Baystone Limited

Cranford Residential Home

Inspection report

15 Cranford Avenue
Exmouth
Devon
EX8 2HS

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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

Cranford Residential home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The Cranford Residential Home can accommodate up to 26 people in a detached property situated in the seaside town of Exmouth. The home consists of two floors with a passenger lift providing level access to each floor. There is a main communal lounge, dining area and seating in the large entrance where people could spend their time as they chose. The home has a large landscaped garden which people could use if they chose.

This comprehensive inspection took place on 11, 17 and 19th July 2018. The first and second day of the inspection was unannounced. This meant that the provider and staff did not know we were coming. At the time of this inspection there were 24 people using the service. Three of these people were staying at the service for a period of respite (planned or emergency temporary care provided to people who require short term support).

We had previously carried out a comprehensive inspection in May 2017. At that inspection we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches related to there not being effective and consistent systems to check some of the safety equipment at the home. The recording of how some risks to people's health were managed was inconsistent. Improvements were needed in how activities were provided, recruitment procedures and how staff were supported. Following the inspection we were sent an action plan which set out the actions the provider was going to take. At this inspection we found the provider had made the improvements and were no longer in breach of these regulations.

There was a new registered manager who registered with CQC in May 2018 (at the last inspection they were working as the acting manager). A registered manager is a person who has registered with 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. Everyone praised the registered manager and the improvements they had made at the home. People said they were happy to approach the registered manager, staff and the provider if they had a concern, and were confident that actions would be taken if required.

The registered manager had put in place a comprehensive quality monitoring system at the service. There were regular audits and checks of the premises and equipment to keep people safe.

Safe recruitment procedures were in place and appropriate pre-employment checks were undertaken. The provider used a new computerised care system where staff completed risk assessments which could be audited by the management team to ensure appropriate action had been taken. Staff were also able to

record the support and monitoring checks undertaken on this system.

Staff were well supported. They received regular supervision sessions which gave them the opportunity to discuss their concerns and future development. Staff said they felt involved with the development of the service with regular staff meetings.

A staff member was responsible for co-ordinating activities and there was a varied timetable of events. They were new to their role and with the registered manager's support had plans to develop activities further. The registered manager had ensured people and their families had been kept informed about changes at the service and asked for their views regarding future developments.

People and their relatives were happy with the way care was delivered and happy with the staff approach. Staff interacted positively with people and had a good knowledge of their care needs. People were cared for without discrimination and in a way that respected their differences.
Relatives were made to feel welcome and where appropriate were involved in the care planning process. Staff provided care in a way that protected people's privacy and dignity and promoted independence.

There was a sufficient number of staff on duty to care for people safely. Where there were any shortfalls the provider used the services of a local care agency, although this was only required occasionally.

The registered manager was passionate about staff receiving training and developing their skills. Staff were up to date with training and 90 percent of the staff were completing a higher qualification in health and social care to enhance their knowledge and skills. Staff also undertook additional training courses linked to the needs of the people using the service. Equality and Diversity and inclusion including human rights was part of the provider's mandatory training requirements.

Care records contained detailed risk assessments and care plans which reflected people's individual needs. People were receiving care that was tailored to their individual needs. Care plans contained detailed information, including life history, to help staff support people in a personalised way. People had individual personal emergency evacuation plans in place. Accidents and incidents were recorded and analysed to look for patterns or trends. Regular maintenance checks and repairs were carried out and all areas of the service were clean and tidy.

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. The registered manager had been working with the local authority Deprivation of Liberties (DoLS) team regarding submitted appropriate DoLS applications. Capacity assessments were being undertaken and best interest decisions were being recorded.

People were supported to maintain their health and wellbeing and had access to health professionals when needed. People were very happy with the food they received. There was a varied menu containing well balanced nutritious options. Snacks and drinks were available if people required them. People's weights were monitored regularly and advice sought from health professionals if there were any concerns.

Staff meetings took place every two months and staff felt able to discuss any issues with the registered manager. Feedback was also sought from people using the service and relatives through regular meetings and surveys.

The staff were committed to ensuring people experienced end of life care in an individualised and dignified

way. The registered manager had developed a leaflet to help guide people and relatives through the end of life stages. There were numerous thank you messages from relatives regarding the good quality care people had received at the end of their lives at the service.

There was a complaints procedure in place and people knew how to make a complaint if necessary. The registered manager had received three complaints since our last inspection. They had responded to the complaints in line with the provider's policy and had made changes as a result of lessons learnt.

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.

Safe recruitment procedures were in place.

The premises and equipment were managed to keep people safe.

People were protected from risk. Staff had completed individual risk assessments for people to assess how to reduce risks as much as possible.

Staff were able to demonstrate a good understanding of what constituted abuse and how to report if concerns were raised.

Medicines were safely managed.

There were sufficient staff levels to meet people's needs.

Infection control processes were in place.

Is the service effective?

Good

The service was effective.

Staff felt supported and had regular supervisions.

Staff had received an induction when they came to the service. Staff received appropriate training to meet people's needs and were undertaking higher qualifications to further develop their skills.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS). Appropriate applications had been made to the DoLS team and best interest decisions were being made where people lacked capacity.

People were supported to maintain their health and wellbeing and their nutritional needs were met.

Is the service caring?

Good

The service was caring.

People were happy with the care they received. Relatives were welcome to visit at any time and were involved in planning their family member's care.

Staff relationships with people were strong, caring and supportive. Staff spoke confidently about people's specific needs and how they liked to be supported.

Staff treated people with dignity and promoted independence wherever possible.

Is the service responsive?

Good

The service was responsive.

Care plans on the computerised care system contained information to help staff support people in a person-centred way.

Staff were committed to ensuring people experienced end of life care in an individualised and dignified way.

People's social needs were met and they were encouraged to follow their interests.

There were regular opportunities for people, and those that mattered to them, to raise issues, concerns and compliments.

Is the service well-led?

Good

The service was well led.

Staff spoke positively about the registered manager and how they were developing the service.

The registered manager had put in place a comprehensive quality assurance system. There were audits and surveys in place to assess the quality and safety of the service people received.

People's views and suggestions were taken into account to improve the service. Feedback was sought from people using the service and their relatives and any issues identified were acted upon.

Staff meetings took place every two months and staff felt able to discuss any issues with the registered manager.

Cranford Residential 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 comprehensive inspection took place on 11, 17 and 19 July 2018 and the first and second day was unannounced. The inspection team consisted on the first day 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. The adult social care inspector returned for the second and third day of the inspection.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. We also contacted the local authority commissioners for the service and the local Healthwatch team to gain their views of the service provided. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spent time with people living at the service. We carried out observations using the short observational framework for inspections (SOFI). SOFI is tool used to capture the experiences of people who use services who may not be able to express this for themselves.

We spoke with eight people who used the service and one relative. We spoke with 14 members of the staff team including the registered manager, the office manager, service manager, supervisor/personal therapist, two deputy managers, the administrator, the activities co-ordinator, four care staff, a member of the housekeeping team and the cook. We also spoke with two of the directors.

We reviewed three people's care records on the provider's computerised system and three staff files which included recruitment, supervision and training information. We reviewed medicine administration records for five people as well as records relating to the management of the service. We contacted eight health and

social care professionals who have worked with the provider, to ask them their views about the service. This included the local GP surgeries, community nurses, social care team staff and the local authority's Quality Assurance and Improvement Officer (QAIT). We received four responses.

Good

Is the service safe?

Our findings

At the last inspection in May 2017 we found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because improvement was needed to some aspects of the recruitment process and managing risks to people's health and well-being. The provider sent us an action plan which set out the checks and audits they had put into place and improvements to the recruitment process they had implemented. At this inspection we found the provider had taken the action set out in their action plan and had met the legal requirements.

There were effective recruitment and selection processes in place to ensure staff were safe to work with vulnerable people. The provider had a recruitment and retention champion who ensured staff files, supervision and training were up to date. They monitored staff sickness and undertook back to work interviews to support staff back to work safely. Staff had completed application forms and interviews had been undertaken. Pre-employment checks were completed, which included references from previous employers. Any gaps in employment history were checked and Disclosure and Barring Service (DBS) checks were completed. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. This demonstrated appropriate checks were undertaken before staff began work.

Premises and equipment were managed and maintained to keep people safe. The provider had a comprehensive development plan for the home, including replacing the lift, driveway and extending the lounge. The driveway was completed during the inspection process. The registered manager and service manager took responsibility for the environmental health and safety of the service by undertaking regular audits and assessments. These included electrical testing, effectiveness of window restrictors, hot water temperatures, wheelchairs, hoists, slings, slides sheets, weekly fire bells and routes of escape; action was taken regarding any concerns found. External contractors regularly serviced and tested moving and handling equipment, fire equipment and lift maintenance. At the time of the inspection extensive work was being undertaken to replace numerous fire doors as recommended by the fire service. Staff recorded repairs and faulty equipment. The provider had systems in place to check the water quality at the service annually against the risk of legionella.

People were safe at The Cranford Residential Home and said they were well supported by staff. Comments included, "I'd change nothing here, I've always liked this room and I feel very safe here. I've always liked everyone here too" and "We're checked every hour or so during the night. I do feel comfortable and safe here."

The registered manager had asked people in a survey in March 2018 if they felt safe at the home. They had received 20 responses with 19 people saying "always" and one person saying "most of the time". The registered manager said, "We would like our next survey report to say 100 percent of people who use the service feel safe all the time. We are working towards this by working with the residents and with their risk assessments to identify individual needs."

People were protected because risks for each person were identified and managed. Care records on the computerised care system contained risk assessments about each person which identified measures taken to reduce risks as much as possible. These included risk assessments associated with people's nutritional needs, moving and handling, pressure damage and falls. People identified as at an increased risk of skin damage had pressure relieving equipment in place to protect them from developing sores. This included, pressure relieving mattresses on their beds and cushions in their chairs. Staff were required to regularly check mattress settings to ensure they were effective for the person. Staff also completed enabling risk assessments. For example, enabling people to go out with our social companion, participate in gardening and looking after the chickens at the home.

An individual risk assessment for evacuation of people in the event of a fire was in place. This provided information about each person's mobility and communication needs and the support they would require in case of an emergency evacuation of the service. These were checked weekly to ensure they remained accurate. First aid boxes were regularly checked and restocked to ensure they have all of the equipment needed in an emergency.

Our observations, together with discussions with people, relatives and staff, showed there were sufficient staff on duty to meet people's needs and keep them safe. Staff worked on the whole in an unhurried way and had time to meet people's individual needs. The only exception was the lunchtime period which was a little disorganised and chaotic. The registered manager had developed a dependency tool to analyse the staff levels at the service and adjust them accordingly. They were also monitoring the dining experience through regular audits and working with staff to improve the dining experience. People said staff responded to their call bells promptly. One said, "I don't use the call bell very often. They don't take long to come. I'd change nothing here" and "Staff come when you use the buzzer it is marvellous."

Staff undertook additional duties and used the local care agencies to cover gaps in the rota if required. The use of agency staff had reduced considerably since our last inspection. One person said, "Staff have turned over, but they have kept the core of the nursing staff here."

Staff who administered medicines had received medicine training and had their competency skills assessed annually by an in house trainer. This was to make sure they had the required skills and knowledge required. People were happy with how their medicines were managed. One person said, "The senior in charge brings in my medicine and they always check that I take it."

People's medicines were checked in when they arrived at the service from the pharmacy and the amount of stock documented to ensure accuracy. Medicines were kept safely in locked trollies and medicine cupboards. These were kept in an orderly way to reduce the possibility of mistakes happening. The medicine fridge temperature was being recorded and staff had guidance regarding the required temperature and what action they should take if it was outside of the required range. Staff administering prescribed topical creams signed when they had administered creams on to cream charts. These directed staff which cream, where to apply, when and how frequently to administer the prescribed creams. During the inspection improvements were made to the topical cream charts to ensure they all reflected people's prescriptions. This was because a few cream charts did not have clear directions for staff.

Medicine audits were completed monthly and action taken if concerns were found. Staff recorded any errors or near misses on the computerised care system. For example, if the amount of medicines in stock did not tally. These were reviewed by the registered manager; where required staff received additional support and supervision to improve medicine administration practice at the home.

Staff demonstrated an understanding of what might constitute abuse and knew how to report any concerns they might have. Staff knew how to report concerns within the organisation and externally such as the local authority safeguarding team, police and to Care Quality Commission (CQC). The registered manager demonstrated an understanding of their safeguarding roles and responsibilities. The registered manager had raised two safeguarding concerns in the last year with the local authority. One in relation to a concern about staff practice and a second regarding conflicting advice from a health professional. On both occasions they had had taken measures to protect people and keep them safe.

Accidents and incidents were reported and appropriate action taken. The registered manager said, "We audit accidents and incidents monthly and summarise trends and developments to help us make the service safer. For example, last year we identified a falls protocol and post falls procedure according to local (ambulance service) and National Institute for Health and Care Excellence (NICE) guidelines." Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally and externally when required. The registered manager and management team worked alongside staff to identify issues and take action when required.

The home consists of two floors with a passenger lift providing level access to each floor. There is a main communal lounge, dining area and seating in the large entrance where people could spend their time as they chose. The home has a large landscaped garden which people could use if they chose. The home had a pleasant homely atmosphere with no unpleasant odours. There was a designated infection control champion who monitored the infections at the home each month, what antibiotics were used and the outcomes. All staff had infection control training annually and discussed infection control during their supervisions. The cleanliness of the home was audited monthly by the service manager and the registered manager.

Staff had access to appropriate cleaning materials and to personal protective equipment (PPE) such as gloves and aprons. The provider had an infection control policy in place that was in line with best practice guidance. The housekeeping staff used a cleaning schedule to ensure all areas of the home were kept clean. People were happy with the cleanliness of the home. Comments included, "Housekeeping come in every day to clean my room", "As we walked through the door there were no nasty smells of urine or food, it was like walking in to a lovely country house" and "It's very clean here and I'm very happy here."

Good

Is the service effective?

Our findings

At this inspection we found the service remained Good. People's needs were consistently met by staff who had the right competencies, knowledge and qualifications. Staff had received appropriate training and had the experience, skills and attitudes to support the complexities of people living at the service.

When staff first came to work at the home, they undertook a period of induction and completed an induction checklist. This included working alongside experienced staff to get to know people and their care and support needs. The registered manager recognised the importance of staff having training in order to have the skills to support people and improve their own personal development. They supported new staff, who were also new to care, to complete the Care Certificate. This is, a nationally recognised Skills for Care training programme for newly recruited staff. Staff said the induction enabled them to perform their role well. They had also enrolled 90 percent of the staff on a higher qualification in health and social care to enhance their knowledge and skills.

Staff had regular opportunities to update their knowledge and skills. The provider had employed a retired health and social care trainer/teacher who assisted with supervisions and one to one training for staff. The registered manager also delivered training as they were a trained 'train the trainer', a registered nurse, and a qualified teacher. Staff had completed the provider's mandatory training which included fire safety, moving and handling, safeguarding, infection control, health and safety, food hygiene, equality and diversity and human rights. Staff had also undertaken other training to ensure they were able to meet people's needs. For example, dementia awareness, mental health awareness, nutrition awareness, cleaning skills, challenging behaviour awareness and autism awareness.

To help progress staff the registered manager had implemented an associate senior role at the home. This was for care staff who wished to develop and take on more skills like medication administration, assisting with the multi-disciplinary team visits, reviewing care plans, and caring out risk assessments. The registered manager said, "The carer must enrol onto a level three health and social care diploma and will be mentored and supported by the in-house tutor, manager and other seniors. They will only be in charge of a shift when the manager or one of the deputy managers is also there." Two care staff were being supported in this role.

Staff and records confirmed supervision was carried out on a regular basis. This was an opportunity to meet with their line manager, reflect on recent work and their own wellbeing as well as discuss any support and training they might need. Staff said they found the supervisions really useful and were positive about the support they received.

People were supported to have regular appointments with their dentist, optician and chiropodist. People were also supported to access other health services when necessary. For example, community nurses, physiotherapists, speech and language therapist (SALT), chiropodists and opticians. The staff had used the services of a physiotherapist to support a person who wanted to increase their independence and mobility. Health professionals said they had no concerns about the service and had confidence in the staff to make referrals promptly. Comments included, "We always feel that our requests are met, they regularly are in

contact with us if they are unsure about something."

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. Where people lacked the mental capacity to make decisions the registered manager and staff followed the principles of the MCA.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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.

We found the home was meeting these requirements. The registered manager understood their responsibilities in relation to DoLS and knew how to make an application if they needed to restrict a person's liberties. Appropriate applications had been made to the DoLS team and best interest decisions were being made where people lacked capacity. Staff had received training on the MCA and demonstrated an understanding of people's right to make their own decisions. One staff member said, "We can help them make choices, just because they have made a bad choice doesn't mean it is wrong."

The staff had been reactive to support people to maintain their independence and interests. The registered manager gave an example of a person with restricted mobility they had supported to research a bariatric wheelchair. The person purchased this equipment which meant they had access to the community and places they chose to visit. Another example was when a person was younger, they had looked after a chicken farm and loved the outside and gardening. Staff had recognised the importance of this and a greenhouse; a potting shed had been put in place and also chickens. This meant this person with an enabling risk assessment could continue to enjoy the activities they enjoyed.

The registered manager had identified in in the infection control audits an increase in the number of infections in the home that they felt needed to be reduced. The registered manager and the chef worked with people, families and GP's to develop infection protection smoothies. The registered manager had analysed the infection rates at the home and found they had reduced significantly. The registered manager said, "We like to work with families to ensure that people feel informed about and involved in their healthcare and are empowered to have as much choice and control as possible."

People were supported to have sufficient to eat and drink and maintain a balanced diet. The registered manager was a qualified clinical nutritionist and nutritional therapist. They ensured the nutrition at the service was in line with government guidelines, on nutritional content of food and supplements to improve nutritional status. Staff gathered information about people's dietary requirements likes and dislikes when they first arrived at the home. This information was available in the kitchen on white boards for the catering team to inform them about people's requirements. People at risk of weight loss had their weight monitored regularly and further action was taken in response to weight loss and appropriate referrals made. Everyone had a nutrition and hydration plan in place and the home had a specific nutrition strategy based on best practice guidelines in place. Where people had any swallowing difficulties, they had been seen and assessed by Speech and Language Therapists (SALT). Where the SALT had assessed a person as requiring a special diet and recommended a pureed food, these meals were provided in the required consistencies for

people. There was a varied menu containing well balanced options with two main meal choices and desserts. Snacks and drinks were available if people required them throughout the day.

We observed a lunchtime meal at the service. A person had laid the tables with folded napkins, table cloths and cutlery. People were offered a choice of refreshments. We discussed with the registered manager that there was a white board with the menu in the lounge but not in the dining room to advise people of the meal choices. They said they would look at options to inform people. The mealtime on the first day was a little chaotic and disorganised with some people having to wait for their meals. The registered manager had been monitoring the dining experience for people and was working with staff to improve the dining experience at the home.

One person who required assistance to eat their specialist meal was sitting with other people in the lounge, and not marginalised or isolated due to their needs. People were happy about the food and said they were offered a choice if they did not want what was on the menu. Comments included, "Food is good" and "Little things make a difference. As I'm a diabetic butter and marmalade already on my toast is no good for me. So after a day here they served it separately for me."

Good

Is the service caring?

Our findings

At this inspection we found the service remained Good. Staff were kind, friendly and caring towards people. People were seen positively interacting with staff, chatting, laughing and joking. People and visitors said they felt the care at the home was very good. People's and relative's comments included, "I used to come here for a week here and a week there, now I'm permanent. I must be happy here"; "It's like a home from home. All the carers here are nice and helpful, nothing is too much trouble. They are all very good and kind"; "I'm happy here. Carers are nice", and "They're all cheery here, always smiles on their face, the night staff are lovely. I do enjoy being here."

Staff all said Cranford was a nice place to work. One staff member said, "I can honestly say, I would come here myself, such fantastic care and everyone treated like family".

On entering Cranford Residential home the atmosphere was calm and welcoming with people living there appearing 'at home'. Staff were aware it was people's home and did not rush around carrying out tasks. People's rooms were personalised with their sentimental possessions, photographs and furniture.

There was a culture of compassion and understanding. Staff were considerate and caring in their manner with people and knew people's needs well. We observed when someone was brought into the lounge, staff were very attentive and spoke and reassured the person throughout the transfer into a chair using a hoist. They then ensured the person was comfortable and had all they needed.

The registered manager had developed a key worker role. This was designated staff allocated to specific people to assist them with all their needs, and to ensure they have everything they required. The registered manager gave examples of where staff had gone the extra mile for people they were keyworkers for. "A carer recently went to Exeter and purchased a book for a resident. This was in the care workers own time… At Christmas time each care worker purchased a (secret Santa) present for a resident (out of their own money). These presents were very relevant to the individual. For example, pillow with an elephant print, book on the national train network, T-shirt, makeup etc."

Staff treated people with dignity and respect when helping them with daily living tasks. One person said, "The staff here have great patience with everybody, they have great empathy." Staff said they maintained people's privacy and dignity when assisting with intimate care. A health professional commented, "We always visit our patients in their bedrooms and staff are always accommodating with moving and handling patients to their bedrooms."

Staff involved people in their care and supported them to make daily choices. For example, people chose where they spent their day and the clothes and jewellery they wore. Staff knew people's preferred routines such as who liked to get up early, who enjoyed a chat and who required reassurance and emotional support.

In people's care plans, staff were reminded to seek consent from people before carrying out tasks. People

had been asked for their preference of gender of carer. Formal consent was also obtained regarding having their photographs taken while staying at the service.

People's relatives and friends were able to visit without being unnecessarily restricted. People and a relative said they were made to feel welcome when they visited the home.

Good

Is the service responsive?

Our findings

At this inspection we found the service had made improvements to meet people's social needs. This meant the previous rating of Requires Improvement has changed to Good. People said the service was good at meeting their individual needs. One person said "They personalise here, it's very personal". It was evident from speaking with the registered manager and staff that people mattered at the service; they spoke with pride about the people they cared for and wanting to make it a lovely place to stay. Staff had received care plan training and person centred care training sessions and had a good understanding of holistic care.

Wherever possible a pre-admission assessment of needs was completed prior to people coming to live at the service. People and their families were included in the admission process to the home and were asked their views and how they wanted to be supported. This information was used to develop care plans.

People were involved in the development of their care plan. People's care plans were individualised and were reflective of their health care needs and how they would like to receive their care, treatment and support. Care plans identified people's aims, goals and aspirations. They took into account the things that define people, their values, beliefs, preferences, choices, culture and religion. For example, one person enjoyed being outside. Staff had developed a programme with them regarding chickens, accessing a greenhouse and potting shed.

Since our last inspection the provider had implemented a computerised care system. This enabled staff to have access to care plans, risk assessments and any updated information immediately on mobile devices. Staff said they found the care plans helpful and were able to refer to them when required. The staff were required to record all interactions with people and the support provided on the mobile devices. This included people's dietary and fluid intake if they were assessed as being at risk. Senior staff could access this system at any time during the day and assess what was happening with people. The system also flagged up when planned care was required and if care had not been delivered according to people's individual's needs.

People's personal information and the relevant people involved in their care, such as their GP, optician and chiropodist was recorded in their computerised care plan. Relevant assessments were completed and up to date, from initial planning through to on-going reviews of care. Each month a designated staff member would review people's care needs. They would involve people and their relatives according to their individual wishes.

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. People had information about their communication needs in their care plans to guide staff how to ensure they had the information required. Staff ensured people had their hearing aids in place and had their glasses cleaned. The registered manager said some information was provided to people in accessible formats where needed, to help people understand the care and support available to them. They said this

would continue to be developed.

There was no one receiving 'end of life' care at the time of our visit. There was an end of life champion to support staff to ensure people were supported with compassion. The registered manager gave an example of a person who they had supported at the end of their life. They explained that a staff member had come in at night to sit with the person so they were not alone.

People had Treatment Escalation Plans (TEP) in place that recorded people's wishes regarding resuscitation in the event of a collapse. Relatives had sent thank you cards to the team thanking them for the care the staff had given their loved one. One of these said, "You made (family members) final months as comfortable as possible, (they) were happy at Cranford." Another said, "Many thanks to you all, for your kindness and affection shown to (person) it was so appreciated."

The registered manager had produced an information document called 'what to expect when a person is approaching death'. This was to help people and their families have a better understanding of what to expect when a person was approaching the end of their life. It gave them clear information about changes in a person's presentation and what to expect.

The registered manager recognised the importance of social activities and understood that these formed an important part of people's lives. A staff member was responsible for co-ordinating activities and there was a varied timetable of events. The staff member was new to their role and with the registered manager's support, had plans to develop activities further. The registered manager said, "This person spends time with people … ranges from chats in their room, to trips out to Pavilion, for lunch, to the beach, church group etc. This means there is more positive aspects and opportunities to meet people's social, emotional, psychological, cultural and spiritual needs."

People were positive about the activities at the home. Comments included, "Activities are good here. We have singing on Friday…we also do gym in the lounge once or twice a week" and "We have activities. They tell me they're on and then take me down." One person praised a staff member in particular saying, "(Staff member) is wonderful with people, sings, dances, does quizzes …wonderful with everyone here."

Staff supported people to maintain their links with the local community and follow their interests. For example, one person went to 'work' each day at a local farm. Staff supported the person to access transport and provided a packed lunch. Another person was supported to attend a local church meeting where they met many friends. Another person, wanted to learn French. The social champion had started to teach the person French which had enabled the person to talk about and practice with other staff.

The provider had a complaints procedure which made people aware of how they could make a complaint. The complaint procedure identified outside agencies people could contact if their complaint was not resolved to their satisfaction. This included the local government ombudsman, local authority and The Care Quality Commission (CQC).

People and relatives said they would feel happy to raise a concern and knew how to. There had been three complaints since our last inspection. The registered manager had responded to the complaints in line with the provider's policy and had made changes as a result. Learning from the complaint had led to improvements. For example, a dedicated transfer procedure staff followed if a person needed to be admitted to another service. This ensured all information was communicated clearly and consistency to transfer care.

Good

Is the service well-led?

Our findings

At the last inspection in May 2017 we found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because Improvements were needed in the running of the home, including how activities were provided, some safety checks, recruitment procedures and how staff were supported. People living at the home had not been kept updated about the management changes within the home. The provider sent us an action plan which said that letters and meetings had been held to inform people and relatives of changes. They had implemented safety checks and audits and improvements had been made to ensure people had the opportunity to partake in regular activities. At this inspection we found the provider had taken the action set out in their action plan and had met the requirement.

The service had a registered manager in post as required by their registration with the Care Quality Commission (CQC). People and relatives were positive about the registered manager and the management team. They said they were approachable and always available if they wanted to talk with them. A health professional said, "It's an excellent home."

The management team worked well together and had the same goals. Staff were complimentary about working at the service and the support they received from the registered manager and management team. Comments included, "(The registered manager) has worked so hard to improve it here", "(The registered manager) is lovely, if you have a problem, go and see them and they do their best for you. I can't fault them … such a lovely person so easy to talk to" and "A lot of staff changes for the better, more teamwork… we are not dismissed but listened to."

The management team had promoted a positive culture by supporting staff. This included recognising staff abilities and supporting them to develop their skills. The registered manager had put in place lead roles for staff. These included champions for infection control, social, medicine, recruitment and retention, health and safety, dementia and tissue viability. For example the health and safety champion was responsible for monitoring the electronic care plans. They ensured people's needs were met, such as if a person required weekly weights they instigated this. The tissue viability champion ensured staff responded effectively and quickly to people whose skin integrity was at risk. They also carried out wound audits monthly and reported to the registered manager any trends and action which had been put into place.

Everyone had a clear understanding of their responsibilities and referred people appropriately to outside healthcare professionals when required. The registered manager had worked hard to get the right staff so there was a good team spirit at the service.

The management team had worked with the local authority Quality Assurance and Improvement Team (QAIT) officer to look at areas for improvement. The registered manager had implemented documentation advised by QAIT; this included a Service Improvement Plan (SIP) which had been completed to structure the development of the service.

The provider used a range of quality monitoring systems, including audits to continually review and improve the service. They had taken appropriate action for issues identified in the audits. There were regular audits which included checks of medicines, infection control, wounds, care records, equipment, staff files, the environment, health and safety as well as room spot checks. The audits were used in conjunction with the SIP to ensure actions remained updated, in the correct priority and relevance. Since our last inspection the provider had introduced a computerised care records system. The registered manager and staff said this had improved people's records and the support given.

The registered manager told us they had used the Kings Fund EHE Environmental Assessment Tool to assess whether Cranford was dementia friendly. This had identified areas for change. For example, a quiet room was being renovated and more specific guidelines regarding care and communication added to care plans. The registered manager said, "We have a dementia champion in the home who works with the manager in developing these areas."

People and staff were actively involved in developing the service. Resident and relatives meetings were regularly held and the registered manager had conducted a survey in March 2018 of people, relatives, staff and health and social care professionals. They had collated the findings which were mainly positive and shared with people and staff.

Staff meetings took place every two months and staff felt able to discuss any issues with the registered manager. Records of meetings showed staff were able to express their views, ideas and concerns. Between each shift there was a handover to give staff key information about each person's care and any issues brought forward. The registered manager said they or one of the deputy managers attended handover each morning to ensure key information was handed over and to identify any concerns. To ensure all staff aware up to date with what is going on in the home, there was a staff email system on the computerised care system. Walkie talkies were used by staff on duty to request assistance and to inform other staff of what was happening. Staff ensured people's confidentiality, dignity and personal information was not discussed on the walkie talkies. One staff member said, "The amount of communication between staff is so much better. We have the walkie talkies so we know who is doing what, always one step ahead of self."

In October 2017 the service was inspected by an environmental health officer to assess food hygiene and safety. The service scored the highest rating of five, which confirmed good standards and record keeping in relation to food hygiene had been maintained.

The registered manager was meeting their legal obligations for example submitting statutory notifications to the CQC when certain events, such as a death or injury to a person occurred. They also provided additional information to the CQC promptly when requested. The provider did not have a website but had displayed the previous CQC inspection report in the main entrance to the service to make people aware of the CQC rating.