Cygnet Health Care Limited

Tupwood Gate

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?	**Requires improvement**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

Tupwood Gate is a residential home which provides nursing care, and accommodation for up to 35 older people with physical health needs some of who require palliative care and some people who are living with mild dementia. Respite care is also provided (Respite care is short term care which gives carers a break by providing care away from home for a person with care needs).

On the day of our inspection there were 26 people living in the home. The registered manager stated that some rooms were for two people and they would be applying to deregister these shared rooms as well as one that was not fit for purpose.

This inspection took place on 24 June 2015 and was unannounced.

The home had a registered manager. They liked to be referred to as 'Matron'. 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.

People told us care staff treated them properly and they felt safe. One person said; "Yes, I have felt safe and I've

Summary of findings

never lost anything." We saw staff had written information about risks to people and how to manage these in order to keep people safe. One person had been assessed as being at risk of skin breakdown, we saw a skin risk action plan detailing actions for staff to undertake to minimise the risk to the person which detailed the appropriate pressure mattress settings, repositioning schedules, and reference to nutrition care plans to promote skin healing.

Staff had received training in safeguarding adults and were able to tell us about the different types of abuse and signs a person may show. Staff knew the procedures to follow to raise an alert should they have any concerns or suspect abuse may have occurred.

Care was provided to people by a sufficient number of staff who were appropriately trained and deployed. People did not have to wait to be assisted. One person said; "I do think there are enough staff about." Another person said "You never have to wait."

Processes were in place in relation to the correct storage and auditing of people's medicines.

Medicines were administered to people with dignity and disposed of in a safe way.

The premises were safe and fit for purpose accept for one room that was being decommissioned.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLs) which applies to care homes. The registered manager and staff explained their understanding of their responsibilities of the Mental Capacity Act (MCA) 2005 and DoLS and what they needed to do should someone lack capacity or needed to be restricted to keep them safe. They had undertaken the appropriate assessments on people who lacked capacity to make certain decisions and the appropriate DoLS had been submitted to the local authority.

People were provided with a choice of freshly cooked meals each day and facilities were available for staff to make or offer people snacks at any time during the day or night.

People were treated with kindness, compassion and respect. Staff took time to speak with the people who they supported. We observed some positive interactions and it was evident people enjoyed talking to staff. However not all staff interacted with people in a social way and addressed people only to provide a task e.g. "Its lunch time, Have a drink. Etc. People were able to see their friends and families as they wanted and there were no restrictions on when relatives and friends could visit. One relative said; "There are all sorts of nice things happening."

People and their families had been included in planning and agreeing to the care provided. We saw that people had an individual plan, detailing the support they needed and how they wanted this to be provided. The home had been commended in the Gold Standards Framework. Staff ensured people had access to healthcare professionals when needed. For example, details of doctors, opticians, tissue viability nurses visits had been recorded in people's care plans.

People's views were obtained by holding residents' meetings and sending out an annual satisfaction survey. Complaint procedures were up to date and people and relatives told us they would know how to make a complaint if they needed to.

Staff recruitment processes were robust to help ensure the provider only employed suitable people.

The provider had quality assurance systems in place, including regular audits on health and safety, infection control and medication. The registered manager met CQC registration requirements by sending in notifications when appropriate. We found both care and staff records were stored securely and confidentially.

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?

Good

The service was safe.

There were processes in place to help ensure people were protected from the risk of abuse and staff were aware of the safeguarding procedures.

Medicines were stored, managed and administered safely.

The provider ensured there were enough staff on duty to meet the needs of people. Staff were recruited safely, the appropriate checks were undertaken to help ensure suitably skilled staff worked at the service.

Assessments were in place to manage risks to people. There were processes for recording accidents and incidents.

Is the service effective?

Good

The service was effective.

Staff had the skills and knowledge to meet people's needs. Staff received regular training to ensure they had up to date information to undertake their roles and responsibilities. They were aware of the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

People were supported to eat and drink to maintain good health.

Staff supported people to attend healthcare appointments and liaised with other healthcare professionals as required.

Is the service caring?

Requires improvement

The service was not always caring.

People were treated with respect but their independence, privacy and dignity were not always promoted.

People told us they were well cared for. We observed caring staff who treated people kindly and with compassion. Staff were friendly, patient and discreet when providing support to people.

Staff did not always take time to speak with people and to engage positively with them.

People and their families (where necessary) were included in making decisions about their care.

Is the service responsive?

Good

The service was responsive.

Care plans were in place outlining people's care and support needs.

Summary of findings

Staff were knowledgeable about people's needs, their interests and preferences in order to provide a personalised service.

People felt there were regular opportunities to give feedback about the service.

Is the service well-led?

Good

The service was well –led.

There was a registered manager employed in the home.

The staff were well supported by the registered manager. There was open communication within the staff team and staff felt comfortable discussing any concerns.

The registered manager regularly checked the quality of the service provided and made sure people were happy with the service they received.

People who lived in the home and their relatives were asked for their opinions of the service and their comments were acted on.

Tupwood Gate

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 24 July 2015 and was unannounced. The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed records held by CQC which included notifications, complaints and any safeguarding concerns. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern at the inspection. We asked the provider to complete 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.

During the inspection we spoke with eight people, six care staff, two relatives, the registered manager and two health care professionals. We observed care and support in communal areas and looked around the home, which included people's bedrooms, the different units within the building, the main lounge and dining area.

We reviewed a variety of documents which included four people's care plans, seven staff files, training programmes, medicine records, four weeks of duty rotas, maintenance records, all health and safety records, menus and quality assurance records. We also looked at a range of the provider's policy documents. We asked the registered manager to send us some additional information following our visit, which they did.

We last inspected the service in September 2013 where we identified a breach in the safety and suitably of the premises.

Good

Is the service safe?

Our findings

People and relatives told us they felt safe living at the home. Comments included; "I've no problems with my safety here" and "Yes, my relative has been safe and also when they move them using the hoist" and "None of her possessions have gone missing."

The registered manager and staff had taken steps to help protect people from avoidable harm and discrimination. The registered manager and staff were able to describe what they would do if they suspected someone was being abused or at risk of abuse. Staff told us they had received safeguarding training and were able to describe the procedures to be followed if they suspected any abuse.people told us they would approach the mregistered manager if they had any concerns.

The risks to individuals and the service; for example health and safety, were managed so that people were protected and their freedom was supported and respected. One person said; "I move around with a walking frame in my room, around the home I freely use my wheelchair."

The registered manager ensured staff assessed the risks for each individual and recorded these. Incidents and accidents were reported appropriately and in a timely manner, the registered manager described to us the action they took analysis each incident. They showed us examples of outcomes of investigations, this included an accident where a person had fallen. The registered manager had reassed the risk and implemented new strategies such as alarm mats to alert staff sooner to the person moving about their room. Staff were able to describe risks and supporting care practices for people. For example people with specific health care conditions and alcohol dependency had individualised risk assessments which staff were able to describe.

We checked a sample of risk assessments and found plans had been developed to support people's choices whilst minimising the likelihood of harm. The risk assessments included people's mobility risk, nutritional risk or specific health risks. One person's risk assessment detailed their assessed skin breakdown risk. The action plan detailed pressure mattress settings, repositioning frequency and nutrition support which should reduce the risk to the person of their skin breaking or them acquiring a pressure wound. We saw that these actions were followed by staff.

People's medicines were well managed and they received them safely. One person said; I do get my medication when they are due", another person said "I get my tablets when I expect them" and "They give me painkillers when I ask for them."

There was an appropriate procedure for the recording and administration of medicines. We saw medicines were stored securely. Each person had a medication administration record (MAR) chart which stated what medicines they had been prescribed and when they should be taken. We observed staff ensuring people had taken their medicines before completing the MAR chart to confirm that medicines had been administered. We looked at MAR charts and saw they were completed fully and signed by trained staff. People who were prescribed 'as required' medicines had protocols in place to show staff when the medicines should be given.

The provider had in place procedures for safe disposal of medicines. The registered manager showed us their last pharmacy advice visit report where the only issue identified was the provider's 'medicine policy' was not meeting NICE Guidelines; The registered manager told us when the pharmacist visited they were not shown the provider's local policy in addition to their overall policy and this met NICE Guidelines.

People said that there were enough staff deployed to meet their needs. One person said; "I do think there are enough staff about." Staff said there were enough staff on duty. One staff member said there were enough staff to keep people safe. We saw people being attended to promptly. We heard care staff acknowledge people when they required assistance and phone colleagues to help people when needed. One person said "The staff do talk to me; you get anything you ask for." The provider used a dependency tool to assess the staffing levels were in place to meet the needs of the people. the registered manager said that one registered nurse and she looked after the daily clinical needs, with the support of eight care staff in the morning and six care staff in the afternoon. We checked the rotas for a four week period and confirmed this happened.

Staff recruitment records contained the necessary information to help ensure the provider employed people who were suitable to work at the home. Staff files included a recent photograph, written references and a Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable

Good

Is the service safe?

people from working with people who use care and support services. Staff members confirmed they had to provide two references and had a DBS check done before starting work. The provider had ensured that qualified staff had the correct and valid registration.

There were emergency and contingency plans in place should an event stop part or the entire service running. Both the registered manager and the staff were aware and able to describe the action to be taken in such events.

Good

Is the service effective?

Our findings

People and relatives told us they thought staff were trained to meet their needs or their family member's needs. One person said, "All the staff are very competent, there is always a sister on duty" another person said; "I'd say they were well qualified." A visiting professional said; "Confident staff make people comfortable from what I've seen, staff seem very nice."

The registered manager told us that all staff undertook an induction before working unsupervised to ensure they had the right skills and knowledge to support people they were caring for. One staff member said the service "Provides training on regular basis I have just finished SG (Safeguarding), and completed dignity in health & social care." The provider ensured that each staff undertook their 'personal Induction booklet & Safe Ways of working.'

The provider had supported staff to learn other skills to meet people's individual needs, such as training for staff to become dignity champions. They said that this training had helped them understand and develop best practice when caring for people.

Staff said they had annual appraisals. This is a process by which a registered manager evaluates an employee's work behaviour by comparing it with pre-set standards, documents the results of the comparison, and uses the results to provide feedback to the employee to show where improvements are needed and why. Staff also had regular supervisions which meant they had the opportunity to meet with their registered manager on a one to one basis to discuss their work or any concerns they had. One staff member said; I had supervision last week, given a written record, discussion re team player, tasks, areas which weaknesses and strengths so can work with registered manager."

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty safeguards (DoLS) which applies to care homes. DoLS are part of the Mental Capacity Act 2005 (MCA). They aim to make sure people in care homes are looked after in a way that does not inappropriately restrict their freedom. Staff had received training in the Mental Capacity Act (MCA) 2005and Deprivation of Liberty Safeguards (DoLs). Some people were restricted from leaving the home for their own safety. The appropriate capacity assessments and DoLS had been submitted to the local authority. The registered manager and staff demonstrated their understanding of DoLS. One staff member said they understood MCA and DoLS and told us "It's about people's choices, preferences to make own decisions, those who can make own decisions."

People's nutritional needs were met. One person said; "The quality of the food is quite good" and "They would be very ready to get me something else if I want, like solid meat, because I have a problem with my teeth." Another person said "Lunch was nice."

We saw a list in the kitchen of people's dietary requirements. The chef was able to identify those people who were on liquidised food. One relative said "The food's excellent. X was on pureed meals and now they are on soft food" and "They eat well" and "My relative always has a jug of orange juice in her room" and "They record what she drinks."

The menu was displayed outside of the dining room and included the main meal of the day, together with the alternatives on offer including a vegetarian option. During the day people had drinks in front of them and tea and coffee was offered throughout the day.

The registered manager said that they promote collaborative care. We were told the GP visits every Tuesday. Staff responded to changes in people's health needs quickly and supported people to attend healthcare appointments, such as to the dentist, doctor or optician. We saw, in individual care plans, that staff made referrals to other health professionals such as the speech and language therapist (SALT), the falls team, district nurse or the dementia nurse when required. One person said; "If I need to see the doctor or the chiropodist, I only need to ask" and "Hospital transport takes me to appointments and my daughter meets me there" another person said; "I do see my GP from time to time".

We spoke to a visiting professional during our inspection who told us that staff made appropriate referrals and in a timely manner. Another external health care professional told us that the technical aspects of the nursing care provided seem ok e.g. in the provision of air mattress, at right pressure.

Requires improvement

Is the service caring?

Our findings

People and relatives told us that the staff were very caring. One relative said; “They (staff) are kind and considerate” and “There is never a long wait for help.” One person said” “When I ring the bell, I get a very ready response.”

People had mixed views about being treated with dignity and respect; we did not always see good examples of this. One person said “I don’t feel the care at bedtime is personal. I feel I am treated like a lump of meat.” One person explained to us they didn’t feel they were always treated with dignity in personal care, they explained that they would like to use the bathroom and toilet facilities however the staff insisted the person used a commode. Whilst we were talking to the person the staff came into the room without knocking pulled the person curtains and brought in a commode. We spoke to the registered manager about this and they said they would address this with the staff team. On the positive side a relative told us “They do knock on her door and ask me to leave the room when attending to my relative.”

Some staff showed that they knew people well and they spoke to each other in a relaxed jovial manner. However we did not observe staff freely sitting with people and engaging in conversation. Most interactions were task related such as “Do you want a cup of tea” and “Its lunch time now.” We observed three people in the communal lounge at lunch time. Staff approached the people without speaking and put fully body ‘bibs’ on the people. One staff member who was supporting a person to eat used phrases such as “Come on luv’”, “Open up” in a loud voice.

Another person stated “It’s very quiet here, and not very interesting- nobody really talks to you.”

We recommend that best practice guidance in dignity and respect is reviewed with staff.

During the inspection, we saw a number of people visited by family and friends. From what we saw, staff had a caring approach and this was confirmed by the professionals, relatives and people themselves. One relative said; “They (staff) are kind and considerate” and “The staff are very good, none treat my relative unprofessionally” and “My relative is always nice and clean.” A healthcare professional said one person they visit was settled, very comfortable at the home.

Staff understood the needs of people in their care and we were able to confirm this through discussions with them. Staff answered our questions in detail without having to refer to people’s care records. This showed us that staff were aware of the up to date needs of people within their care.

Staff explained they offered information to people and their relatives in connection with any support they provided or that could be provided by other organisations e.g. Parkinson’s Society and Age Concern. We saw the reception area had various leaflets which provided advice on advocacy, bereavement and safeguarding. Each person had a comprehensive residents guide in their room.

When people were nearing the end of their life they received compassionate and supportive care. These people, those who matter to them and appropriate professionals contributed to their plan of care so that staff knew their wishes and made sure the person had dignity, comfort and respect at the end of their life. We asked people and family members if they had been involved in their care planning or the care of their relative. They all felt that they were included and kept up to date one person said “I know there is a care plan and they do talk to me about things in it.”

Good

Is the service responsive?

Our findings

One person said, "I feel I get the care I need" and "I am given choice and I choose not to take part in things" and "I think they provide a varied programme of activities. " Another person said "The activities are not bad" and "I just plod along but I think I get what I need."

Before people moved into the home they had an assessment of their needs, completed with relatives and health professionals supporting the process where possible. This meant staff had sufficient information to determine whether they were able to meet people's needs before they moved into the home. Once the person had moved in, a full care plan was put in place to meet the needs which had earlier been identified. We saw these were monitored for any changes. Full family histories were drawn up so that staff knew about a person's background and were then able to talk to them about their family or life stories.

Personalised care plans had been developed with regard to the way that people chose to be supported and if risks had been identified, a risk assessment had been put in place to minimise them as much as possible. For example: some people like to have a cigarette, risk assessments were in place to support people maintain their lifestyle choice. The registered manager showed us that the care plans were in the process of being changed to an electronic format. Staff members had hand held tablets that had been donated that they typed all daily notes in as and logged if people's need changed and the action that had been taken.

Staff were responsible for a number of people individually which meant they ensured people's care plans were reviewed on a regular basis. We read that reviews were undertaken and staff discussed with people their goals. A staff member said they got to know what people wanted, including what time they wanted to get up and how they liked to spend their day. Staff said they had handovers when they first came on duty. This was an opportunity for staff to share any information about people.

Individual care plans contained information which related to people's preferred name, allergies, family history, personality, the social activities they liked doing and their care needs. There were also details about how they wished to be looked after if they became unwell. Staff showed us a file which recorded people's weights. People were weighed regularly and staff calculated people's body mass index (BMI), so they could check people remained at a healthy weight. We saw that one person had lost weight and staff had referred this person to the GP for a dietician referral and to the SALT team for further guidance on managing the weight loss and nutritional needs. The computerised system gave full details and analysis of people's changing needs which showed easy to read graphs etc. of weight, and risk increase or improvements.

There were regular activities going on throughout the week. An activities coordinator was employed who had specific responsibility for planning social activities. A relative said "She does not take part in things but there are all sorts of nice things happening" The activities person checked throughout the day that people were happy to participate in the activity and asked for suggestions from people of how they would like the activity to run. They told us that they had spoken to each person and had tried to provide a mixture of group and individual activities to meet peoples' likes and preferences.

The activities co coordinator said that on the organised event was school children visiting people and this was regular event. They said that an outside entertainer comes weekly as well as a full programme of daily activities. They told us said when they are next on annual leave a volunteer who used to work at the home comes in to provide activities for people.

People told us they knew how to make a complaint if they needed to. One person told us "I've no major complaints but I'm sure they would respond to a grumble. I would go to Matron."

We saw how the registered manager had dealt with previous complaints and had identified improvements or actions that needed to be taken. The complaints policy was displayed in the foyer and each person had a copy of it in their service user guide.

People felt they had a say in how the home was run. People told us that they remembered filling out a survey and one person said; we observed a residents meeting; One suggestion from people was for 'better communication about the delayed start to meals and activities.' This had been agreed by the home registered manager and said that

Good

Is the service responsive?

she would discuss with all staff. People and relatives said "There is a resident's meeting every month and relatives meet every two months" and "They do try to resolve issues brought up at the meeting."

Good

Is the service well-led?

Our findings

The home had a registered manager. The registered manager was in day to day charge and supported the nurses with clinical care within the home. People and relatives we spoke with all knew who the registered manager was and felt that they could approach them with any problems they had. One person said "I find Matron a nice competent person."

We observed the registered manager interact well with the people. An external healthcare professional said "The registered manager is approachable." Care staff said "I can go to the matron and they listen." We observed on numerous occasions them sitting and chatting to people and asking if there was anything that people needed.

Staff were positive about the management and the support they gave to them. They told us they felt supported and could go to them if they had any concerns. One member of staff said "It was a good group of staff who worked well together and there was good communication." They had staff meetings in which they could speak openly and make suggestions. Staff meetings were regularly held and minutes of the meetings were recorded and made available to all staff. We saw a record of staff meeting minutes. Best practice guidance was discussed during these meetings and any concerns that staff had. For example discussions around the handover forms and the new tablets for staff to use for daily care documenting.

The registered manager told us about the homes missions and values. Staff we spoke to understood and followed the values to ensure people received kind and compassionate care. This was implemented from staff induction process and reviewed regularly. We saw that the values were promoted in the 'Residents Guide', which anyone wanting to find out about the home or who lived there could read.

One member of staff said when new staff started they received training on the aims and objectives of the service. It was then up to senior staff to monitor them to ensure they put these aims into practice. Any issues identified would be covered in an individual supervision session. Which would develop consistent best practice and drive improvement. One member of staff said "I have supervision every month, I had it last week, given a written record, discuss regarding being team player, tasks, areas which weaknesses and strengths so can work with manager."

The registered manager told us about the systems they used to ensure the delivery of high quality care. We saw the quality assurance systems in place were robust. We saw evidence of audits for health and safety, care planning, medication and infection control. This enabled the registered manager to identify deficits in best practice and rectify these. The registered manager explained that regular health and safety meetings and staff meetings were held. The minutes of the meetings were recorded and made available to all staff. We saw a record of staff meeting minutes. Best practice guidance was discussed during these meetings including the handover forms and answering call bells. This showed that the registered manager was continually assessing the quality of the home and driving improvements.

The registered manager had ensured that appropriate and timely notifications had been submitted to CQC when required and that all care records were kept securely within the home.