances. This information was recorded in individual assessments and in the care management plans.

People had access to appropriate health care professionals and support services to meet their individual health needs. The care plans and records that we looked at showed that people were being seen by appropriate professionals to meet their physical and mental health needs.

We asked staff about their training and the newer staff about their induction. We could see from training and development plans that new staff had completed a 12 week induction programme and the staff confirmed this. This included recorded competence and knowledge tests that had been signed off by senior staff to help make sure staff clearly understood what was required.

We looked at the registered manager's training plan and training needs log. We could see that training was being monitored and planned for by the registered manager across the year. The registered manager had requested places on the training courses staff needed to attend to keep their training up to date and the dates when this would be provided. This included planned updates for safeguarding adults, fire warden and fire training updates, food safety, dementia awareness and equality and diversity. This proactive approach helped to make sure staff training was kept up to date so staff had the right knowledge and skill for their roles.

The training records indicated that care staff had not received training on the MCA and DoLS. However the supervisors had done this training and they and the registered manager demonstrated an awareness of the MCA codes of practice. Staff told us they would take any concerns about decision making for people or restrictions on liberty to the supervisor to take forward. Staff and supervisors we spoke with told us that they felt they had received appropriate training to carry out their work. They also confirmed that they received regular supervision from the supervisors and records confirmed this and that staff had received an appraisal.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and the Mental Capacity Act 2005 (MCA). The MCA and DoLS provide legal safeguards for people who may be unable to make decisions about their care. We saw that people who had capacity to make decisions about their care and treatment had been supported to do so.

Some people were not able to make important decisions about their care or lives due to living with dementia or

Is the service effective?

mental health needs. We looked at care plans on the suites to see how decisions had been made around their treatment choices and 'do not attempt cardio pulmonary resuscitation' (DNACPR). The records in place showed that the principles of the Mental Capacity Act 2005 Code of Practice were used when assessing an individual's ability to make a particular decision.

We noted that the information around who held Power of Attorney for a person was not always written in some people's care plans. Some care plans had this and some did not. Powers of Attorney show who has legal authority to make decisions on a person's behalf when they cannot do so themselves and may be for financial and/or also care and welfare needs. However supervisory staff we spoke with did have this information in their files and would be able to act appropriately and inform staff. We were told staff also had access to the office to check up if there were no supervisors available, such as on night duty. Staff told us that they would go to the supervisor to make sure before they did anything where they were uncertain. To promote effective shared communication amongst all staff providing care and support information should to be clear in all the care plans on units not just in the supervisor's files.

We recommend that the service consider introducing system to make sure information relating to people's needs is clearly shared at all levels of staff in the home.

Is the service caring?

Our findings

All the people living in the home and the relatives we spoke with made positive comments about the care and support provided in the home. They told us that they made decisions about their daily lives in the home and said the staff listened to them and respected the choices they made. People told us the staff who supported them knew them well and what they preferred in regard to the care they needed. One person told us, “I’ve not been here long, it’s very nice here, I am settling in” and also “I’m glad I came in, it’s comfortable, clean and the girls are kind and patient”.

Relatives told us there were no restrictions on visiting and told us, “They [staff] always make me feel welcome whenever I come and there is always a cup of tea for me”. We were told “The family is welcome here” and also, “They [staff] have always been gentle and kind to [relative]”.Relatives told us they were kept informed by the staff about their family member’s health and the care they received.

All the people we spoke with told us they felt their privacy and dignity were respected and they were always asked how they wanted to be looked after. We saw that when care staff assisted people with their mobility they made sure that people’s clothing was arranged to promote their dignity. We saw that staff knocked on the doors to private areas before entering and ensured doors to bedrooms and toilets were closed when people were receiving personal care. People told us that staff got the doctor when they wanted them and that doctors and district nurses saw them in their bedrooms for medical examination or discussions.

Some people used items of equipment to maintain their independence. We saw that the staff knew which people needed pieces of equipment to support their independence and provided these when they were needed. This included providing people with their walking frames, toilet aids, seat cushions to relieve pressure when sitting and the appropriate use of moving and handling equipment.

We saw that people who needed support with eating were helped by staff in a patient and respectful way. During our observations we saw that the staff offered people assistance but also respected their desire for independence. We saw that staff made the most of opportunities to interact with people and speak with them even if just in passing. This approach can help enhance people’s social wellbeing. We saw that people who could not easily speak with us were comfortable and relaxed with the staff helping them.

We found that a range of information was available for people in the home, and on display in the entrance hall, to inform and support their choices. This included information about the providers, the services offered and about support agencies such as advocacy services that people could use. An advocate is a person who is independent of the home and who can come into the home to support a person to share their views and wishes.

A small number of care staff had received training in end of life care and also a supervisor had done 'The Six Steps' palliative care programme that aims to enhance end of life care. All the care staff we spoke with said they understood how important it was to support people and families properly at the end of life. They told us they had received “very good support” from the district nursing team when caring for people at the end of their lives.

Is the service responsive?

Our findings

All of the people that we spoke with told us that routines in the home were flexible and that they made choices about their lives and activities. They told us they chose where to spend their time, where to see their visitors and how they wanted staff to help. We spoke with people in all the communal areas and we received positive comments about daily life in the home. We were told, by one person that "I think we are all pretty happy here, it's open house for my family and friends to come in and out and I've just seen the optician this morning".

People's health and support needs had been assessed before admission. Assessment continued including gathering personal information that was aimed at reducing their risk of someone becoming socially isolated. Staff demonstrated a good understanding of people's backgrounds and lives and felt that knowledge helped them to support them and be aware of things that might cause them anxiety. We saw that a lot of attention had been given to gathering individual and personal information under 'Story and Gifts' stating what mattered to people and what they enjoyed doing. Some people had chosen to give less information than others and that wish was respected.

We could see where people were actively involved in deciding how they wanted to be looked after. We could see where people had signed their plans and had been involved in reviews with their own link worker in the home and their social worker. Relatives we spoke with told us, "I can talk to the staff and manager anytime and they keep us well informed about any appointments or if [relative] has seen the doctor or nurse.

Information in people's care plans about how they wanted to be supported was clear for staff to be aware of. For example how people wanted to dress, when they wanted to see their hairdresser, attendance at religious services, whether they likes a bath or a shower or carers of the same sex to help them. People we asked said that staff supporting them knew their preferences and interests. Support staff we asked about people's care and recreational preferences were knowledgeable about people's individual needs and choices.

Information on people's preferred social, recreational and religious preferences was clear in their individual care plans. We saw on all the units in the home that staff encouraged people to take part in activities that they enjoyed. Throughout the day we saw people singing, playing musical instruments and visitors and staff joining in. The atmosphere was relaxed and engaging and people living there told us that that did not have to join in with anything unless they wanted to.

People living there told us they were able to follow their own faiths and beliefs. They told us that there were multi denominational religious services if they wanted to attend and that they could see their own priests and ministers if they wanted to.

People living there told us they were supported and "encouraged" to keep up their outside interests and community contacts such as their musical interests. Some people were going out during the day we visited with family and friends to have a meal out or visit the cinema. We saw that some people had developed their own 'memory files with their family and staff. This could be used to provide stimulus for reminiscence and individual activities. Memory boxes help to capture memories and stories about a person's life. They can help to open up communication channels between someone living with dementia and those caring for them.

We found that the registered manager was mindful of the effect admitting too many people with high care needs could have on the person centred support being provided to other people living there. We saw that the registered manager had taken this into account recently when carrying out an assessment with a potential admission to the home where the person had high care needs. The pre-admission assessment had been thorough and effective. It had identified that the person's needs could not have been met in the home without compromising the individual care of others living there without an increase in staff levels.

The home had a complaints procedure that was available and on display in the home for people living there and visitors. Any complaints or concerns raised with the manager or through staff had been logged and records of investigations and correspondence had been kept. People who lived there we spoke with told us they had not felt the need to make a complaint but knew what to do if they felt they needed to. We were told, "I would tell the supervisor or [manager], they would do something if I was unhappy".

Is the service responsive?

We saw from the minutes of the 'resident's meeting' that it was also used as a place to remind people about how to make a complaint or if they had any concerns about someone. Relatives we spoke with also had confidence in the registered manager to act on any complaints. One relative told us, "I actually have had to raise a matter that concerned [my relative]. I was very pleased with the response, [the manager] listened to everything we had to say and did something about it very quickly".

Is the service well-led?

Our findings

Audits of medication records and practice were being done by the manager but had not been formally recorded for monitoring purposes so that they could be monitored. The registered provider had also carried out their own internal quality audits and the last one was in November 2014. At that audit areas of good practice in medication management issues were identified as needing improvement. It was noted that this had been found at the previous four audits and that the service was not following the registered providers' own medication policies.

The manager had addressed this with the supervisors at supervision and at their meetings and through competency checks following the audit and had done random checks. However there were no formal records of the spot checks or audits they did. Therefore the registered manager's audit was not verifiable. We found there were still inconsistencies in good practice in some medication records that had not been picked up using this informal approach and improvements that had been made were not being maintained and therefore the system was not working.

We saw that care plans had been reviewed by supervisors monthly. The registered manager told us that they checked that these reviews were completed and that care plan information was up to date. The registered manager followed up any omissions they had identified from their check with the supervisor at their supervisions. The registered manager did this to help make sure the reviews were done so care staff had the right information to work from. Supervision was used to record this activity and follow up but no separate audit of care plans was recorded to provide an overview and to monitor staff performance.

These demonstrated a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the systems used to monitor the quality of the service people received had not operated effectively to record, evaluate and improve aspects of service provision.

Everyone we spoke with told us that they felt that the home was being well run for them. People who lived in the home and their visitors said they knew the registered manager of the service and saw them on a daily basis. We were told that the registered manager was "easy to talk to" and "I can tell the manager anything and know she will be sympathetic".

We could see that the registered manager was gathering people's views using a variety of methods. We were told by people living there that they had regular meetings so they could discuss what they wanted in their home. The minutes of these bi monthly meetings were displayed so those who did not attend could see what was discussed and agreed. At the last meeting we could see that quality issues had been discussed around food, cleanliness and the support people had received and the agreed actions to be taken. We saw that issues that had been previously raised had been addressed by the registered manager.

We saw that an annual satisfaction survey was done to get people's views of the service and this years had recently gone out to people to get their views.

The home had a registered manager in place as required by their registration with the Care Quality Commission (CQC). All the staff we spoke with told us that they were well supported in the home. They said they had regular staff and supervisor's meetings to discuss practices, share ideas and any areas for development. One staff member told us, "I enjoy my work, I feel I am appreciated".

We saw that the home's two infection control link workers did an annual update on infection control and that included an audit of infection control. There was also an annual financial audit and health and safety audit undertaken by the provider. We could see from records that the home's Operations Manager checked any financial records where the home held people's spending money.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The system in operation to monitor the quality of the service people received had not operated effectively to record, evaluate and maintain improvements made to aspects of service provision. Regulation 17 (1) (2) (a).