Mrs C Lurie

# Philip Cussins House

## Inspection report

33 Linden Road
Gosforth
Newcastle Upon Tyne
Tyne and Wear
NE3 4EY

Tel: 01912135353

Date of inspection visit:
12 January 2016
15 January 2016

Date of publication:
18 March 2016

## 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

The inspection took place on 12 and 15 January 2016 and was unannounced. This means the provider did not know we were coming. We last inspected Philip Cussins House in February 2014. At that inspection we found the service was meeting the legal requirements in force at that time.

Philip Cussins House is a 26 bed care home that provides accommodation for people who require support and personal care. Care was provided to older people, including people living with dementia. Nursing care is not provided. At the time of our inspection there were 19 people living at the home.

The service had a registered manager. 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 said they felt safe at Philip Cussins House. Staff were trained in and understood the importance of their duty of care to safeguard people against the risk of abuse. Staffing levels were based on people's needs and enabled safe and responsive care to be provided. New staff were suitably checked and vetted before they were employed.

The home was clean and there was an on-going programme to maintain the building and furnishings. Safety checks were conducted to ensure people received care in a safe environment. Medicines were managed safely to promote people's health and well-being.

Staff were supported in their roles to meet people's needs. They received training relevant to their roles, their performance was appraised and they received regular, formal supervision.

People's nutritional needs and risks were monitored and people were supported with eating and drinking where necessary. Particular care was taken to ensure people cultural and religious needs were met in this and other areas. People were supported to meet their health needs and access health care professionals, including specialist support.

People were consulted about and were able to direct their care and support. Formal processes were followed to uphold the rights of those people unable to make important decisions about their care, or who needed to be deprived of their liberty to receive the care they required.

Staff knew people well and the ways they preferred their care to be given. People and their relatives told us the staff were kind, caring and respectful in their approach. Our observations confirmed this. Alarm bells sounded infrequently and were responded to promptly. Staff assessed people's needs and risks before they moved in and periodically thereafter. Staff ensured care plans were in place and regularly reviewed. A variety of activities were made available to encourage stimulation and help people meet their social needs.

A range of methods were used that enabled people and their families to express their views about their care and the service they received. This included formal care reviews, 'residents and relatives' meetings, quality surveys and a complaints system.

The management arrangements ensured clear lines of accountability. The home's trustees were a visible presence in the home and knew people using the service well. They were able to articulate the challenges faced by the service, had a clear vision to address these and demonstrated a strong value base that underpinned the operation 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.

Appropriate arrangements were in place to minimise risks and people were cared for safely. Work and storage areas were locked to minimise unauthorised access. The home and equipment was kept clean.

Staff had a good understanding of safeguarding people from harm and abuse and how to report any concerns. A thorough recruitment process was followed when new staff were employed.

People were supported in taking their prescribed medicines at the times they needed them.

### Is the service effective?

Good

The service was effective.

Staff provided effective care that met people's needs. Arrangements for training staff helped them to understand their roles and meet people's needs effectively.

Staff acted in accordance with mental capacity legislation to ensure people's rights were upheld.

People accessed health care services and were supported to maintain their health and welfare. Risks to good nutrition were assessed and people were supported with their eating and drinking needs.

### Is the service caring?

Good

The service was caring.

People and their families had positive relationships with the staff team.

Staff understood people's needs and preferences and treated people with dignity and respect.

People were encouraged to express their views and be involved in making decisions about their care and support.

## Is the service responsive?

Good

The service was responsive.

People's care needs were regularly assessed and recorded in care plans which were kept under review. Staff provided personalised care and were responsive to people's changing needs.

Various social activities were offered and people were supported to access and engage in their local community.

There was a clear complaints procedure which people using the service and their relatives were aware of.

## Is the service well-led?

Good

The service was well led.

A registered manager was in post and there was a visible presence and involvement from the board of trustees.

The registered manager provided leadership and was committed to developing the service.

The registered manager was responsive to feedback from people and this was acknowledged and acted upon. Quality monitoring processes were in place, findings were acted upon and improvements embedded in practice.

# Philip Cussins House

**Detailed findings**

## Background to this inspection

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

The inspection took place on 12 and 15 January 2016 and was unannounced. The inspection team consisted of one adult social care 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.

We reviewed information we held about the home prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We contacted the local authority's commissioning team before the inspection, who provided positive comments about the service.

During the inspection we talked with five people living at the home and three relatives. We spoke with four staff, including the registered manager, and two members of the board of trustees. We observed how staff interacted with and supported people, including during a mealtime. We looked at four people's care records, people's medicine records, staff recruitment and training records and a range of other records related to the management of the service.

Good

# Is the service safe?

## Our findings

People said to us they felt safe and comfortable at Philip Cussins House. One person told us, "I feel very safe here; there is always someone around to help or talk to." Another person commented, "I have worked in several care homes and this is one of the best, if it wasn't I would move." Regarding staffing levels we were told by a person using the service, "There always seems to be enough staff around." They continued, "I don't know about during the night," qualifying this by telling us they always slept very well, and were comfortable with the care they received 24 hours a day.

Staff were able to explain how they would protect people from harm and deal with any concerns they might have. They were familiar with the provider's safeguarding adults' procedures and told us they had been trained in abuse awareness. This was confirmed by the training records we looked at. Staff told us they would report any safeguarding concerns to the registered manager, or if necessary to the local safeguarding team or to the Care Quality Commission (CQC). Staff expressed confidence in the registered manager and felt that if they raised a concern this would be acknowledged and acted upon.

To support the training staff had received, there were procedures and guidance documents available for staff to refer to. These provided explanations of the steps staff would need to follow should an allegation be made or concern witnessed. The registered manager was aware of when they needed to report concerns to the local safeguarding adults' team. There was evidence of safeguarding concerns having been reported to the local authority and investigated appropriately, and these had been notified to CQC. Where necessary, procedures and updated plans of care were put in place to protect people from further risk of harm.

Arrangements for identifying and managing risks in relation to the building were in place. Gas and electrical safety certificates were available and up to date. Working and service areas, such as the laundry, sluices and electrical cupboards were locked to ensure access to these potentially hazardous areas was limited. Corridors, toilets and bathrooms were free from clutter and excess storage, ensuring trip hazards were minimised. Equipment for the safe handling of people was available and subject to regular servicing and safety checks. Where complex moving and handling tasks were carried out, these were subject to an assessment. Staff received training on this area of care.

Staff assessed and documented risksrelated to people's care; covering areas such as pressure area care, nutrition, mobility and behaviour that might challenge the service. Where appropriate, these had been done using recognised assessment documents. Where staff had identified a risk, there was clear guidance included in people's care plans to help staff support them in a safe manner. Staff introduced and updated risk assessments promptly. For example, staff had developed risk assessments relating to falls, pressure area care and bathing. Where needs changed, staff had completed the risk assessment and updated the care plan to provide staff with appropriate guidance on keeping the person safe. Staff we spoke with were able to explain how they would help support individual people in a safe manner.

Staff were safely recruited. We looked at the recruitment records for two staff members and the documentation and checks required by regulation were in place. Before staff were confirmed in post the

registered manager ensured an application form with a detailed employment history was completed. Other checks were carried out, including the receipt of employment references and a Disclosure and Barring Service (DBS) check. A DBS check provides information to employers about an employee's criminal record and confirms if staff have been barred from working with vulnerable adults and children. This helps support safe recruitment decisions.

The registered manager explained there was a minimum of four care staff employed during the morning, up to 2pm, then three in the afternoon and two at night. In addition, two staff were placed 'on-call' each night. A staffing rota was drafted to help plan staffing deployment and record actual shifts worked. We observed staff were busy, but had sufficient time to chat to and build positive relationships with people, in addition to carrying out care tasks and other duties. Call alarms sounded infrequently and were answered quickly. Those staff we spoke with expressed the view that staffing levels were sufficient to provide safe care.

A monitored dosage system (MDS) was used to store and manage the majority of medicines. This is a storage system designed to simplify the administration of medication by placing the medicines in separate compartments according to the time of day. These medicines were stored safely and securely in a locked room. Medicines supplied in the manufacturer's packaging, the supply of which might not always correspond to MDS supply cycle, were subject to regular stock checks to ensure any errors or omissions were minimised and if found quickly resolved. Medicines where the dose varied over time were subject to close monitoring, and those we check had been administered appropriately. Administration records for tablet and topical medicines were completed appropriately and stocks corresponded accurately to those documented.

Staff supported a person to maintain their skills and independence to manage their own medicines. This arrangement was subject to an assessment of risk and kept under review. This ensured the person remained safe and appropriately supported.

Medicines arrangements were subject to periodic audits and the competency of staff to administer medicines was checked. Staff responsible for administering medicines received training on this area of care. Where shortfalls were identified, actions to be taken were highlighted within the audit and an overall action plan compiled. This meant there was a focus on ensuring medicines were managed safely.

Good

# Is the service effective?

## Our findings

People using the service confirmed that staff were caring, supportive and suitably trained. They also told us staff promoted and encouraged their independence. They said they were able to come and go as they wished, and could request the company of staff if they left the building for walks, appointments and other events. One person told us, "I like to do most things myself and the staff encourage me to do as much as possible for myself." Another person said, "The managers are very supportive of staff and encourage their training." People were complimentary about the food. One person said, "The food is lovely, I have put on weight." Another commented, "The food here is kosher and is really good."

Staff told us about the training they had received and this was confirmed by the records we examined. Staff told us they felt supported and attended formal supervision meetings. Staff described the training as "useful," and their supervisions as "helpful." All staff whose records we examined received regular supervisions and had attended a performance appraisal meeting annually. Each staff member had a detailed training record kept on their file to enable monitoring of the training they had received and to aid the planning of that needed in the future. The registered manager also maintained a training matrix document to act as a quick and effective visual guide to review and plan training for the whole staff team.

The training staff had attended included fire safety, food hygiene, adult protection, infection control and first aid. Dementia awareness and supporting people with distressed behaviour were also covered. Training or awareness raising sessions on health and personal care related needs, such as nutrition and hydration and sensory loss, were also evident.

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. 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 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).We discussed the requirements of the Mental Capacity Act (MCA) 2005 and the associated DoLS with the registered manager. They demonstrated an awareness of the MCA and DoLS and had made appropriate applications where required. Staff we spoke with were also aware of the MCA and DoLS. Records showed staff had received training in this area.

Staff recorded people's decision making capacity within care plans and capacity and decision making was considered as part of a formal assessment. These assessments were recorded on documentation supplied by the authorising authority (Newcastle City Council). Where people were subject to a DoLS the registered manager had notified CQC of the outcome of the application.

The people we spoke with told us they liked the food provided. Staff undertook nutritional assessments and if necessary drew up a plan of care. This was reviewed periodically. People's weight was regularly monitored to ensure care was effective and to identify the need for additional advice and support from the GP or dietitian. We saw this support and advice had been arranged where a person was at risk of malnutrition and supplementary food products had been prescribed for them.

People using the service and their relatives confirmed that health care from health professionals, such as the GP's or dentist could be accessed as and when required by making a request via staff or the registered manager. One person told us the carers helped them if they needed to attend any hospital appointments and that staff were observant and attentive; staff would notice if they were unwell and would call a doctor if necessary. We saw a compliment form a relative who had praised the staff for how they had promptly sought medical intervention for a person using the service. The compliment continued, "The outcome could have been much more serious if (staff names) had not been so determined to have my relative seen at the (hospital) that day."

Records we looked at confirmed people were registered with a GP and received care and support from other professionals, such as the chiropodist, dentist and optician. Links with other health care professionals and specialists to help make sure people received appropriate healthcare had been documented. For example the input of hospital staff was documented and their advice was incorporated into care plans. This confirmed people's healthcare needs were considered within the care planning process. Care plans were up to date and completed appropriately. Medical history information was gathered and some people had advanced health care plans which detailed their wishes and the care and treatment to be provided in certain situations, such as when they became seriously ill.

Good

# Is the service caring?

## Our findings

People told us the staff were caring. Comments made to us included, "It's the best place to live, the staff are all very caring;" "The staff are lovely here, they do a very good job;" "The staff are very caring, they look after me very well;" and "They treat me with great respect, I think that is so important."

We observed people using the service appeared happy and were well-dressed; with co-ordinated clothing and jewellery. One of two similar comments made to us was, "I am very happy with the laundry. It is taken away and comes back clean and ironed."

People using the service confirmed that staff knocked on the door or called out, awaiting a response before entering the room. We observed staff doing this in practice. People also told us that staff asked their permission before providing care or assistance. We saw visitors come and go throughout the day and they were made to feel welcome.

During lunch staff interacted well with people, providing support when asked or required and regularly checking if people required more food and drink and encouraging others to eat more. Staff ensured meal times were a positive experience. We saw the dining tables were nicely set with cloths, napkins and flowers. The required cutlery and crockery was laid out for the meal in readiness. The chairs are comfortable with arms and there was plenty of floor space for people with wheelchairs to access the tables. Juice and water were made available throughout the meal. Those people who took a little longer than others to finish their food were not rushed. The registered manager told us about themed 'food from around the world' meals. Each month food from a different part of the world was prepared and this formed part of themed activities.

People using the service and staff were very comfortable in each other's company. We observed staff to be caring. For example we observed staff speaking in a kind and gentle manner to the people they had contact with.

Staff we spoke with understood their roles in providing people with effective, caring and compassionate care and support. Staff were knowledgeable about people's individual needs, backgrounds and personalities and were able to explain how they involved people in making decisions. We observed people being asked for their opinions on matters, such as drink choices and they were routinely involved in day to day decisions within the service.

People we spoke with and records confirmed that people using the service and their relatives (where appropriate) were aware of their care plans. Where people lacked capacity, relatives were involved in care decisions and kept up to date about their relative's needs.

People said their privacy and dignity were respected. We did not observe any instances of people receiving personal care within public areas. Staff we spoke with and the registered manager were able to clearly explain the practical steps they would take to preserve people's privacy. Examples they gave included knocking and awaiting a reply before entering a person's room, and closing doors, blinds or curtains when

providing personal care. This was observed in practice and meant people's privacy and dignity was respected.

Good

# Is the service responsive?

## Our findings

People and their relatives said staff were responsive to their needs and that they were listened to. People also confirmed activities were offered. One person said, "When I press the call button I never wait long for someone to come to me." A relative told us, "The home encourages relatives and residents to have an input into the residents care plan." They continued, "The (care) plan was reviewed six months after my relative came to live here, and we were invited to attend the meeting. I strongly believe that our views were welcomed and listened to and our suggestions included in the (care) plan." All the people we spoke with told us they were happy with the response of the carers when they requested something, or pressed their call buttons. A person commented to us that the notice board was not at a suitable height for them to view. We raised this comment with the registered manager who acknowledged this and undertook to address the concern.

We observed instances of staff being responsive to people's various requests, such as when using their call alarms and when they were mobilising (moving around). Such alarms were answered promptly and sounded infrequently.

People's care plans included needs assessments being carried out before a service was provided. From the information outlined in these assessments individual care plans were developed. These were put in place to ensure staff had the correct information to respond to people's health needs, well-being and individual identity.

Care plans covered a range of areas including diet and nutrition, psychological health, personal care, managing medicines and mobility. We saw if new areas of support were identified then care plans were developed to address these. Care plans were reviewed regularly and were sufficiently detailed to guide staffs care practice. The input of other care professionals had also been reflected in individual care plans and these documents were generally well ordered.

To monitor people's needs, and evidence the support provided, staff kept individual progress notes. These offered an ongoing record of people's well-being and outlined what care was provided. Staff also completed a daily handover record, so oncoming staff were aware of people's health, their immediate care needs and any forthcoming appointments. Staff periodically reviewed care plans, documented people's changing needs and progress and these documents were up to date. The language used in care records was factual and respectful. Records also focussed on people's strengths and were positively worded.

When talking about personalised care, staff had a good knowledge of the people using the service and how they provided care that was important to the person. The staff we spoke with were able to answer the queries we had about people's preferences and needs.

We saw visitors coming and going freely and a range of activities were offered. Staff spent time socialising with people as well as providing care. We saw staff take time to sit and talk with people using the service. A computer was available for people to use, and we saw this being accessed during our inspection. Staff

maintained files detailing the activities provided, which included a photographic record of such events. Examples of activities included games, competitions and themed evenings. From the photographic evidence kept on the different activities files, it was apparent that the majority of people took part in various activities. People's spiritual and religious needs were also respected and promoted. This included supporting people's religious observance and ensuring care plans recorded people beliefs and preferences.

A copy of the complaints procedure was available in a public space. We reviewed the records of complaints received since the beginning of 2015 and saw there was one logged as received. Record showed the complaint was acknowledged, investigated and an outcome communicated to the person concerned. We reviewed our own records and no complaints were made to CQC about the service. A record of compliments was also kept, as well as numerous thank you cards. Comments included; "What can I say about the carers; I'm afraid it is nothing but good;" and "Their patience is supreme."

Good

# Is the service well-led?

## Our findings

At the time of our inspection there was a registered manager in place. They had been registered in respect of this service in September 2014.

People we spoke with told us they were happy at the home and with the leadership there. They told us that staff interacted well with people using the service and that they were caring, supportive and helpful. When we were shown around the home by the registered manager, people using the service knew who the registered manager was, who in turn appeared to know people well. People told us the registered manager was approachable and was always available. Staff told us they felt supported and that there was good leadership. One said, "The manager's very approachable and down to earth." Another told us, "We're kept informed and up to date."

More senior leaders also had a visible presence in the service, and during the inspection members of the board of trustees visited the home and took time to speck with us. They appeared to know all the people using the service well and we observed them spending some time talking with people. The trustees we spoke with were able to articulate their priorities for the service; clear about the challenges the service faced, and explained their plans for overcoming these. Along with the registered manager, their stated values were focussed on meeting the care and spiritual needs of the people living at Philip Cussins House.

The registered manager was present and assisted us with the inspection. They walked round with us for part of the inspection and records we requested were produced for us promptly. The registered manager was able to highlight their priorities for developing the service and was open to working with us in a co-operative and transparent way. They were clear about the need to send CQC notifications for notifiable events on behalf of the registered provider. Relevant events were notified to us.

We asked people using the service what they felt could be improved to enhance life in the home. We received no suggestions for improvement; they told us they were very happy with the standard of care and the building. One person told us, "It's like living in a five star guest house."

The registered manager encouraged relatives and people using the service to attend three monthly meetings to bring forward any suggestions and comments about the service.

The management arrangements ensured clear lines of accountability. The registered manager held overall responsibility for the day to day operation of the home, and they were supported by a deputy and senior carers. Care staff were aware of who the registered manager was and confirmed they had a visible presence in the home. Staff also said they would recommend the home to a friend or relative.

The register manager's stated philosophy for the home was, "Ensuring service users are at the centre of what we do." Values included, "Ensuring respect and being mindful of the transition to care; offering support and being caring for people." The registered manager was aware of good practice through studying at degree level in disability studies, having completed a registered manager's qualification and by ensuring they

attended network group meetings.

There were arrangements in place for assessing and monitoring the quality of care, which included scrutiny and oversight from the trustees. Quality checks covered areas such as infection control, medicines and fire safety. Audits and other quality checking systems were completed thoroughly and there was evidence that the system were used to identify areas for continued improvement. Quality monitoring arrangements included seeking and acting on feedback from the people using the service and their relatives and also included seeking the comments from stakeholders, such as social workers and service commissioners. Comments from a stakeholder survey included, "The service users are always happy and speak very highly of the home and their care," "There is always lots going on for service users to look forward to," and "From what I have observed service users appear to have their needs met and catered for."