St Cuthbert's Care

Holy Cross

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

This inspection took place on 25 January 2018 and was unannounced. This meant the staff and provider did not know we would be visiting.

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

Holy Cross accommodates 56 people in one adapted building. Accommodation is provided on two of the four floors. One of which provides accommodation for people with nursing care needs. On the day of our inspection there were 50 people using the service.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like 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.

We last inspected the service in November 2015 and rated the service as 'Good.' At this inspection we found the service remained 'Good' and met all the fundamental standards we inspected against.

There were sufficient numbers of staff on duty in order to meet the needs of people who used the service. The provider had an effective recruitment and selection procedure in place and carried out relevant vetting checks when they employed staff. Staff were suitably trained and received regular supervisions and appraisals.

Accidents and incidents were appropriately recorded and risk assessments were in place. The registered manager understood their responsibilities with regard to safeguarding and staff had been trained in safeguarding vulnerable adults.

Appropriate arrangements were in place for the safe administration and storage of medicines.

The home was clean, spacious and suitable for the people who used the service, and appropriate health and safety checks had been carried out.

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.

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs. Care records contained evidence of people being supported during visits to and from external health care specialists.

People who used the service and family members were complimentary about the standard of care at Holy Cross.

Care records showed that people's needs were assessed before they started using the service and care plans were written in a person-centred way. Person-centred means ensuring the person is at the centre of any care or support plans and their individual wishes, needs and choices are taken into account.

Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible. Support plans were in place that recorded people's plans and wishes for their end of life care.

Activities were arranged for people who used the service based on their likes and interests and to help meet their social needs.

The provider had an effective complaints procedure in place and people who used the service and family members were aware of how to make a complaint.

The provider had an effective quality assurance process in place. Staff said they felt supported by the registered manager. People who used the service, family members and staff were regularly consulted about the quality of the service via meetings and surveys.

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 remained Good.

Is the service effective?

Good

The service improved to Good.

Staff were suitably trained and received regular supervisions and appraisals.

People were supported by staff with their dietary needs.

The provider was working within the principles of the Mental Capacity Act 2005 (MCA).

Is the service caring?

Good

The service remained Good.

Is the service responsive?

Good

The service remained Good.

Is the service well-led?

Good

The service remained Good.

Holy Cross

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 25 January 2018 and was unannounced. One adult social care inspector, a specialist advisor in nursing and an expert by experience formed the inspection team. An expert by experience is a person who has personal experience of using, or caring for someone who uses this type of care service.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, statutory notifications and complaints. A notification is information about important events which the service is required to send to the Commission by law. We contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. We also contacted Healthwatch. Healthwatch is the local consumer champion for health and social care services. They give consumers a voice by collecting their views, concerns and compliments through their engagement work. Information provided by these professionals was used to inform the inspection.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with eight people who used the service, five family members and a visiting health care professional. We also spoke with the registered manager, head of care, duty manager, nurse, nine members of staff and a volunteer.

We looked at the care records of four 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 records relating to the management of the service, such as quality audits, policies and procedures.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe at Holy Cross. One person told us, "Safe? Oh Yes, no harm comes to me. They [staff] look in all the time to see if I'm okay." Another person told us, "Yes, I have no falls here but I did at my previous home. I don't need to lock my door even at night as the staff check on me during the night as well." Another person told us, "I feel very safe. My house was broken into, but nothing like that happens here. We all have a lock but don't think anyone bothers to use the lock to be honest." A family member told us, "Safe? Definitely. I can go home at night knowing he is in good hands."

We discussed staffing levels with the registered manager and looked at staff rotas. Staffing levels varied depending on the needs of the people who used the service. There were some staff vacancies at the home and the provider was recruiting for new staff, including nursing staff. The registered manager told us agency nurses were being used to cover vacancies. Some people who used the service told us staff were busy. One person told us, "Sometimes it's a bit thin. They do their best though." Another told us, "They are all very helpful but always seem so busy." However, other people told us staffing levels were sufficient. One person told us, "There are ample staff. If I press my buzzer they come straight away." A family member told us, "There are always enough staff whenever I come." Another family member said they had pressed the buzzer as their relative was uncomfortable in bed. They told us, "Three staff came to hoist him into a more comfortable position within four minutes." None of the staff we spoke with raised any concerns about staffing levels and our observations confirmed there were enough staff on duty to keep people safe.

The provider had an effective recruitment and selection procedure in place and carried out relevant security and identification checks when they employed new staff to ensure they were suitable to work with vulnerable people. These included checks with the Disclosure and Barring Service (DBS), three written references and proof of identification. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults.

Accidents and incidents were individually recorded and a summary of incidents was produced at the end of each month, which was analysed. The same process was carried out for any falls. A manager's investigation report was completed for each accident and incident, detailing action taken and any lessons learned to reduce the risk of a recurrence. Action taken included reviews of support plans, sensor mats put in place and referrals to the falls team.

The service had a risk register and a risk management process in place. The aim of this was to protect people who used the service, staff and visitors, to achieve the highest standards, to provide a clear auditing system for quality assurance, and enhance the reputation of the service. Accidents, incidents and any other identified risks were discussed in the monthly managers' meeting and any relevant incidents were escalated to the provider's risk meeting. This meant the provider had taken seriously any risks to people and put in place actions to prevent accidents from occurring.

The provider's safeguarding adults' policy described the responsibilities of staff with regard to identifying, reporting and investigating any allegation of abuse, and the requirements when recruiting and training staff. Out of hours contact information was available for the registered manager and the provider's safeguarding lead. A safeguarding matrix was maintained that included information on each safeguarding related incident, what action had been taken and who had been informed. The provider also had a whistleblowing policy in place. We found the registered manager understood safeguarding procedures and had followed them, statutory notifications had been submitted to CQC and staff had been trained in how to protect vulnerable people.

The home was clean, communal areas such as toilets and bathrooms were clean with appropriate hand washing facilities, and there were no unpleasant odours present. The service had an infection control champion whose role was to encourage good hygiene and cleanliness. An annual infection control audit took place and additional hand hygiene audits were carried out. We spoke with the head housekeeper and viewed daily cleaning schedules. These were up to date.

Appropriate checks and servicing had been carried out to ensure the service was safe. These included electrical testing, gas servicing, portable appliance testing (PAT), hot water temperature checks, and lifting and hoisting equipment.

Risks to people's safety in the event of a fire had been identified and managed. For example, fire alarm and fire equipment service checks were up to date, and fire drills took place regularly. The provider had an emergency plan in place and people who used the service had Personal Emergency Evacuation Plans (PEEPs). This meant appropriate information was available to staff or emergency personnel, should there be a need to evacuate people from the building in an emergency situation.

Appropriate arrangements were in place for the safe storage, administration and disposal of medicines. Medicines were stored in secure trolleys inside locked rooms. Medicines that required cold storage were stored inside secure refrigerators. Temperatures for the rooms and refrigerators were recorded daily to ensure medicines were stored at the correct temperatures. We observed a medicines round at lunch time and saw the correct procedures were followed to ensure the safe and effective administration of medicine.

Medicines administration records (MAR) were checked and found to be accurate and up to date. A MAR is a document showing the medicines a person has been prescribed and records whether they have been administered or not, and if not, the reasons for non-administration. There were no missing signatures and the correct codes were used. A daily audit was completed for each MAR and additional audits were completed by senior staff. Staff had received training in the administration of medicines and regular competency assessments.

Good

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. A person who used the service told us, "They [staff] are very good and help at any time, nothing is too much trouble." Another person told us, "I don't have anything to worry about here I am very well looked after." A family member told us, "They [staff] are very professional, I haven't got a bad word to say about them. They all seem to know their jobs." Another family member told us, "[Name] has a lot of health issues but the girls are spot on in noticing when he is starting to get an infection. They call the doctor and tell me. It's just spot on and such a weight off my mind." A visiting health care professional told us, "Staff are well informed and happy to assist" and "They are very good here."

Staff were supported in their role and received regular supervisions and an annual appraisal. The registered manager maintained a supervision matrix. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. The registered manager told us promoting staff internally was important to the service and we saw staff had been supported to develop and gain promotion within the organisation.

Staff mandatory training was up to date. Mandatory training is training that the provider deems necessary to support people safely and included food safety, safeguarding, dementia, care of the dying, pressure care, falls, equality and diversity, nutrition, and mental capacity. Additional training was available to staff depending on their role. For example, 'React to red' pressure ulcer prevention training and training in identifying sepsis. New staff completed an induction and were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training and forms a set of minimum standards for new staff working in health and social care. The home had a large training room that was also used by external health and social care staff.

People's needs were assessed before they started using the service and continually evaluated in order to develop support plans. The service employed a family liaison manager, whose role was to liaise with families and work closely with new admissions for the first six weeks, ensuring their needs were being met.

At the previous inspection we identified that although most people had a pleasant lunch time experience, some people had to wait a long time before receiving their meals. At this inspection we found people were appropriately supported with their dietary needs. We observed lunch on the ground floor and first floor of the home. Some of the people in the dining room on the first floor required assistance with their meals and we saw staff sit down next to them and assist them in a caring and unhurried manner. People did not have to wait long for their food and clearly enjoyed their meal. Staff reminded people of the choices they had made and regularly asked if everything was ok or whether they wanted further assistance. The menu was clearly displayed and included a pictorial menu that people had chosen from but were able to change their mind. We also observed the chef went around everyone asking them what they thought of the meal, as did the registered manager.

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 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 MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider followed the requirements of the DoLS. The registered manager maintained a DoLS matrix, applications were submitted to the supervisory body in a timely manner and CQC were notified when they had been authorised.

Some people's care records included a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form which means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). Records we saw were up to date and showed the person who used the service had been involved in the decision making process.

Emergency health care plans were in individual care records that provided staff with guidelines for caring for the person should they become unwell. These stated whether the person wished to go to hospital or preferred to be cared for at the home. They included details of who the staff needed to contact in certain situations.

A family member told us, "We wanted the doctor for my [relative] but the doctor said he had already been and didn't need to come again. But the nurse insisted that he came again and it was a good job as [relative] needed different antibiotics and would have been in pain all weekend if it hadn't been for their insistence."

The home was aligned with a local GP practice. All the people who used the service were asked whether they wanted to align with the practice or stay with their original GP. Community nurses and nursing practitioners visited the home weekly, which reduced the number of visits to and from the GP. The registered manager told us it was working well and they had a very positive relationship with the practice staff. Staff also commented on how well the system was working and there was a good relationship between the home, GP and community nursing teams.

People were supported with their health care needs and to visit or be seen by health care professionals. These included GP, specialist nursing teams, dietitians, speech and language therapists (SALT), falls team, community mental health teams, dentists, opticians and chiropodists.

The service had incorporated some dementia friendly design into the premises. Communal bathrooms and toilets were clearly signed, and people's bedroom doors were clearly identifiable. Some dementia themed activities took place, such as rummage boxes, looking at books and pictures to stimulate memory, a sensory bath and people helped staff with the cleaning. The registered manager was the home's dementia champion and told us further work was being done to identify improvements and activities to aid people with dementia. We saw this was included in the service's action plan.

Good

Is the service caring?

Our findings

Without exception people and family members told us staff were very caring. One person told us, "The staff are kind and listen. Two [staff] take me for my bath and treat me with dignity. The bath is brilliant. It has different colours and is a jacuzzi and music plays from the 40s. I used to think getting a bath was a chore but now I look forward to them. Bring them on! I can also go to bed or get up when I want." Another person told us, "They [staff] are kind. They come and chat to me when they have time." A family member told us, "Unless you are in this position yourself you do not realise how caring they are. Marvellous!" Another family member told us, "[Staff member] always has a smile on their face and nothing, and I mean nothing, is too much trouble for them."

People we saw were well presented and looked comfortable in the presence of staff. We saw staff speaking with people in a polite and respectful manner and staff interacted with people at every opportunity. People were assisted by staff in a patient and friendly way and we saw and heard how people had a good rapport with staff. For example, at lunch time we heard a staff member say, "You're doing really well today, I'm going to give you a Blue Peter badge." The person smiled at this comment.

People were supported to be independent where possible. We observed some people mobilising independently around the home and others were supported by staff where required. Communication support plans were in place that recorded people's individual communication needs. We observed how staff communicated with people in a clear and patient manner. For example, when assisting a person to mobilise around the home, staff clearly explained what was going to happen, were skilled and careful, always engaged with the person and ensured they were comfortable at the end of the activity.

Staff had received specific training in dementia and dignity. This included the understanding of dementia, enabling rights and choices, enabling interaction and communication, equality and diversity, meeting nutritional requirements, administration of medicines, legal frameworks, life history and advanced care planning.

We saw staff knocking on bedroom doors and asking permission before entering people's rooms. A person who used the service told us, "Yes, I'm well looked after, I get enough privacy as everyone knocks." Our observations confirmed staff treated people with dignity and respect and care records demonstrated the provider promoted dignified and respectful care practices to staff.

People were supported with their religious and spiritual needs. There was a large chapel in the home and Mass took place every day. People from the local community also attended the service at the home. People did not have to be of the Catholic faith to live at the home and all faiths were welcome to participate in services.

We saw that records were kept securely and could be located when needed. This meant only care and management staff had access to them, ensuring the confidentiality of people's personal information as it could only be viewed by those who were authorised to look at records.

Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities. We discussed advocacy with the registered manager who told us none of the people using the service at the time of our inspection had independent advocates however two people had appointees to manage their finances.

Good

Is the service responsive?

Our findings

Care records we looked at were regularly reviewed and evaluated. Records were reviewed and evaluated monthly or more often as changes occurred.

Care records were person centred, which means the person was at the centre of any care or support plans and their individual wishes, needs and choices were taken into account. It was clear from the records that people and their family members had been involved in planning their care.

Support plans were detailed and reflected individual needs, identifying what the person needed assistance with and how they would like to be cared for. Support plans included mobility, personal hygiene, social and spiritual, finance, hearing and sight, health, medicines, eating and drinking, skin integrity, communication, and end of life. Each support plan stated what the person could do for themselves and clearly explained how staff would support and assist the person in a safe and effective way that ensured their individual needs would be met. Support plans provided very clear and concise information that explained exactly how conditions and problems could affect a person and what needed to happen to alleviate or solve the situation. Appropriate risk assessments were in place where required.

People had end of life support plans in place, which described people's preferences for their care at this time. For example, where they would prefer to be cared for, who they wanted to be contacted and any other arrangements. Staff had received training in caring for people at their end of life and the home had an end of life champion. Their role was to offer support to people with life-shortening illnesses and help with the choices they have to make.

Support plan evaluations were detailed and gave a very clear indication of how the person was responding to the plan. For example, a person who was admitted with multiple areas of skin damage now had only one small area remaining which was nearly healed. Any changes made to support plans were discussed during handovers or as they occurred throughout the shift. Following handovers a specific policy or topic was chosen for discussion.

We found the provider protected people from social isolation. Care staff carried out activities as the service was recruiting for a new activities coordinator. Activities took place every morning and afternoon. Coffee mornings were held where people could have a chat and discuss the news before attending Mass if they wished. A variety of activities were held in the afternoon, including bowls, singalongs, bingo and exercise sessions. Visiting entertainers and activities included singers and pet therapy. The provider had a minibus that the service could book electronically. Transport was also booked via a local company and people were able to access the local community and go on trips. For example, the local shopping centre, pantomime, garden centres and the coast.

The home had Wi-Fi Internet. Some of the people had their own electronic tablets but everyone was able to access the Internet if they wished. Some had used it to keep in touch with friends and family via Skype, which is used for video calls via the Internet. The home's shop opened twice per week selling religious

articles, cards, gifts, toiletries, sweets and snacks. People we spoke with told us they enjoyed the activities at the home and also told us they could choose to stay in their own bedroom if they wished.

A guide to making a complaint was displayed on the notice boards around the home. This provided an explanation on the complaints process, for example, how to make a complaint, what happens next and who to contact if the person was not satisfied. There had been two formal complaints recorded in the previous 12 months. We saw records included details of the complaint, what action had been taken and copies of correspondence. We saw from the residents' and relatives' meeting minutes that people were reminded to speak with management straight away if they had any concerns and not wait for the next meeting. People and family members we spoke with did not have any complaints to make.

We also viewed some recent compliments about the home. These included, "Food was fabulous. Staff were very helpful and jolly. A great big thank you to everyone at Holy Cross", "It [Christmas lunch] was first class. The service was brilliant and the food delicious" and "I witnessed great loving care from the care staff with [staff members] giving her frequent attention and medical help. Well today it was so pleasing to see my mam when I came in this morning. I am certain the loving care from [staff members] and others was so beneficial that it took my mam to this good state. Much appreciated and well done ladies."

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the service had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. They had been registered since November 2016 however had worked at the service for over 20 years. In recognition of their service, they had been awarded with a personal achievement in care leadership and management award in an event at a local college. We spoke with the registered manager about what was good about their service and any improvements they intended to make in the next 12 months.

They told us they were planning to change to a new electronic care records and medicines system in April 2018. The head of care and registered manager had been involved in the planning to ensure the new system incorporated their needs.

Other plans for the service included the development of a resource room to include training and reference resources and each of the home's 'champions' would be responsible for information on their area. This would also reduce the amount of training staff had to do in their own time. Plans were also in place to improve the outside area. There was a large garden to the front of the premises and plans were in place to make it more secure. Another garden was to be created at the rear of the home. Refurbishment plans for the building included new flooring, carpets and blinds.

The provider was meeting the conditions of their registration and submitted statutory notifications in a timely manner. A notification is information about important events which the service is required to send to the Commission by law.

The service had good links with the local community. They took part in the Sunderland in Bloom competition every year. They held a luncheon club twice a week where members of the community could come into the home for lunch. People from the local community also attended Mass at the home and local volunteers also worked there. The service had good links with the local police force and local schools, who visited regularly.

The service had a positive culture that was person centred and inclusive. Staff we spoke with felt supported by the management team, staff meetings took place regularly and annual surveys were carried out. People and family members we spoke with knew who the registered manager was and felt they could approach them. A family member told us, "The friendliness and welcome here is second to none. Second to none I tell you!"

The head of care told us about the new management structure that was in place. They told us, "We have a very strong staff team", "Communication is excellent" and "They're [staff] not frightened to ring us if they need something." They also told us, "I am proud to work for St Cuthbert's Care and see it as a privilege to be Head of Care and responsible for the people we care and support." The registered manager told us, "The staff work really hard", "They get good support" and "Our day doesn't stop at 5 o'clock."

We looked at what the provider did to check the quality of the service, and to seek people's views about it. Regular audits of the service were carried out and action plans were in place to identify any areas for concern and what was action needed. Action plans identified what the areas for improvement were, who the responsible person was, timescale and expected completion date.

The registered manager or duty manager conducted a daily walk around of the home, which included visiting people in their own bedrooms to make sure there were no issues or concerns.

As records were updated electronically, the registered manager and senior staff could access up to date reports to see if anything needed action. For example, weights, fluids and bowel charts. This allowed senior staff to keep up to date via their laptop, tablet or mobile phone with any issues or concerns, and check actions had been carried out. Staff we spoke with confirmed this. The registered manager also used the system to monitor staff supervisions and training.

The provider carried out a monthly visit to the home and completed an inspection report that was based on the CQC five key questions. This included an action plan. For example, the most recent inspection had identified some people did not have clear social or communication plans in place. We saw this had been actioned.

Residents' and relatives' meetings took place regularly. These included discussions on activities, staffing, meals, laundry and any other feedback or comments. Annual questionnaires were also sent out to obtain feedback from family members and visitors. The registered manager told us they had an "Open door" and "Any resident or relative can see me anytime." People we spoke with confirmed this.

This demonstrated that the provider gathered information about the quality of their service from a variety of sources and acted to address shortfalls where they were identified.