Susash Sheffield Ltd

Cambron House

Inspection report

3 Flanderwell Lane
Bramley
Rotherham
South Yorkshire
S66 3QL

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09 October 2018

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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

We carried out an unannounced inspection of Cambron House on 9 October 2018. Cambron House is a care home which provides nursing care and support for up to 38 older people. At the time of this inspection there were 31 people living at the service. 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 service is a detached building on two floors with access to the upper floor via stairs or a passenger lift. Some rooms have en-suite facilities and there are shared bathrooms, shower facilities and toilets. Shared living areas include a lounge on the ground floor, a reminiscence room and a dining room. The service stands in its own grounds with accessible mature garden areas.

There was a registered manager in post who was responsible for the day-to-day running of the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This was the first inspection of the service since a change of registered provider.

People told us that they felt safe living at Cambron House. Staff had received safeguarding training and understood how to recognise and report abuse. We observed warm and friendly interactions between staff and people throughout the inspection. Staff knew people well.

People's risks were well documented and care was provided to people in the least restrictive way whilst being aware of people's personal risks. Risks were regularly reviewed.

Medicines were well managed and people received their medicines safely and on time. People received 'as needed' medicines when necessary. There were protocols to guide staff when to administer these medicines.

Staff were aware of infection control and how to keep people safe from the spread of infection. The home provided gloves and aprons for staff when delivering personal care. There were regular maintenance checks and staff were aware of how to report maintenance issues.

Staff received regular supervision, appraisal and training to support them in their role.

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 support this practice.

There were individualised care plans written from the point of view of the people that were supported. Care plans were detailed and provided enough information for staff to support people. Care plans were regularly reviewed and updated immediately if changes occurred.

There was a variety of activities that people could choose to take part in. People were supported and encouraged to engage in activities. People received good quality food and there were always drinks available to ensure hydration. Where people required specialist diets, we saw that this was being provided.

People and relatives were encouraged to help plan end of life care in a tailored way. Staff were compassionate regarding caring for people at the end of their lives.

There was a complaints process in place and people and relatives knew how to make a complaint. Complaints were investigated and followed up.
Visitors told us that they felt welcome within the home and able to visit whenever they wanted.

Audits were carried out across the service on a regular basis on medicines management, health and safety and the quality of care. Surveys were completed with people who use the service and their relatives. Where issues or concerns were identified, the manager used this as an opportunity for change to improve care for people.

People and relatives felt the registered manager and management team were accessible to people and relatives were confident in the care that was being provided.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from risks to their safety and wellbeing, including the risks of abuse and avoidable harm.

The provider employed sufficient staff and carried out recruitment checks to make sure staff were suitable to work in a care setting.

Processes were in place to make sure medicines were administered safely, and to protect people from the risk of infection.

Is the service effective?

Good

The service was effective.

Assessments completed prior to people moving into the service were detailed.

Staff had a good understanding of the Mental Capacity Act 2005(MCA) and Deprivation of Liberty Safeguards (DoLS).

Staff received the training and support they needed to enable them to meet people's needs.

People had a choice of food that met their individual needs and preferences.

People's health needs were met. They were supported to access healthcare services when they needed them.

Is the service caring?

Good

The service was caring.

People had developed positive relationships with staff.

People were supported to take part in decisions affecting their care and support.

People's independence, privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

People's care was planned in a person-centred way.

Staff regularly reviewed people's needs and responded to any changes.

End of life care was planned in a sensitive and personalised way.

People were informed of how to raise a complaint and complaints had been handled in line with policy.

Is the service well-led?

Good

The service was well-Led

Staff were supported in their role and felt valued. There was a positive culture where staff understood the ethos of the service.

Quality assurance audits were in place and concerns identified were addressed.

The registered manager worked alongside other agencies to improve the service.

People and their relatives were involved in the development of the service.

Cambron House

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 checked 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 9 October 2018 and was unannounced. The inspection was undertaken by one adult social care inspector.

Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service. This included past reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with a range of people about the service; this included five people who lived at Cambron House. During the inspection we spoke with five staff members, the registered manager, the registered provider and nurse on duty. We also spoke with two visitors and a visiting district nurse.

We looked at care records of six people who lived at the service and training and recruitment records of three staff members. We also looked at records relating to the management of the service. In addition, we checked the building to ensure it was clean, hygienic and a safe place for people to live.

During our inspection, we used a method called Short Observational Framework for Inspection (SOFI). This involved observing staff interactions with people in their care. SOFI is a specific 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 and staff consistently told us they felt the service was safe. People had developed positive and trusting relationships with staff that helped to keep people safe. One person told us, "I think I am very safe here." Another person said, "I don't have any safety worries, I am well looked after." One relative commented, "I believe it is a very safe environment here."

The provider had put measures in place to protect people from the risk of avoidable harm and abuse. Staff had undertaken adult safeguarding training within the last year and understood the correct safeguarding procedures to take should they suspect abuse. A member of staff told us, "If I suspected there was anything wrong I would report it straight away, either to the manager or an appropriate external agency." The home held the most recent local authority multi-agency safeguarding policy as well as current company policies on safeguarding adults.

People were protected from being cared for by unsuitable staff because there were robust recruitment processes in place. Staff confirmed that they were asked to complete an application form which recorded their employment and training history. Records included a recent photograph, written references and a Disclosure and Barring (DBS) check. DBS checks identify if prospective staff had a criminal record or were barred from working with adults at risk. Staff confirmed they were not allowed to commence employment until satisfactory criminal record checks and references had been obtained. The registered manager also verified staff's qualifications and membership to professional bodies, such as, the Nursing and Midwifery Council (NMC). The NMC is the regulator for nursing and midwifery professions in the UK. The NMC maintains a register of all nurses, midwives and specialist community public health nurses eligible to practise within the UK.

People had assessments in place which identified risks in relation to their health, independence and wellbeing. There were assessments in place which considered the individual risks to people such as mobility, nutrition and hydration, and personal care. Where a risk had been identified, for example a pressure risk, the assessment had looked at factors such the person's mobility and skin condition as well as nutrition. The service referred such risks to the person's GP, Tissue Viability Nurse and ensured the necessary equipment was made available, for example, pressure mattresses. Staff could tell us about people's individual risks and how they were being managed. Records were up to date and showed what action had been taken in response to changes in level of risk. The provider kept records of routine maintenance of equipment used to support people, and there was regular checks of fire detection and prevention equipment, emergency lighting, electrical equipment and the passenger lift.

People were cared for by a sufficient number of suitable staff. One person told us, "I have no concerns about the staff they are always there when I need them." A relative said, "The staff are busy but there are usually enough and in my experience, the bells seem to get answered quickly." We spoke to some staff who had been there for a number of years. They told us, "As a consistent staff team we are able to build proper relationships with people. This gives us a real understanding of people's care and support needs." Staffing rotas were based on the dependency and individual needs of people.

Safe medicines practices were followed and guidance for staff was available. People were happy with the way they were supported with their medicines. One person told us, "I always get my tablets on time." Another person said, "They put my cream on gently." Care records detailed the support each person required to take their medicines. Medicines were stored securely in locked trolleys and rooms, and administered by trained staff. Medicine Administration Records (MAR) contained sufficient information such as photographs and allergies to ensure safe administration of people's medicines. MAR sheets were completed accurately and stocks we checked corresponded with the balances recorded. Guidance was available to staff for the administration of 'when required' medicines (PRN). Records confirmed this guidance had been followed with clear documented reasons why the medicines had been administered. Topical creams and liquids were dated when opened to ensure they were used within set time limits. Medicines were managed by staff who had received the relevant training and who underwent annual assessments of their competency.

There were appropriate systems in place for managing controlled drugs (CD). Controlled drugs are medicines that are included under The Misuse of Drugs Regulations (2001) because they have a higher potential for abuse. Medicines classed as controlled drugs have specific storage and administration procedures under the regulations. CDs were audited daily and we found that audits accurately reflected the usage of CDs within the home. There were suitable systems in place for the disposal of medicines.

Equipment had been serviced and maintained as required. Records were available confirming gas; electric and fire systems were being maintained and were safe to use. Equipment including moving and handling equipment (hoist and slings) were safe for use and were being regularly serviced. We observed they were clean and stored appropriately so people were safe when moving around the premises.

The environment was clean, tidy and maintained although some aspects were in need of attention. The registered provider had identified this and was in the process of upgrading some aspects of the home. For example, during our inspection external professionals were upgrading aspects of the roof, measuring for a new lounge carpet and a new cooker had been purchased and was awaiting fitting by a qualified gas professional. One staff member said, "I take great pride in making sure the home is clean." There were designated staff for the cleaning of the premises. Infection control procedures were in place and regular checks were made to ensure cleaning schedules were completed. During the day of inspection, we observed staff making appropriate use of personal protective clothing such as disposable gloves and aprons.

There were records of accidents and incidents and staff knew what to do if someone had an accident or sustained an injury. Incidents were recorded in detail and any action taken at the time of the incident had been recorded. Any accidents or incidents, such as falls, were discussed at staff meetings and any learning shared.

Good

Is the service effective?

Our findings

Staff were knowledgeable about the people living at the service and had the skills to meet people's needs. People using the service and relatives told us they were confident that staff knew them well and understood how to meet their needs. People told us they received good care and support and that they were given choices about their care. One person told us, "Staff are lovely and know how I like things done." People's needs and choices were assessed and met within the home. These assessments helped staff to understand people's individual care needs and supported them to provide effective care. Relatives we spoke with felt that staff were well trained and provided good care. Relatives commented, "I think staff are very confident and know what they are doing" and "Staff appear to be knowledgeable and experienced."

Staff told us they received formal supervision and appraisal to support them in their role. Nurses received clinical supervision from the registered manager. There were daily shift handovers attended and delivered by nursing staff with information and updates given to the next staff team. This made sure staff coming on duty had current details for the people they would be supporting and caring for.

Newly employed staff were required to complete an induction before providing support independently. This included training identified as necessary for the service and familiarisation with the organisation's policies and procedures. The induction programme and training records covered orientation to the premises and included fire procedures, staff handbook and safer working practice. Training topics included, safeguarding, infection prevention and control, moving and handling, practical skills, medicines and record keeping. The induction was in line with the Care Certificate which is designed to help ensure care staff that are new to working in care have initial training that gives them an adequate understanding of good working practice within the care sector.

Staff also received training in equality and diversity which focused on current Equality Act legislation and ensured staff understood what discrimination meant and how to protect people from any type of discrimination.

There was use of assistive technology to support people. This included pressure mats to alert staff when people were moving around. These were used only as necessary and identified as part of the risk assessment and mental capacity assessment.

People were offered a choice of nutritious food and drinks. One person told us, "The food is always nice." Menus were displayed in the dining area and people were provided with a pictorial choice of meals. There was range of breakfast items available including a cooked breakfast. We observed that if people changed their mind and wanted a different option this was provided. The chef told us, "I ensure I get feedback from people and ensure their preferences are met." People were asked where they would like to eat their lunch and staff respected this. Tables in the dining room were nicely laid and staff sat with people to have their lunch which created a friendly atmosphere. Where people required support to eat this was provided at the person's pace and in a respectful manner.

Where people had specific dietary needs, these were clearly documented and plans were implemented to meet them. Where people had difficulty swallowing, we saw that a speech and language therapist (SALT) had seen them and recommended soft foods and thickened fluids to reduce the risk of choking. Their care plan was updated with guidance for staff on the types of foods they could eat and the thickness their drinks needed to be. We observed staff providing food and drink to one person in line with this guidance.

The provider had developed a good working relationship with local healthcare providers. Records showed people had access to a variety of healthcare services when needed to ensure they were adequately supported in their health and welfare. These included the district nurse team, dieticians, speech and language therapists and tissue viability nurses. We spoke with a visiting health professional who had visited the home previously. They told us staff referred to them appropriately and always acted on advice and support given quickly and effectively.

Cambron House is a purpose-built home to ensure people's needs were met with the design of the home. When we visited there were some upgrades being made to the home, with further improvements planned to the fabric and décor of the building. People's rooms were personalised so they had a 'homely' feel and people had personal possessions and photos in them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty 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 are called the Deprivation of Liberty Safeguards.

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. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible.

The policies and systems in the service supported this practice. We noted a number of people had been referred to the local authority for a Deprivation of Liberty Safeguards assessment. The registered manager had ensured they made appropriate and timely applications and reviews were carried out in the timescales given. Appropriate records were kept to show the correct process was followed. There was evidence of best interest meetings being held where this was required.

Good

Is the service caring?

Our findings

People told us that they were supported by caring staff. One person said, "The staff are very good, they do anything I ask for." Another person told us, "They [staff] chat to me and are always nice." A relative told us, "Staff are always very good, I have no negative experiences."

During the inspection, we saw some pleasant caring interactions between people and staff. We saw staff used a hoist to support someone to move from their chair to a wheelchair. Staff engaged in conversation throughout the procedure and smiled. Staff used eye contact and touch to reassure the person as they were lifted from their chair. The person was at ease and smiling as they joked with staff.

We observed mostly positive interactions between people and staff in relation to asking permission before intervening or assisting. Although we did see instances where this aspect of interaction could be improved. For example, a member of staff was assisting a person to eat at lunchtime. There was very little conversation, encouragement or interaction. We discussed this with the registered manager who informed us this issue would be highlighted at team meetings and individual staff supervision.

Staff were able to describe to us how they enabled people to have choice, such as; by showing people different choices of clothes, offering a variety of meals to choose from, or a choice of activities. Staff were responsive to people's needs and addressed them promptly and courteously. It was evident all staff knew all people very well; for example, staff knew people's food preferences without referring to documentation.

Throughout the inspection visit we observed staff responded to people's needs and treated people with dignity. They were polite and attentive and quick to respond to people who required their assistance. Staff demonstrated they knew and understood people's life history, likes, dislikes, needs and wishes. They knew and responded to each person's diverse cultural and spiritual needs and treated people with respect and patience.

Some people told us they were involved in their care planning and decisions about how they wanted to receive support. However, some people were unable and consultation could only occur with people's representatives such as their relatives or advocates. People told us staff always asked them if it was alright with them before providing any care and support.

People's dignity and privacy were respected. Staff knocked on people's doors and announced themselves before entering. People sitting in communal areas were asked discreetly if they wanted any support with their personal care and this was done in private with all doors closed. One staff member told us, "We do a lot of intimate tasks so it's important to do it whilst maintaining the person's dignity." They went on to describe how they would cover people during when supporting them with their personal care so they did not feel exposed.

Relatives told us they were made to feel welcome when visiting their loved ones. One relative told us, "I am always made to feel welcome and comfortable, I always get a cup of tea. They [staff] make a real effort to

talk to me. They look after me as well." Another relative told us, "I can come and visit at any time, there are no restrictions." We observed staff greet visitors warmly, offer refreshments and check they were comfortable.

Good

Is the service responsive?

Our findings

Individual care plans were in place for people and had been created with their support needs and risks detailed. Each care plan included a description and monthly reviews on topics including hearing, speech, comprehension, relationships and social interaction, dietary needs, oral care, washing and dressing, foot care, skin condition, medication, financial arrangements and end of life care. Each file contained a one page profile that included a summary of an individual's background, skills, likes and dislikes, tips for communication, critical care and support needs and what was important for each person. Care documented people's life history and what was important to them. For example, types of music, family relationships and childhood memories.

Each care plan also provided information around people's cognitive abilities. A section documented people's decision-making ability and included, what people could do and what they found difficult. This gave staff guidance on how to support people with decision making in the least restrictive way and how people could best be supported in their day to day lives.

People's communication needs were well documented in care plans. This included if the person required aids such as hearing aids or glasses. It also included information on how people communicated through gestures or sounds. This gave staff guidance on how to recognise if a person was distressed, happy or needing something if they were unable to effectively communicate verbally.

The home had a dedicated activities coordinator. We saw that there were posters around the home advertising activities including arts and crafts, baking and exercise. There were daily activities for people to participate in, including quizzes, dancing, arts and crafts, movement to music, singing and bingo. We observed people were smiling and singing. There was a happy, calm atmosphere throughout the home and some people that did not wish to engage in activities were seen to be observing. We saw photographs displayed of previous activities including, pub lunches and trips to a local country park. There were also newspaper clippings celebrating a person receiving military honours. There was a poster on the door at the main entrance showing the activities for each day.

There was a large garden which was overlooked from light and airy conservatory. The registered manager told us people accessed the garden in good weather. The home had a hairdressing salon and a hairdresser regularly visited. People were able to make appointments when they wished.

The home had a complaints procedure that was available for staff and people to read and was displayed by the front door. And included the service user handbook. There were no recent complaints however, historic complaints had been acknowledged, an investigation carried out and a response provided to the complainant. The registered manager told us transparency and communication were central to good governance. Relatives told us that they knew how to complain if they wanted to and felt that their concerns would be listened to. A relative said, "I know who to complain to but have never found the need to." Relatives also told us that any minor issues were discussed with management and immediately addressed.

We saw written compliments from a range of people. A social worker had remarked, "Impressed by the quality of patients care plans, very person centred." Relatives and visitor comments included, "Delicious meals," "Thank you for your selfless efforts and care," and "Fantastic care, you guys rock."

There were end of life procedures in place to take account of people's wishes wherever possible, as well as ensuring the service could access any specific medical needs for people at these times. This helped the service to contact and liaise with the end of life service ensuring peoples urgent care needs were supported. The service worked closely with the family and health professionals, reducing the need for avoidable hospital admissions and providing the right care at the right time.

Good

Is the service well-led?

Our findings

People we spoke with were all very positive about the management of the service. They described the registered manager as being supportive and approachable. We observed the registered manager getting involved, speaking to people and asking staff how certain people were. One relative told us, "The manager is always available." A visiting healthcare professional told us, "The registered manager is always available and has up to date knowledge on every person here. You don't find that that everywhere. We work well together." One staff member told us, "I can go to the manager any time, they are really supportive." Another staff member said, "The manager demands high standards but you wouldn't want anything less."

There was a clear vision to provide a high standard of care and support based on the values of care, passion and openness. These values were communicated to people and their families in a welcome folder and emphasised to staff through interview, supervision and day to day interactions, such as the daily meeting for staff.

The registered manager walked round the home daily which enabled her to make sure the values were embedded in the daily practice of staff. Staff told us that the values were applied in relationships between staff and management as well as in relationships with people. One staff member told us they liked working at the home, "I love it here, I left to work nearer home but quickly returned as it really is the best place to work."

The registered provider and registered manager regularly checked and monitored the quality of the care that people received. A variety of audits were carried out that checked areas such as health and safety, documentation, food and infection control. Records showed these audits were robust and where they identified any areas for improvement, these were added to an action plan which the registered manager used to keep track of actions and sign off where completed. Audits were also used to monitor clinical needs. The registered manager carried out a monthly analysis of clinical needs such as infections, weight loss and falls. These were monitored each month and a record was kept in order to identify any patterns or trends. Although one person had been recorded as requiring their weight to be taken weekly due to weight loss. This had not happened with the regularity intended. The registered manager told us this would be addressed through individual supervision and team meetings.

There was evidence of people's views being considered through daily communication and through resident's meetings. There was a survey system in place to take account of people's views. The results from the previous survey were positive with comments suggesting the service was excellent or very good and nobody had reported any concerns. People reported they felt the staff were professional, knew them well and respected their wishes.

The provider had developed links with stakeholders and the wider community. People's care records showed frequent communication with stakeholders such as commissioners and social care professionals. The provider understood the responsibilities of their registration. Providers are required to notify CQC of any important events such as serious injuries, deaths or allegations of abuse. Records showed that where

required, the provider had notified CQC.