Rockley Dene Homes Limited

Cherry Hinton Nursing Home

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?	Good

Summary of findings

Overall summary

Cherry Hinton Nursing Home is registered to provide accommodation, nursing, and personal care, for up to 59 people. At the time of our inspection there were 42 older people and people living with dementia at the service. There are a number of communal areas, including a hairdressing salon, lounges and dining areas, a conservatory and a secure garden for people and their visitors to use. The home is situated over three floors, with the ground floor and first floor providing accommodation. There are bedrooms on both floors which can be accessed by either the stairs or a lift. There were communal toileting and wash facilities for people who used the service.

This unannounced inspection was carried out on 18 September 2017. At the last comprehensive inspection on 28 October 2016, the service was rated as 'requires improvement.' This was because we found a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014; Safe care and treatment. This meant that we could not be assured that people would be given their medication safely.

We carried out a focussed inspection on 7 December 2016 due to further concerns raised with the Care Quality Commission. We found that the service had made improvements around the safe management of medicines but was now in breach of the following regulations:

- Regulation 18 Registration Regulations 2009; Notifications of other incidents.
- Regulation 12 HSCA RA Regulations 2014; Safe care and treatment.
- Regulation 13 HSCA RA Regulations 2014; Safeguarding service users from abuse and improper treatment.
- Regulation 17 HSCA RA Regulations 2014; Good governance.

We undertook another focused inspection on 7 April 2017 to check that the provider had followed their plan. During this inspection we were able to confirm that they now met legal requirements.

At this comprehensive inspection carried out on 18 September 2017, we found that the service had continued to make the necessary improvements.

There was no registered manager at the time of this inspection. However, provision had been made as there was an interim manager in post and deputy manager to oversee the day-to-day running of the service. This was until the new manager commenced their employment. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Staff encouraged people to make their own choices. Staff assisted people in a way that promoted their safety and in the main; people were looked after by staff in a kind and caring manner. Staff were

knowledgeable of how to report incidents of harm and poor care. Additional safeguarding training for all staff had been put in place as a result of a recent alleged incident.

People's privacy and dignity was promoted and maintained by staff. Staff were trained to provide effective and safe care. People were supported to take their medicines as prescribed and safely.

People and their relatives or advocates were involved in the setting up and agreement of their or their family member's care plans. People's care records took account of people's wishes and any assistance they required. Risks to people who lived at the service were identified and adequate plans were put into place by staff to minimise and monitor these risks. However, these plans were not always a detailed record.

People were looked after by enough, suitably qualified staff to support them safely with their individual needs. Where there was a shortfall in staffing numbers, agency staff were used. here was a documented process to determine safe staffing levels in conjunction with people's assessed dependency needs.

People were supported to eat and drink sufficient amounts of food and fluids. Staff monitored people's health and well-being needs and acted upon issues identified. Staff supported people to access a range of external health care services where needed and people's individual health needs were met.

Activities took place at the service; however, some people felt that the number and type of activities taking place could be increased or improved to enhance social interactions. People were encouraged to maintain their links with the local community to promote their social inclusion.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff enjoyed their work and were supported by the interim and deputy managers. Staff understood their roles and responsibilities and were supported to maintain their skills by way of supervision and appraisal. Pre-employment checks were completed on new staff members before they were deemed to be suitable to look after people living at the service.

The service was responsive and flexible to people's needs. People maintained contact with their relatives and friends and they were encouraged to visit the service and were made welcome by staff.

There was a formal process in place so that people's concerns and complaints could be listened to and acted upon. However, concerns documented in people's communication books were not always acted upon by staff. Wherever possible, formal complaints were resolved to the complainants' satisfaction.

Arrangements were in place to ensure the quality of the service provided for people was regularly monitored. People who lived at the service, their relatives and staff were encouraged to share their views and feedback about the quality of the care and support provided. Actions were taken as a result to drive forward any improvements required.

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's medicines were managed safely.

Staff were aware of their responsibility to report any concerns about suspicions of harm and/or poor care.

People's care and support needs were met by a sufficient number of suitably trained staff who had been recruited safely.

Is the service effective?

Good

The service was effective.

The provider was acting in accordance with the principles of the Mental Capacity Act 2005. People had no unlawful restrictions imposed on them.

People's nutritional and hydration needs were met.

Staff were trained to support people effectively. Staff performance was reviewed via supervisions and appraisals.

People were enabled to access external healthcare provision when required.

Is the service caring?

Good

The service was caring.

People's privacy and dignity was promoted and maintained by staff.

People and their relatives were involved in the setting up and review of their care records.

Arrangements were in place to support people with accessing advocacy services if needed.

Is the service responsive?

Good

The service was responsive.

Activities for people living at the service were sometimes limited. This meant that people were put at risk of social isolation.

People's support and care needs were assessed, discussed, planned, agreed and appraised to make sure they met their current requirements.

There was a process in place to receive and manage people's suggestions, concerns and/or compliments.

Is the service well-led?

Good

The service was well-led.

Governance and audit arrangements were effective in identifying areas for improvement.

People were given opportunity to engage with the service and feedback on the quality of service provided.

A registered manager was not in post. There was an interim manager in place to oversee the running of the service and they supported an open and honest staff culture.

Cherry Hinton 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 unannounced inspection took place on 18 September 2017. The inspection was carried out by two inspectors and an expert-by-experience. An expert-by-experience is somebody who has had experience of a family member living in this type of service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at this and other information we hold about the service. This included information from notifications received by us. A notification is information about important events which the provider is required to send to us by law. Before the inspection we received information from a fire safety officer to aid us with planning this inspection.

During the inspection we spoke with eight people who used the service, three relatives, the operations director, the interim manager; project manager; deputy manager; and sales and marketing administrator. We also spoke with a visiting GP, a nurse; three care staff and an activities co-ordinator. We looked at four people's care records and records in relation to the management of the service, management of staff, management of people's medicines and staff files.

We also observed staff interactions with the people they supported to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People and relatives of people said that they, or their family members, felt safe living at the service. This was because of the support and care provided to them or their family member by staff. They confirmed to us that they knew who to contact if they had any concerns. One relative told us, "I have booked a holiday. I feel that [family member] is safe here and that I can go." A person said, "I am safe here, I know someone will come and so I feel safe." Another person told us, "I feel safe here, they [staff] check and see if I am okay and I feel comforted by that."

During the inspection, a safeguarding concern was raised with the CQC about how a person was supported by staff member during the night time. This concern echoed a similar safeguarding concern shared with the CQC and the local authority safeguarding team by the management of the service prior to this inspection. As a result of this allegation, all staff were expected to attend additional mandatory safeguarding training, which set out the expectations of the service. CQC shared the new allegation with the interim manager and deputy manager on the inspection day and asked them to investigate. The local authority adult social care and safeguarding team were also informed.

Staff spoken with were able to show that they knew how to recognise and report any suspicions of poor care and/or harm. They gave different examples of the types of harm and described what action they would take in protecting and reporting such incidents. This included reporting concerns internally or to external agencies. One staff member said, "There is a telephone [number on display] in the downstairs entrance to use to report a concern." Another staff member told us, "I would report [concerns] to the nurse in charge." A person confirmed to us, "They aren't a forceful staff. We can do things as we want to." Training records confirmed that staff had received training in respect of safeguarding adults. This meant that staff knew the processes in place to reduce the risk of harm occurring and their duty to report concerns in a timely manner.

Records showed and staff told us that they had to complete an application form, when applying to work at the service and had attended a face-to-face interview. Records looked at showed that there was a process of pre-employment checks carried out. These were to confirm that the proposed new staff member was deemed to be of a good character. Staff spoken with confirmed that these checks were in place prior to them starting work at the service. Checks included, but were not limited to; proof of identity; reference checks from previous recent employment; criminal records checks from the disclosure and barring service (DBS) and gaps in employment history explained. This showed us that there were checks in place to make sure that staff were deemed suitable to work with the people they supported.

Staff were aware of their responsibilities and roles in keeping people safe. Care and support plans and risk assessments were in place with guidance set out for staff to follow. Risks included, but were not limited to; people being at risk in relation to their moving and handling needs; being at risk of falls; the risk of having bedrails in situ; self-neglect and social isolation and a person's nutritional and hydration risk. These assessments included any actions to be taken by staff to minimise the risk of harm to people as far as possible. However, we saw that some people's care and support plans and risk assessments were not

always detailed records. For example, a person's preferred toiletries during their personal care and the type and size of continence pad used were not recorded. We spoke with the interim manager about this during the inspection and they confirmed to us that this would be reviewed.

There was fire register of all people living at the service; this was in the event of a foreseeable emergency such as a fire. The service had a recent inspection by the local fire safety service and the findings were deemed satisfactory. On the day of this inspection, staff were attending fire safety training. This showed us that there were arrangements in place to assist people to be evacuated safely in the event of an emergency.

We looked at records for checks on the home's utility systems and building maintenance. These showed that the interim manager made checks to make sure people were, as far as possible, safely cared for in place that was safe to live in, visit and work in.

People and their family members did not raise any concerns with the way prescribed medicines were managed. Observation showed that the medicines trolley was locked by the nurse during the medicines round when they were not in attendance. We noted that the nurse did not sign to say that the prescribed medicine had been given until people were seen swallowing their medicine. People had their medicine explained to them prior to administration and were encouraged to take their medicine from the nurse. We observed that this was done in a patient and kindly manner that was at the person's preferred pace.

We saw that medicines were stored securely, at the correct temperature and disposed of safely. There was basic information in place for people who required support with their 'as and when needed' (prn) medicines. Such as those for pain relief and/or increased agitation and the frequency people could have these medicines if required. Medicine administration records (MARs) we looked at, showed that medicines had been administered as prescribed.

The interim manager told us that one of the services biggest challenges was the recruitment of staff. This meant that agency staff were used. To try to ensure continuity of care, consistent agency staff were utilised, wherever possible, so that they would know the service and the people they were assisting. A staff member told us, "There is usually enough staff unless people [staff] are sick and phone in at the last minute." A visiting GP said, "I visit every week. It is much easier when you have the same staff; it is harder when there is agency staff. The management have made huge efforts since the last CQC visit. They are trying to get more staff and continuity of staff."

A dependency tool was in place to determine safe staffing numbers based on people's assessed health, care, and support requirements. We found that there was a mixed response from people and their relatives who told us whether there was enough staff on duty to meet their or their family member's needs. One person said, "Someone [staff member] usually comes quite quickly, unless it is a busy period." However, one person told us, "Sometimes I ring the bell [care call bell] when I need the toilet and then if they don't come quickly it is difficult." A third person said, "They [staff] are lovely but they are short staffed and they don't have time to chat except when they are helping me." During this inspection we saw that there were adequate numbers of staff to meet people's needs. Staff were very busy but did not hurry the people they were supporting.

Good

Is the service effective?

Our findings

Staff told us, and records confirmed that they received training to deliver effective care and support that met people's individual requirements. One staff member said, "We get lots of training." Records of training undertaken included; basic life support; equality and diversity; moving and handling; food hygiene awareness; safeguarding adults; dementia awareness; health and safety; and fire safety. Other training included, but was not limited to; the Mental Capacity Act (2005), deprivation of liberty safeguards; challenging behaviour; pressure area care awareness; privacy and dignity; information governance and infection control. Records showed that not all staff had completed their training, and the interim manager told us that there was an expectation for staff to complete their training and that this was being monitored.

Supervisions and appraisals (performance and development plans) were used by the interim manager to monitor staff members' progress. These meetings were also a place to discuss any additional support needed, and any training and developmental needs. This demonstrated to us that staff were supported to maintain and develop their skills and knowledge. However, we noted, and the interim manager told us that one of the improvements that was on-going was for all staff to receive regular supervisions.

New staff completed an induction programme. Staff told us that their induction consisted of training, getting to know the organisation and service, and 'shadowing' a more experienced staff member. This was until the interim manager deemed them competent and confident to carry out care and support.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes are called the Deprivation of Liberty safeguards (DoLS). People's capacity to make day-to-day decisions had been assessed by the registered manager. Staff we spoke with demonstrated to us a basic understanding of how they put their MCA and DoLS training into practice by supporting people to make choices using visual prompts. We found that people were supported with making their decisions and had no unlawful restrictions imposed on them.

People told us that staff asked them their preferred choices and respected these decisions. This was confirmed by observations throughout the inspection. One relative said, "The choices of the family are respected. I make decisions on [family member's] behalf and they [staff] always respect my choice." Another person told us, "Some days I just like to stay here (in bed) and that's fine. That's what I do." This demonstrated to us that people's choices were respected by the staff members assisting them.

Our observations showed that people could eat in the communal dining areas or have their meal in their room or lounges if they preferred. Dining tables were laid with a tablecloth, and a placemat to enhance the dining experience for people. Adapted cutlery and plate guards were used to support people, who required this assistance, to help maintain their own independence. However, there were no pictorial/visual prompts used to aid people with short term memory to choose what they would like to eat. This was a missed opportunity for people who may have benefited from having this additional visual prompt.

We saw that the majority of staff supported people, who required additional assistance in an engaging and patient manner. We observed one staff member interacting with the person they were assisting and was rewarded with conversation and jokes. This meant that the dining experience for that person was enhanced due to this positive interaction. However, we also observed a staff member watching the television whilst supporting a person with their drink. This meant that the dining experience for this particular person would have been less positive as the staff member was not engaging with them whilst supporting them.

Alternative meal options were offered to people if they did not want the two main options on offer. People and their relatives had positive views about the food on offer. One person said, "I have a small appetite but if I don't like the choices I can have an omelette." Another person told us, "The chef is very good and will try to help if someone wants something different." A relative said, "I eat here sometimes and the food is very good." People were given the option to have hot and cold drinks and snacks, between meals. Observations showed that when people asked for extra food and drink, that staff facilitated these requests.

People were supported to access a range of health care services to maintain their health and well-being. Records showed that external health care professionals such as, dieticians, community nurses and GP's were involved in people's care as and when required. One person told us, "A GP comes in and we can ask to see her." Another person said, "If I am not well they [staff] put me on the list for the GP." A third person told us, "If I need any appointments at the hospital then the home [staff] arranges it for me." A visiting GP told us, "In general staff follow guidance given, staff do listen."

Good

Is the service caring?

Our findings

Our observations during this inspection showed that staff cared for people in a kind and caring way. We saw one staff member giving a person a hug because the person was a little distressed and we observed another staff member putting their arm around a person to reassure them. These positive interactions helped elevate the person's increased anxiety. The majority of people and relatives of people we spoke with had positive comments to make about how kind the staff were. One person said, "They [staff] are very kind to me." A relative told us, "On the whole [family member] is very well looked after." Another relative said, "The carers [staff] are very good mostly, they look after me too." However, another person told us, "On average the staff are very good, there's always one or two that aren't so nice."

One room within the service was for double/shared occupancy. People's privacy and dignity within these rooms were promoted and maintained by the use of a separating curtain. People and relatives of people told us that staff respected their family member's privacy and dignity. One person said, "They [staff] are very careful, they close the door if they are helping me." Another person told us, "They [staff] always ask [me], they never just go ahead and do things."

We saw that staff were kind and patient, particularly when people were becoming distressed. We observed that staff kneeled beside people who were sitting, so that they were at eye level, took people's hands to reassure them and talked calmly to them about topics that would distract the person. We noted that throughout the inspection, people recognised staff, interacted with them and responded to them often with smiles, a 'thumbs-up' and humour. With the support from staff and the interim manager, people's rooms had been individually decorated with their own belongings, including furniture items. This meant that these individualised rooms enabled each person to make the service their own home.

During this inspection we saw that people were supported to maintain contact with their relatives and friends. Visitors to the service told us that they were made to feel welcome by staff. One relative said, "I can come in and out whenever I want to." Another relative told us, "There is no charge for lunch [when visiting] and I came on Christmas day and we had a wonderful Christmas lunch, all provided."

People's needs were planned for; this included a person's wishes. These plans gave adequate information to staff to help them understand how to support people to meet their required needs. Although, these records were not always as detailed as they could be, particularly around people's individuality and their specific health care conditions. Records also included people's end of life wishes, including, where appropriate, a wish to not be resuscitated. One relative confirmed to us that, "The family discussed everything and the home [staff] have been very good and respect our wishes, so does the doctor."

Records confirmed that people and/or their relatives were involved in the setting up of their care plans. Relatives told us that they felt involved in their family members care. One relative said, "[Family members] care plan is always discussed. I am very involved and they always contact me at home or on my mobile if there is any problem at all."

People's care records were held securely. This decreased the risk of other people and visitors to the home having access to these records.

Advocacy services were available to people at the service should they wish, on request. Advocates are people who are independent and support people to make and communicate their views and wishes.

Good

Is the service responsive?

Our findings

We looked at compliments and complaints received by the service. We saw that there was a formal process in place if people ever needed to complain, raise concerns, make suggestions and provide compliments. Compliments received by the staff at the service included, "We are very happy with the care provided in the short time of respite that our [loved one] received," and, "How happy we were with his care…always compassionate."

People and relatives of people using the service, said that they knew how to make a complaint. One person told us, "I haven't had the need to complain, I would sort things out with the carer [staff] or nurse." In each person's room, there was a communications book. This was a book in which people or their relatives could make suggestions or concerns they may have had, for staff to respond to and resolve. One relative told us of how they had written five entries over a six week period about the same concern; however staff had not made the requested improvement. We spoke with the interim manager about this during this inspection and they told us that they would look into this.

We looked at the services formal complaints records. We saw that the complaints listed within this record had been investigated and actions taken to resolve the complaint, where possible to the person's satisfaction. Staff we spoke with were aware of the procedures to follow if anyone raised a concern with them. This showed us that the majority of people's complaints were taken seriously and dealt with appropriately.

Records showed that people's requirements had been assessed before they moved into the service to make sure that the staff could meet the person's needs. Care plans contained basic information about people's life history before they moved into the service and their current care and support needs. These records were reviewed on a regular basis. These reviews also looked at what was working well and that any changes to the person's care and support required. One relative said, "I am very involved in the care. I even sit in if the doctor comes in [family member] wants me to and I want to know what is going on too. They [staff] support that because it is what we want."

People and relatives of people living at the service told us the interim manager, deputy manager and staff were willing to listen to their views. Meetings were held as a forum for relatives and people to be given organisational updates and raise any suggestions or concerns that they may have. One person said, "We do have a residents meeting, I don't go much but they can be useful." Another person told us, "Yes, there are residents meetings." These included discussing the proposed redecoration of the service, staff and management updates and the use of agency staff.

People, and their relative's told us and we observed that they or their family member had access to activities within the service and some links within the community. During this inspection we observed limited activities taking place. The interim manager explained to us that they were currently recruiting an additional activities co-ordinator. People's opinions of the activities provided were mixed. One relative said, "There are things going on and [family member] does like to join the [religious service] and scrabble." Another relative

said, "[Family member] loves animals, they have a pat dog [visit] and some donkeys came in. They [staff] always come and get [family member] if there are animals in [visiting], they know she loves them." A third relative told us, "Everyone gets a birthday cake and residents are given birthday and Christmas presents." However, one person said, "There are activities going on sometimes, but they really aren't my kind of thing." Another person told us, "Sometimes I go to the exercises, they are alright but a bit silly."

People were encouraged to maintain their links with the local community. One person said, "My son comes and he takes me out." A relative said, "They went to the zoo, the people who went had a great day." This showed us that people's social inclusion was promoted.

Good

Is the service well-led?

Our findings

There was no registered manager in post. To help with the day-to-day running of the service there was an interim manager in place supported by the deputy manager. This was until the new manager took up their position. The interim manager was supported by a team of care and non-care staff. An agency staff member told us, "I like to come back here to this home because they treat me as a member of the team." Staff demonstrated to us that they understood their roles and responsibilities and told us that they felt supported to carry out these roles.

The interim manager showed us that there were arrangements in place to monitor the quality and safety of the service provided. Examples of quality monitoring checks that took place included night visits to the service; weekly home manager report on the service; infection control audits; housekeeping standards; catering audits; health and safety; people's oral health and medication audits. Actions from the most recent audits included improvements in housekeeping and catering. We noted that these improvement actions were completed or on-going.

Organisational quality monitoring of the service was also in place. These checks included a 'quality assurance frame work' and a 'monthly visitor's experience,' report. Actions from one of these visits were that fresh fruit and snacks were to be available to people living at the service at all times. This was observed during this inspection. There was also a 'continuous improvement plan' in place that looked at all areas within the home and the improvements required. Actions from this plan included, but was not limited to; improvements in people's dining experience,' to be made. This demonstrated to us that the provider had a system in place that assessed the quality of the service, including shortfalls and actions taken to address them to drive forward improvements.

Some relatives and people were unsure of who the interim manager was at the service. This was due to a number of changes of the management team in the past few years. One relative told us, "There have been a lot of changes so I am not sure [who the manager is]." People and their relatives had positive opinions about the management team. One person said, "There's the [deputy manager] he's helpful." Another person told us, "[Deputy manager] is on the ground and with us a lot. There's a lady involved [interim manager] in some things but I don't know her name."

Meetings were held at the service to keep people and their relatives updated with any changes. Relatives described the service as having an 'open door policy' which meant that they, in the main, felt listened to and engaged with. To aid with communication we saw also saw that the management team had introduced a newsletter for relatives which updated them on the service, introduced new staff members and any up and coming activities planned. This showed us that there were meetings held to engage people living at the service and their visitors, with the running of the service.

Staff attended meetings and they were well attended. Staff said that they could raise any suggestions and/or concerns that they might have and be listened to. Records showed that at these meetings, information and ideas on how to improve the service were discussed and updates on people's health, care and support

needs. Staff meetings were informative about the expectations of the provider and updated staff about any changes to the management team. Updates also included any organisational changes and reminded staff of their roles, responsibilities, and standards expected when providing people with safe care that met their individual needs.

Surveys for people were carried out so that people could voice their opinion on the service provided. Feedback received showed that people found the care and support provided to be positive, but actions documented to improve the service included, 'improvements in the food' and 'more staff.'

Staff were also asked to feedback on the service in 2017. The feedback was mainly positive with some areas for improvement noted. However, staff said that that they believed that the provider of the service would take action based on the feedback from this survey.

Staff were aware of the whistleblowing policy and procedure and their responsibility to raise any concerns that they may have. They told us they would have no hesitation in whistle-blowing if the need arose.

Notifications are for events that happen at the service that the interim manager is required to inform the CQC about such as a person experiencing a serious injury after a fall or safeguarding concern. Our findings indicated to us that the interim manager informed the CQC of these events in a timely manner.