Bupa Care Homes Limited

Croft Avenue Care Home

Inspection report

Croft Avenue
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Penrith
Cumbria
CA11 7RJ

Tel: 01768867155

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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

This inspection took place on 23 and 24 August 2017. The first day of the inspection was unannounced. This meant the staff and provider did not know we would be visiting.

Croft Avenue Care Home provides personal care and accommodation for up to 30 people some of whom were living with dementia On the day of our inspection there were 26 people using the service.

There was no registered manager in post. A new manager had been appointed and was in the process of registering with CQC. Croft Avenue had not previously been inspected by CQC under its current registration.

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.

There were suitable numbers of staff on duty during our inspection. We received feedback that staffing had improved of late although we received mixed reviews about this. We have therefore recommended that staffing remain under review in light of concerns raised.

Staff had received training in the safeguarding of vulnerable adults and were aware of the procedures to follow. Recruitment processes included the vetting of applicants to ensure they were suitable to work with vulnerable adults.

Procedures for the ordering, receipt storage and administration of medicines were satisfactory. The trolley was not secured to the wall when medicines were administered from the corridor. We received feedback from the provider following the inspection that this was now secured following our feedback.

Risks to people and general risks were assessed and plans were in place to mitigate these. The building was clean and tidy and well maintained. Regular safety checks on the premises and equipment were carried out. The environment did not fully meet best practice in relation to supportive design for people living with dementia. We have made a recommendation about this. We also found the laundry door did not have a lock and there was a risk people might access this area who lacked capacity. All hazardous substances were locked away. A key pad was immediately put in place to reduce this risk.

Staff received regular training, supervision and appraisal to ensure they had the skills and support necessary to do their job effectively. Specialist training was provided, for example in relation to mental health needs, when required.

People were supported with eating and drinking. Nutritional needs were assessed and plans were in place to support people to maintain a healthy body weight. Support from a GP or dietitian was sought when

required.

The service was operating within the principles of the Mental Capacity Act 2005. 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.

We observing caring interactions between staff and people. Staff supported people sensitively and discreetly and demonstrated they knew people well. They were cheerful and supported the privacy and dignity of people as they went about their work.

A new manager was in post who was in the process of registering with CQC. We received a number of reports regarding the positive impact the manager had on the service and staff morale was good. They were aware of their responsibilities and were proactive in addressing any issues we identified during the inspection.

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.

Suitable procedures were in place for the management of medicines and feedback we provided was acted upon to make further improvements.

We received feedback that there had been an increase in staffing but there remained mixed views about the numbers of staff available. We have made a recommendation about keeping staffing under review.

Staff had received training in the safeguarding of vulnerable adults and were aware of the procedures to follow. Recruitment practices supported the provider to make safer recruitment decisions through the vetting procedures followed.

Is the service effective?

Good

The service was effective.

Staff received regular training to provide them with the skills to do their job effectively. Supervision and appraisals were carried out to provide support and meet development needs of staff.

People were supported with eating and drinking and nutritional assessments and records of weight were kept under review. People were referred for dietary support where necessary.

The service was operating within the principles of the Mental Capacity Act 2005 [MCA]. Applications to provide people of their liberty were submitted to the local authority in line with legal requirements.

The environment was clean and homely. Not all areas met best practice with regards to supporting people living with dementia. We have made a recommendation about that.

Is the service caring?

Good

The service was caring.

We observed kind courteous and caring staff interactions. People and their relatives were complimentary about the staff and the good relationships they had with them.

The privacy and dignity of people was respected. Care was offered sensitively and discreetly, people living in the home were seen to be caring towards each other and a culture of acceptance and support was fostered.

Staff took time to explain what they were doing and did not rush people.

Is the service responsive?

Good

The service was responsive.

Person centred care plans were in place which were up to date and regularly reviewed.

People were involved in a range of spontaneous and planned activities and there were good links and involvement with the local community.

A complaints procedure was in place and people knew how to make a complaint and had other opportunities to share the views and ideas.

Is the service well-led?

Good

The service was well led.

A new manager was in post and was in the process of registering with CQC. There had been gaps in record keeping at the beginning of the year but there were no gaps identified since the new manager came into post. Staff and visiting professionals credited the new manager with a number of positive changes.

Staff told us they enjoyed working in the service and that morale was good.

Regular checks on the quality and safety of the service were carried out and the views of people and their relatives were sought on a regular basis.

There were close links with the local community

Croft Avenue Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 23 and 24 August 2017. The first day of the inspection was unannounced. This meant the staff and provider did not know we would be visiting.

The inspection team comprised of two adult social care inspectors and a pharmacist.

Before the inspection, we reviewed information we held about the service including statutory notifications. Notifications are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

We spoke with the local authority commissioning and safeguarding team and Care Home Education and Support Service [CHESS] used the information they provided when planning our inspection.

During our inspection we spoke with 15 people who used the service and six family members. We also spoke with the manager, operations director, five care staff, two housekeeping staff and a cook.

We looked at the care records of five people who used the service and observed how people were being cared for. We also looked at the personnel files for four members of staff and a variety of records relating to the quality and safety of the service.

Good

Is the service safe?

Our findings

People told us they felt safe at Croft Avenue. One person told us, "I had to come in, I fell at home, I wasn't safe at home anymore, I do feel safe here" another said, "There is enough staff, even at night and if you push your buzzer they do come." A relative told us, "I'd say it's improved recently, there is more staff now," and a visiting professional said, "There always seems to be enough staff here, I can always easily find somebody."

We observed there were sufficient staff on duty during our inspection. Call bells were answered promptly and people were supported in a calm unhurried manner by staff. Although the majority of people we spoke with said staffing had improved, some people said that they felt staffing was low at times. One person said, "I think there should be more staff, especially at night. There is no leeway if someone goes off sick." We were aware of historical difficulties with staffing, including at night.
We spoke with the manager who confirmed staffing levels had increased and they were in the process of recruiting additional care staff and a team lead. We contacted the service after the inspection and found these additional staff were now in post.

We recommend in light of concerns raised that staffing remains under review.

We checked recruitment records and found safe procedures were followed when recruiting staff. Two references were provided and checks were carried out by the Disclosure and Barring Service [DBS]. The DBS checks that staff are suitable to work with vulnerable people, helping employers to make safer recruitment decisions. Right to work and identity checks were also carried out.

Staff had received training in the safeguarding of vulnerable adults, and when questioned were able to identify various forms of abuse. They were aware of the procedures to follow, but told us they had not seen anything to concern them. A safeguarding log was maintained by the manager who was aware of their requirement to notify CQC of concerns of a safeguarding nature.

Procedures for the ordering receipt, storage and administration of medicines were satisfactory. Good practice was noted, including the use of allergy identification stickers, Warfarin warning charts, and Fentanyl patch charts. This meant that additional measures were in place to maintain the safety of people from harm from medicines potentially harmful if administered incorrectly. Regular routine reviews of people's medicines were carried out by a GP and pharmacist.

We found that a medicine trolley was not secured to the wall, as per best practice while medicines were being administered from a corridor, although the trolley was locked when unattended. This was immediately rectified by the provider following our inspection. We also recommended that signatures should be included on fridge temperature checks and the manager told us these would be added.

The building was clean and generally well maintained and some refurbishment had taken place. We noted there was an on-going programme of redecoration, and regular reports recorded rooms that had been decorated and those due.

We found hazardous substances were stored safely, and housekeeping staff were aware of procedures to follow to avoid the spread of infection, including contamination in the laundry. Single use mops and cloths were used for each room, and staff were able to tell us the procedure they would follow in the event of an outbreak. Staff were observed wearing personal protective equipment such as gloves and aprons which were in ample supply.

We found the laundry was unlocked although located up a small flight of stairs. When we entered it, a recently used hot iron was on the ironing board and a fire door to the back of the laundry opened onto an external fire escape. This could pose a potential hazard to people if they accessed the area by mistake, including those living with dementia. The room had been in use like this for a number of years without incident, but the provider was proactive in addressing the issue and fitted a key pad immediately after our inspection to reduce this risk.

Risks to people had been assessed and monitored including risks to skin integrity and choking. These were regularly reviewed and plans were in place to mitigate risks. A detailed general environmental risk assessment was carried out annually, and there were regular additional checks on the safety of the building and premises. These included gas, electrical and portable appliance [PAT] testing. Procedures were also in place to prevent the growth of Legionella bacteria and regular tests to the water system were carried out.

Equipment used for the moving and handling of people had been tested in line with the requirements of the Lifting Operations and Lifting Equipment Regulations 1998 (LOLER). Routine checks of other equipment such as the nurse call system were carried out. We found evidence that where defects had been detected, these had been reported and rectified.

Regular fire safety checks were carried out internally, and by external contractors, to ensure fire safety equipment, alarms and lighting were in good working order. Some staff were trained fire wardens and staff received regular fire safety training. A fire risk assessment and plan was in place, describing a progressive horizontal evacuation in the event of a fire. This meant there were clear fire safety instructions for staff to follow. A sprinkler system was in place and had been recently serviced.

Good

Is the service effective?

Our findings

Staff received regular training considered mandatory by the provider in order to keep people safe. Staff told us and records confirmed staff had received training in nutrition and hydration, moving and handling, bed rails, infection control, behaviours that challenge, food safety, medicine awareness and fire safety. Staff told us they had requested additional training and this had been provided, one said, "I asked for more in depth training about medication and got it. I also asked for first responder and resuscitation training which I got. It came in handy and I have used it."

Specialist nurses employed by the NHS provided training to staff. All staff had received training in pressure ulcer prevention and the nurse told us it meant an initial increase in reports of minor skin damage due to heightened awareness of staff, but said this had settled and there had been a reduction in skin damage overall since the training had been completed.

A nurse from the Care Home Education and Support Service [CHESS] team told us they had delivered a programme of training in mental health awareness including, dementia, delirium, depression, psychosis and behaviours that challenge. They said the provider had committed to the training and staff were responsive and took it on board. A visiting nurse told us, "They seem to spot and manage delirium well." Delirium is a condition often associated with physical illness which can cause a sudden increase in confusion. It can become a medical emergency if not identified and treated quickly.

Staff received regular supervision and annual appraisals were carried out. Supervision sessions enable managers and staff to discuss support and development needs to ensure staff are well supported and competent in their roles. Staff told us they felt well supported by the new manager.

People were supported to eat and drink. There were regular drinks and snacks provided throughout the inspection. There were jugs and cups with drinks in people's rooms, and the drinks trolley had tea and coffee. There were biscuits or fruit in slices, covered by cling film, and served with serving tongs. Service users were offered a hot drink and a choice of biscuits and fruit. One person said, "Fruit please, no Kiwi". This was served to people on plates which were put on side tables with a drink. Drinks were given in a choice of china mugs, cups and saucers or adaptive cups.

We checked the weights of all people living in the home at the time of the inspection. We found most people's weight was stable or increasing. Where people were found to be losing weight, we saw that professional dietary advice had been sought. People told us that in the main, they enjoyed the meals. On person said, "The food is really good, I like my food" another said, "The food is alright, it's not home cooking but what do you expect in a place this size?" We spoke with the cook and they were aware of individual dietary needs. They carried out regular surveys regarding choices and the quality of meals.

The main meal of the day was served at lunch time. We joined people for lunch and found they were nicely supported in a relaxed unhurried manner. Staff were encouraging and attentive. One person complained their meat was too dry so a gravy boat was brought for them. We saw a staff member checking the salt was

coming out of the salt pot for another person.

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 checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

A consent policy was in place. DoLS applications had been made to the local authority for authorisation. Care records contained evidence of mental capacity assessments and records of specific decisions made in the person's best interest. This meant the provider was following the requirements of the MCA and DoLS. Details of the decisions people were still able to make were recorded. This meant people continued to be supported to make every day decisions despite being unable to make more complex choices in other areas of their lives. For example, we found one person received support from a family member with authority to manage their financial affairs, but they were able to choose the colour of their nail varnish.

The health needs of people were met. Care records showed people had access to a variety of services and professionals including GP, podiatry and physiotherapy. One person told us, "My doctor comes in if I need him, he says to me [name] what have you done now?" Do Not Attempt Cardiopulmonary Resuscitation Orders [DNACPRs] were in place where appropriate, had been kept under review and were held in a prominent location within care files. People's medical history and records of allergies were kept.

The premises were homely and rooms were personalised. There were a number of smaller lounges which were beneficial in terms of the variety of places people could choose to sit, although this could make observation difficult. There had been a number of unwitnessed falls. The operations director and manager showed us a new falls monitoring tool which captured greater detail in terms of the times and locations of falls. Falls were logged on a map of the layout of the home to assist with analysis and solutions. It was hoped the increase in staffing would enable closer supervision of people. Staff we spoke with also had a good understanding of falls. One staff member told us, "They can be because someone forgets they can't walk as well as they used to, they may have an infection or because their blood pressure drops. We try to observe and check the lounges regularly."

Not all areas of the home met best practice in terms of design to support people living with dementia. There were changes in floor colour at door thresholds which can cause difficulty for some people who may perceive darker areas as steps or holes. Some carpets were also patterned which may cause illusions in some people living with dementia or who may stoop to pick up objects (patterns).

We recommend attention is paid to supportive design for people living with dementia during on-going refurbishment.

Good

Is the service caring?

Our findings

People and their relatives told us staff were caring. Comments included, "The girls are very nice, very attentive," and "It's very nice, I've lived here a long time, the girls are very nice, well I know them all." A relative told us, "The staff are lovely. [Name] really likes them; they make her laugh." Another relative told us they were very pleased with how well their relation had settled into the home.

We spoke with two visiting professionals who told us people always appeared well cared for. A number of people spoke positively about the welcoming atmosphere in the home. People spoke to each other in a companionable way and helped each other and it was obvious that there was a supportive network amongst people living in the home. One person became upset at times and another person told us, "Don't mind them, they aren't well you know, poor soul, they will settle in a minute." This mirrored the accepting and caring responses towards the person of staff.

We observed that staff were caring and thoughtful. People enjoyed joking with staff and we observed good natured teasing and fun. Staff told us they enjoyed working in the home and caring for people. One staff member said, "It is a lovely home, lovely atmosphere and staff are all brilliant, friendly and helpful. It is a big change for the better compared to other homes I have worked in."

Staff were cheerful in their tone and took time to explain to people what they were doing, to avoid startling them. They appeared to know people and their likes and dislikes well. Care was not rushed and people were nicely supported during mealtimes. We observed a staff member helping someone to eat and they gently encouraged them to try more. They told the person, "You can have little and often, because you are only little. We'll sneak you your favourite chocolate bar later!" The person smiled warmly at the staff member.

A relative told us staff went to great lengths to support their relative to attend a family wedding. They told us, "The staff went to loads of trouble to help [name] to understand what was happening. They got them ready for the wedding and decorated their wheelchair with ribbons."
The privacy and dignity of people was respected. We observed staff knocking on doors and offering support with care sensitively and discreetly. Staff told us, "We make sure curtains are closed and we shut doors. We explain and always ask people first if we need something."

End of life care was provided in the home if that was people's wish and appropriate support was provided by community nurses.

No one was receiving support from an advocate at the time of our inspection, but the manager told us they knew how to access this service if required. An advocate is an independent person who supports people to make and communicate their decisions.

Good

Is the service responsive?

Our findings

Person centred care plans were in place. This meant that people's personality, behaviour, likes, dislikes and previous experiences were taken into account when planning care. We saw that these were up to date and had been regularly reviewed. Care plans were in place to address physical and psychological needs. Records of people interests and hobbies were recorded under the headings; 'My Life' and 'My Story'. This included information about where people grew up, holidays, memories, and things they enjoy doing currently. There was also and activities and interaction record.

Behaviour care plans were in place for people experiencing behavioural disturbance or distress. We found some of these could be more detailed, for example when recording possible causes of behaviour the answer recorded in some plans was 'dementia'. Identifying possible causes of behaviour, such as fear, embarrassment, frustration, misinterpretation for example can help staff to develop a possible exolanation as to the cause and take action to prevent or reduce the severity of future reactions. We observed in practice, that staff responded well to distress.

Specialist support was sought when planning care for people. The CHESS team visited the service regularly. They told us, "Staff are very good at referring people to us. They are very responsive and follow our advice. They try suggestions and follow things through."

There were plans to hold Dementia Friends sessions for people living in the home to help them to understand the needs of some people living there with cognitive impairment. Dementia Friends sessions give attendees an awareness of how dementia can affect people and how best to support them. People who had been approached about this had been receptive to the idea.

A community nurse told us staff sought timely advice, they said, "They don't tend to panic but ask for support before there is a crisis" Another said, "If they say there is a problem there usually is. They aren't on the phone every five minutes." This meant care professionals respected the judgement of staff when they called them for support.

People told us there had been an increase in activities. One person said, "We have activities and in between times we please ourselves, we do go out, we went to Blackpool last year and we are going again in October." A relative told us, "There is lots of stimulation and the activities coordinator is great," another told us, "They go to the trouble of getting to know likes and dislikes. My relative likes to help. They make her feel included and valued; they give her a lot of self-esteem." A visiting professional told us, "There always seems to be something going on, and more innovative activities. I don't see that at other places."

We spoke with the activities coordinator who told us they tried to engage and make links with the local community wherever possible, and invited people into the home. For example, they had extended an invitation to the local agricultural college to visit. We contacted a visiting professional for feedback following the inspection and they told us when they visited there had been a student visiting with a lamb, chicken and collie dog. They thought this was quite innovative. Volunteers were also employed who were fully vetted and

visited at various times during the week. One volunteer came regularly to play dominoes.

During our inspection, children from a local out of school club visited as it was the school holidays. They had spent the morning practising various routines and then visited the home in the afternoon. They sang songs and nursery rhymes, and individual children danced and recited poetry. People laughed at a poem chosen by one child about nose picking. During a song about boat rowing, children sat on the floor in the lounge in pairs and rowed enthusiastically. People joined in singing and laughed at the children having fun. One person told us they enjoyed the children coming and said, "Oh I like them, and the nursery children came in the other day." The activities coordinator told us they were well supported by the manager to develop activities.

In addition to planned activities, there were numerous books, newspapers and magazines throughout the home. One person told us, "I'm not going to do much today, but I'm happy with that." The television was on at times, but the channel was changed at the request of people and it was switched off when no one was watching. A record player with vinyl records was also available.

A complaints procedure was in place, and details of how to make a complaint were displayed. We reviewed complaints records and found they had been addressed in line with the provider's policy. We also read a number of compliments about the care people received. 'Resident and Relatives' meetings were held. This gave people the opportunity to express their views, choices or any concerns about the service. One person told us "I went to the residents meeting and I speak to the manager if I need to, but I have never seen anything wrong."

Good

Is the service well-led?

Our findings

A new manager was in post and had applied to register with CQC. We received positive feedback about the manager from relatives, staff and visiting professionals. A staff member told us, "I feel really well supported. [Name of manager] will be excellent when she finds her feet," another said, "I can go to [name of manager] with any problems and she always finds a way to help." A relative told us they had initially been concerned about a change in manager but told us things were working well. Visiting professionals including community nurses and representatives from Cumbria County Council Quality and care governance teams told us they had noted improvements in the service and raised no concerns. A nurse told us, "The manager is very patient focused, not managing from a distance and knows people well. Staff are saying how much better it is, they support us and seem interested. Staff respond well to [name of manager] management style. They are involved, role model and are not shut up in an office."

Another visiting professional provided a written compliment to the manager which said, "It was a real pleasure coming to the home today to see so much activity going on, residents happy and alert; you've made a real difference in a short space of time."

We found that there had been gaps in a number of management records and manager signatures were missing from maintenance logs for example. These gaps were from earlier in the year, prior to the new manager coming into post. We found no gaps in records since the new manager came into post and found records were well organised and maintained. The manager was aware of their responsibility to submit notifications to the Commission to inform us of certain events in line with legal requirements.

Regular audits were carried out by the manager and a daily meeting enabled the manager to meet with heads of department and senior staff to discuss operational risks and clinical issues. Monthly home reviews were carried out which were developed into a home improvement plan which were reviewed six monthly. The views of people and relatives were sought on a regular basis.

A new team lead had been appointed and allocated 12 hours per week supernumerary hours to support the manager to oversee care, and worked with the team the remainder of the week.

Regular staff meetings were held and minutes were available. Staff told us they were happy working in the home and that morale was good. People and their relatives also had the opportunity to meet and suggestions, compliments and complaints were collected. Dates of future meetings were advertised on notice boards. Feedback was also displayed.

There were good links with the local community including schools, churches, colleges, voluntary organisations and theatre.