

C & K Homes Limited

# Cromwell House Residential Care Home

## Inspection report

Cromwell House  
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Devon  
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### Ratings

<b>Overall rating for this service</b>	<b>Requires improvement</b>	
Is the service safe?	<b>Requires improvement</b>	
Is the service effective?	<b>Requires improvement</b>	
Is the service caring?	<b>Good</b>	
Is the service responsive?	<b>Good</b>	
Is the service well-led?	<b>Requires improvement</b>	

### Overall summary

This unannounced inspection took place on 8 July 2015. We returned on 13 July 2015 as arranged with the assistant manager who was employed by the registered manager. After receiving information of concern from health and social professionals about how people's complex needs were being managed by staff, we brought the inspection forward.

Cromwell House is registered to provide care for one individual with a learning disability.

When we visited there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

# Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's risks were not managed robustly. As a result health and social care professionals had needed to intervene to support the service. Staff did not have up to date physical intervention training tailored to people's needs and said they felt ill-equipped to deal with incidents if they occurred.

Staff had not received up to date training in core subjects specific to people's needs. The training programme had only been recommenced following involvement of outside agencies who were concerned about staff being unable to support people appropriately. Staff also had not received an annual appraisal to help them develop in their roles.

The service was not working in accordance with the Mental Capacity Act (MCA) (2005). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time.

There were some systems in place to ensure the quality and safety of the service but staff had not proactively managed situations where a person using the service presented behaviour that was challenging to the service.

Staff relationships with people were strong, caring and supportive. Staff were motivated and inspired to offer care that was kind and compassionate.

People's likes, dislikes and preferences were taken into account in care plans. They were supported to maintain a balanced diet. Health and social care professionals were regularly involved in people's care to ensure they received the right care and treatment. Staff understood their safeguarding responsibilities and knew how to report concerns.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

# Summary of findings

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Some aspects of the service were not safe.

People's risks were not managed robustly.

Staff did not have up to date physical intervention training tailored to people's needs and said they felt ill-equipped to deal with incidents if they occurred.

Staffing arrangements were flexible in order to meet people's individual needs.

People's medicines were managed so they received them safely.

Requires improvement



### Is the service effective?

Some aspects of the service were not effective.

Staff had not received up to date training in core subjects specific to people needs. The training programme had only been recommenced following involvement of outside agencies who were concerned about staff being ill equipped to support people appropriately.

The service was not working in accordance with the Mental Capacity Act (MCA) (2005). The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time.

Staff also had not received an annual appraisal to help them develop in their roles.

People's health needs were managed well.

People were supported to maintain a balanced diet.

Requires improvement



### Is the service caring?

The service was caring.

Staff were caring and kind.

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

Good



### Is the service responsive?

The service was responsive.

People's likes, dislikes and preferences were taken into account in care plans.

Activities formed an important part of people's lives.

There were opportunities for people and people that matter to them to raise concerns.

Good



# Summary of findings

## Is the service well-led?

Some aspects of the service were not well-led.

There were some systems in place to ensure the quality and safety of the service but staff had not proactively managed situations where a person using the service presented behaviour that was challenging to the service.

Recordkeeping was not always robust and up to date.

Staff spoke positively about communication between the team. They felt the assistant manager worked well with them, encouraged team working and an open culture.

**Requires improvement**



# Cromwell House Residential 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 unannounced inspection took place on 8 July 2015. We returned on 13 July 2015 as arranged with the assistant manager who was employed by the registered manager.

The inspection team consisted of one inspector.

Before the inspection, we reviewed the information we held about the home and notifications we had received.

Notifications are forms completed by the organisation about certain events which affect people in their care.

We spoke with one person receiving a service and four members of staff, which included the registered manager and assistant manager.

People who used the service at Cromwell House had a learning disability and were unable to tell us about their experiences. To help us to understand their experiences we used our SOFI (Short Observational Framework for Inspection) tool. The SOFI tool allowed us to spend time watching what was going on in the service and helped us to record how people spent their time, the type of support they got and whether they had positive experiences

We reviewed one person's care file, two staff files, staff training records and a selection of policies, procedures and records relating to the management of the service. Before and after our visit we sought feedback from relatives and health and social care professionals to obtain their views of the service provided to people. We received feedback from three health and social care professionals and two relatives.

# Is the service safe?

## Our findings

Risk management was not robust. An incident had happened in the community. As a result health and social care professionals had needed to intervene following various assessments. Risk assessments were present but only provided basic details. For example, behaviour management risk assessments did not detail specific triggers, flashpoints and ways of managing these behaviours if they occurred. This would help staff to respond appropriately if needed. People did not have positive behaviour support plans in place for staff to follow if an incident occurred. A positive behaviour support plan is a document created to help understand and manage behaviour in adults who have learning disabilities and display behaviour that others find challenging.

Various professionals were now supporting the staff to develop risk assessments and specific plans to manage behaviours. The assistant manager had produced brief challenging behaviour guidelines which showed an understanding of situations where people's risks increased. These were to help formulate positive behaviour support plans. Staff knew how to support people by means of routines and ensuring a low stimulus environment. They recognised that new situations created anxiety for people.

Incident reports showed that sometimes physical intervention was needed to ensure the safety of people when a person was displaying behaviours which challenged their safety and others. Staff confirmed that they had received breakaway technique training accredited by the British Institute for Learning Disabilities (BILD) in 2013. However, they felt the training was out of date, not tailored to the people they supported and felt ill equipped to deal with incidents which required physical intervention to be used. Interim training had recently taken place by an approved physical intervention trainer. But this was as a result of an incident happening in the community and health and social care professionals intervening. Therefore this was not a measured and proactive approach and rather more a reaction to concerns being raised. Further training was being arranged which would give staff greater skills in managing incidents.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living at the home were not able to comment directly on whether they felt safe so we spent time in communal areas and spoke with staff to help us make a judgement about whether people were protected from abuse. Staff responded appropriately to people's needs and interacted respectfully to ensure their human rights were upheld and respected. Relatives commented: "Cromwell House is X (relatives) home, he feels safe and settled with the staff who know him so well." We observed a relaxed atmosphere, where people appeared happy in their surroundings and with the staff supporting them.

Staff demonstrated an understanding of what might constitute abuse and knew where they should go to report any concerns they might have. For example, staff knew how to report concerns within the organisation and externally such as the local authority, police and to the Care Quality Commission. Staff had received recent safeguarding training to ensure they had up to date information about the protection of vulnerable people.

The assistant manager demonstrated an understanding of their safeguarding role and responsibilities. They explained the importance of working closely with commissioners, the local authority and relevant health and social care professionals on an on-going basis. There was a safeguarding policy in place for staff to refer to. However, this was in need of being updated with the correct contact details of the local authority.

Staff confirmed that people's needs were met promptly and felt there were sufficient staffing numbers. We observed this during our visit when people needed support or wanted to participate in particular activities. For example, staff were seen to spend time with people doing art work. We asked how unforeseen shortfalls in staffing arrangements due to sickness were managed. They explained that regular staff would fill in to cover the shortfall so people's needs could be met by the staff members that understood them. At night a staff member slept in. We asked the assistant manager about on call arrangements, especially at night. They explained that staff would call them or another colleague if needed. There was no formal on call procedure in place which meant an overreliance on someone being available and near a telephone to respond, which had the potential not to be a reliable system.

There were effective recruitment and selection processes in place but telephone references needed to be logged. Staff

## Is the service safe?

had completed application forms and interviews had been undertaken. In addition, pre-employment checks were done, which included references from previous employers and Disclosure and Barring Service (DBS) checks completed. However, we could not locate one reference for a member of staff. This was due to a telephone reference being given and not recorded by the assistant manager. On the whole this demonstrated that appropriate checks were undertaken before staff began work in line with the organisations policies and procedures. This was to help ensure staff were safe to work with vulnerable people.

People's medicines were managed so they received them safely. Appropriate arrangements were in place when obtaining medicine. The home received people's medicines from a local pharmacy on a monthly basis. These were supplied, where appropriate, in blister packs so that staff could administer people's medicines with ease.

Medicines were kept safely in a locked medicine cupboard. The cupboard was kept in an orderly way to reduce the possibility of mistakes happening.

Medicines were safely administered. The medicines records were appropriately signed by staff when administering a person's medicines. When the home received the medicines from the pharmacy that they had been checked in by staff and the amount of stock documented. Additional checks had been put in place by the home to ensure that people received the correct type and dose of medicines. For example medicines were dispensed by two members of staff, with one dispensing and the other witnessing the procedure. On 8 July 2015, there was no 'as required' medicines protocol in place to ensure staff were consistently following agreed guidance when giving people extra medicines. When we returned on 13 July 2015 the protocol had been put in place by the assistant manager.

# Is the service effective?

## Our findings

There had been a gap in staff training between 2013 and 2015. Staff had not received up to date training in core subjects specific to people's needs. A training programme was now being developed and courses accessed via the internet and a local training company. The training programme had recommenced following the involvement of outside agencies who were concerned about staff being ill equipped to support people appropriately. Staff were now completing training in autism awareness, safeguarding vulnerable adults, behaviour and risk management and the Mental Capacity Act (MCA) (2005). Staff did hold nationally recognised qualifications in health and social care.

Staff received on-going supervision in order for them to feel supported in their roles. However, staff had not received annual appraisals. Appraisals enable the assessment of recent performance and focuses on future objectives, opportunities and resources needed to support staff to develop in their roles. The assistant manager recognised these needed to be done, but were having to prioritise other tasks first, such as staff training.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff demonstrated an understanding of the Mental Capacity Act (2005) (MCA) and Deprivation of Liberty Safeguards (DoLS) and how these applied to their practice. For example, what actions they would take if they felt people were being deprived of their freedom to keep them safe. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

When we visited on 8 July 2015 there were few mental capacity assessments and best interest meetings completed for people around specific decisions. The last one was dated November 2013 around financial matters. Due to the complex needs of people and their limited capacity to make decisions the service was not working within the framework of the MCA. Health and social care professionals were now working with the staff to complete mental capacity assessments for people. There was no MCA

and DoLS policy in place for staff to refer to. The assistant manager explained that the local authority was in the process of assisting them to put one in place. When we returned on 13 July 2015, the assistant manager had made available the MCA Code of Practice for staff to refer to.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

No-one was subject to DoLS at the time of our visit. However, an application had been completed in March 2015 and the DoLS authorisation process was now progressing. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. The safeguards exist to provide a proper legal process and suitable protection in those circumstances where deprivation of liberty appears to be unavoidable and, in a person's own best interests.

Staff had completed an induction when they started work at the service, which included training. The induction required new members of staff to be supervised by more experienced staff to ensure they were safe and competent to carry out their roles before working alone. The induction formed part of a three month probationary period, so the organisation could assess staff competency and suitability to work for the service.

Staff knew how to respond to specific health and social care needs. For example, recognising changes in a person's physical or mental health. Staff spoke confidently about the care practices they delivered and understood how they contributed to people's health and wellbeing. For example, how people preferred to be supported when feeling anxious through effective communication to allay their anxieties. However, there was an overreliance on informal methods of sharing information about how to respond to situations. This was now being addressed through care planning and risk assessment.

People were supported to see appropriate health and social care professionals when they needed, to meet their healthcare needs. A relative commented: "The staff always ensure X (relative) sees professionals if he is poorly." There was evidence of health and social care professional involvement in people's individual care on an on-going and timely basis. For example, GP, dentist, chiropodist and optician. These records demonstrated how staff recognised changes in people's needs and ensured other health and social care professionals were involved when necessary.

## Is the service effective?

Before people received any care and treatment they were asked for their consent and staff acted in accordance with their wishes. Throughout our visit we saw staff involving people in their care and allowing them time to make their wishes known through the use of individual cues, such as looking for a person's facial expressions, body language and spoken word. People's individual wishes were acted upon, such as how they wanted to spend their time.

People were supported and encouraged to eat and drink. Staff cooked the main meals within the home and

encouraged people to be involved in baking. People were provided with a wholesome diet which was balanced and nutritious. There was a menu in place and meals were generally planned around whatever people wanted to eat. We observed how people were offered a choice of what they wanted to eat and drink. Snacks and drinks were available at any time. People's weight was also monitored on a regular basis.

# Is the service caring?

## Our findings

We spent time talking with people and observing the interactions between them and staff. Interactions were good humoured and caring. Staff involved people in their care and supported them to make decisions. Relatives commented: “The staff are wonderful with X (relative)” and “You could not ask for more caring staff.”

Staff treated people with dignity and respect when helping them with daily living tasks. Staff told us how they maintained people’s privacy and dignity when assisting with intimate care. For example by knocking on bedroom doors before entering, being discreet such as closing the curtains and gaining consent before providing care. Staff adopted a positive approach in the way they involved people and respected their independence. For example, supporting people to make specific activity decisions. People were completing art work during our inspection. We observed the wide range of art work already completed. Staff supported people in a kind and empathetic way. Staff were kind and gentle when helping a person with their art work, encouraging them to make choices when choosing pictures to cut out and stick on the paper. Staff showed an understanding of the need to encourage people to be involved in their care. For example, how one person wished staff to talk with them about things which interested them, such as tractors and helicopters.

Staff relationships with people were caring and supportive. For example, staff spoke confidently about people’s specific

needs and how they liked to be supported. Staff were motivated and inspired to offer care that was kind and compassionate. For example, staff spoke about how they were a caring team who wanted the best for people. Staff were observant to people’s changing moods and responded appropriately. For example, we heard a member of staff reassuring a person when we were spending time with them. The member of staff supported them in a caring and calm manner by talking with them about things which interested them and made them happy.

Staff were involving people in their care through the use of individual cues, and looking for a person’s facial expressions, body language, spoken word and objects of reference on the picture board. Staff gave information to people, such as when they would be going out for a milkshake. We observed that staff communicated with people in a respectful way. This showed that staff recognised effective communication to be an important way of supporting people to aid their general wellbeing.

Staff showed a commitment to working in partnership with people. Staff spoke about the importance of involving people in their care to ensure they felt consulted, empowered, listened to and valued. They were able to speak confidently about the people living at Cromwell House and each person’s specific interests. They explained that it was important that people were at the heart of planning their care and support needs and how people were at the centre of everything.

# Is the service responsive?

## Our findings

People received personalised care and support specific to their needs and preferences. For example, people's bedrooms were personalised to reflect their likes and personalities. Care plans reflected people's health and social care needs and demonstrated that other health and social care professionals were involved. People were involved in making decisions about their care and treatment through their discussions with staff. The staff worked closely with relatives to ensure they were acting in people's best interests. Relatives commented that when important decisions were made they were well informed.

Care files gave information about people's health and social care needs. They were personalised and reflected the service's values that people should be at the heart of planning their care and support needs. For example, supporting people to identify specific activities to aid their wellbeing and sense of value.

Care files included personal information and identified the relevant people involved in people's care, such as their care manager and GP. The care files were presented in an orderly and easy to follow format, which staff could refer to when providing care and support to ensure it was appropriate. People's likes, dislikes and preferences were taken into account in care plans. This demonstrated that when staff were assisting people they would know what kinds of things they liked and disliked in order to provide appropriate care and support.

Care plans were up to date and were clearly laid out. They were broken down into separate sections, making it easier to find relevant information. For example, communication, health needs, personal care, behaviour management, activities and eating and drinking. Staff told us that they found the care plans helpful and were able to refer to them at times when they recognised changes in a person's physical or mental health. Recent input from health and social care professionals had resulted in referrals being made for specific assessments, such as to speech and language and positive intervention services. Some of these assessments had been completed and were now helping to formulate bespoke plans of care for individuals.

Activities formed an important part of people's lives to increase their quality of life. People spent time doing activities within the home and participated in trips in the community. People enjoyed spending time baking, looking through books and magazine, arts and crafts, going out for drives in the van and relaxing watching television.

There were opportunities for people and people that matter to them to raise issues, concerns and compliments through on-going discussions with them by staff. However, when we visited on 8 July 2015 there was no complaints policy for people to refer to. When we returned on 13 July 2015 a complaints policy had been put in place. Staff told us that any concerns were managed as part of their discussions with people. The home had not received any complaints. However, the assistant manager recognised that if they received a complaint, they would now attend to it in line with the organisation's procedure now in place.

# Is the service well-led?

## Our findings

Staff confirmed they had attended staff meetings and felt their views were taken into account. Meeting minutes showed meetings took place on a regular basis and were an opportunity for staff to air any concerns as well as keep up to date with working practices and organisational issues. However, staff had continually raised concerns about the lack of specialist training specific to people's needs. The assistant manager had spoken on several occasions to the registered manager and providers, but funding for training had not been released. As a result of health and social care professionals concerns, monies had now been released and a training programme started. We looked at the organisation's statement of purpose which stated: 'Offer our staff a range of training that is relevant to their induction, foundation experience and further development'. What we found did not reflect the organisation's statement of purpose.

We found recordkeeping was not robust and up to date. Records were not accurately kept and there was an overreliance on informal methods of sharing information. For example, when we asked to see staff competency records the assistant manager was unable to produce these; and risk assessments did not contain the level of detail to mitigate risks. They said the staff had the knowledge and 'the best interests of people at heart', but could not demonstrate any of this due to the lack of paperwork. Policies and procedures were also outdated and contained incorrect contact details for outside agencies. As the organisation's statement of purpose under 'management and administration' states: 'Keep up to date and accurate records on all aspects of Cromwell House and its residents.' This meant the service was not running as per their own statement of purpose.

There was a registered manager and assistant manager working at Cromwell House and we spent the majority of our time working alongside the assistant manager. The assistant manager embraced the recent involvement of other professionals to ensure the service was of good quality. During our inspection they were working closely with them, acting on advice and developing key documents in line with best practice.

As a result of a recent police incident in the community there was evidence that appropriate changes were being implemented. For example, changes to a person's care plan

and risk assessments to reflect current circumstances. These changes were being made in conjunction with other professionals who possess up to date knowledge on behaviour management.

Audits were completed on a regular basis. For example, the audits reviewed people's care plans, medicines and finances. This enabled any trends to be spotted to ensure the service was meeting the requirements and needs of people being supported. However, the audits had not been robust enough to pick up risk management issues which had led the service to needing support from other professionals.

The above was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We had not received a notification of the police incident. A police incident is by law an incident which should be notified to CQC in line with the Health and Social Care Act (2008). The assistant manager acknowledged that he lacked understanding of what was notifiable. He agreed to complete the notification retrospectively.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Staff spoke positively about communication between the team. They felt the assistant manager worked well with them, encouraged team working and an open culture. Staff commented: "The assistant manager is very supportive" and "We are always able to discuss things with X (the assistant manager)."

The service adopted informal methods when seeking people's views. This was through regular family contact, postcards and birthday cards and flowers and chocolates being sent to relatives. There was regular contact with family members throughout our inspection.

The premises were adequately maintained and a maintenance programme was in place. Health and safety checks were completed on a daily, weekly, monthly and annual basis by staff employed by the organisation and external contractors. For example, fire alarm, fire extinguishers and electrical equipment checks. This demonstrated that people were protected because the organisation took safety seriously and had appropriate procedures in place.

This section is primarily information for the provider

## Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Risk management was not robust. Risk assessments only provided basic details. People did not have positive behaviour support plans in place for staff to follow if an incident occurred. Physical interventions were carried out by staff unlawfully without authorisation to do so in accordance with the Mental Capacity Act (2005) Deprivation of Liberty Safeguards.

Regulation 12 (2) (a) (b)

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

Staff training was not up to date to reflect current best practice and appraisals had not happened to ensure they felt supported to develop in their roles.

Regulation 18 (2) (a)

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 11 HSCA (RA) Regulations 2014 Need for consent

Staff were not acting in accordance with the Mental Capacity Act (MCA) (2005) when it came to completing mental capacity assessments for people around specific decisions. There was no MCA and Deprivation of Liberty Safeguards (DoLS) policy in place for staff to refer to.

Regulation 11 (1)

### Regulated activity

### Regulation

This section is primarily information for the provider

## Action we have told the provider to take

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA (RA) Regulations 2014 Good governance

The provider did not have systems and processes that ensured the quality and safety of the service.

Regulation 17 (1) (2) (a) (b) (c) (d) (f)

### Regulated activity

Accommodation for persons who require nursing or personal care

### Regulation

Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

The service had not notified the Care Quality Commission (CQC) about a police incident. A police incident is by law an incident which should be notified to CQC in line with the Health and Social Care Act (2008).

Regulation 18 (Registration) (1) (2) (f)