Cavendish Care Home Limited

Cavendish Care Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Cavendish Care Home is a residential care home for up to 24 people living with dementia. At the time of the inspection there were 18 people living there and three people were staying for respite care. Two double sized rooms provide accommodation for people who have agreed to share accommodation. Privacy screens are provided. Four bedrooms have en-suite facilities. People share two lounges/dining areas. The grounds to the front and rear of the home are accessible to people providing pleasant areas to sit or walk around.

At the last inspection, the service was rated Good. At this inspection we found the service remained Good.

People's care was individualised reflecting their personal wishes, likes and dislikes and any routines important to them. Staff understood people's needs well and treated them with dignity and respect. Staff were passionate about the care they provided. People were respected and their diversity and individuality was celebrated. Staff sang along with people, laughing and sharing jokes. Music was used as a means to communicate with people encouraging them to walk and participate in activities. People were able to join in with a variety of meaningful activities provided by an activities co-ordinator and external providers. A dementia friendly environment was provided and dementia friendly resources available for people to engage with. People's nutritional needs had been assessed. A choice of meals and snacks were provided which reflected their cultural diversity.

People were kept safe from the risk of harm and abuse. Their medicines were safely administered. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People benefited from staff who had access to training and support to develop professionally. They said they felt supported and communication within the team was good. They said the staff team worked effectively together and they felt that their opinions mattered. There were enough staff, scheduled to work flexibly to meet people's needs. Four staff had received awards from a local care awards scheme recognising their skills. Staff said the registered manager was open and accessible. The registered manager worked alongside staff promoting best practice. The registered manager and staff worked closely with health care professionals to support people to stay healthy and well. People's views and those of their relatives and staff were sought to make improvements to the service. A range of quality assurance processes were in place to monitor the quality of care provided. The registered manager had plans to make further improvements to the environment and care records.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Cavendish 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 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 6 and 7 September and was unannounced. 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 also reviewed information we have about the service including notifications. A notification is a report about important events which the service is required to send us by law.

We spoke with five people living in the home and two relatives. We also spoke with a representative of the provider, the registered manager, the senior lead carer, two chefs, the activities co-ordinator and three care workers. We looked at the care records for six people and we observed medicines being administered. We also looked at the recruitment records for four staff, staff training records, complaints, accident and incident records and quality assurance systems. We joined staff at a handover between shifts. We observed the care and support being provided to people. We used the Short Observational Framework (SOFI) for inspection. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We received feedback from two social and health care professionals. In this report we have used feedback given to the provider as part of their quality assurance process.

Good

Is the service safe?

Our findings

People's rights were upheld. Staff had a good understanding of how to recognise and report suspected abuse. They had completed safeguarding training. Safeguarding information was displayed on notice boards ensuring they had access to the contact details for the local authority. Staff said they were confident the registered manager would take the appropriate action in response to their concerns. Records had been kept for any safeguarding referrals which had been raised with the local safeguarding team, social workers and the Police. The Care Quality Commission had been informed. It was evident the appropriate action had been taken to keep people safe.

People were protected against the risks of harm or injury. Accidents and incidents were recorded and monitored to ensure action had been taken to prevent them reoccurring. In response to the increasing likelihood of falls people had been referred to their GP to make sure there was no underlying health issue. They had also been referred to a physiotherapist and occupational therapist. When needed the appropriate equipment had been provided to keep them safe such as mobility aids, hoists and slings and high/low beds with crash mats should people be at risk of falling out of bed. Sensor alarms and pads had also been provided to alert staff when people were moving so they could respond quickly to keep them safe. We discussed how risks were managed for people identified as at risk of choking. One person at risk of choking's care plan described the strategies to prevent choking such as positioning the person correctly and providing a soft fork mashable diet, which staff were following. Staff understood how to minimise risks keeping people safe when supporting them with moving and handling and eating or drinking.

People were protected against the risk of emergencies. Each person had a personal evacuation plan in place which was kept in a secure holdall by the front door. A business continuity plan was in place providing information about how staff should respond in an emergency such as utility failure or extreme weather. Systems were in place to maintain the safety of the environment. For example, fire system checks were in place, water temperatures were monitored and legionella and portable appliance checks were completed annually.

People were supported by enough staff with the right skills to meet their individual needs. A relative commented, "I am impressed with the staff/patient ratio which makes for individual attention." Staff rotas were flexible reflecting people's changing needs. For example shift patterns had been changed to provide additional cover at lunch time. Early shifts started at 6am in the summer when people got up earlier and at 7am in the autumn/winter when they started getting up later. Care staff were supported by an activities co-ordinator, a chef, a domestic and the registered manager was available to help out if needed. Agency staff were used occasionally. The registered manager confirmed the same agency staff were requested to ensure consistency and continuity of care. People told us staff were "alright" and "ok". Visitors said, "Staff are really good" and "In general staff are ok."

People were supported by staff whose competency and character had been checked through a recruitment process. A checklist evidenced when information had been received such as references confirming the reason for leaving former employment with adults or children. This information was missing for one

applicant but was obtained during the inspection. Any gaps in employment history had been followed up with applicants. There was evidence a satisfactory Disclosure and Barring Service (DBS) check had been obtained. A DBS check is carried out before potential staff are employed to confirm whether applicants had a criminal record and were barred from working with vulnerable people.

People's medicines were administered safely. People received their medicines as prescribed and according to their individual preferences. Staff were observed giving people their medicines at times they preferred and making sure they were given them with the appropriate intervals in between each dose. Occasionally a person needed their medicines to be given with their food or drink. This had been discussed with their GP and family and agreed in their best interests. Medicines were stored securely and at the correct temperature. Medicine administration records (MAR) were completed appropriately. Stock levels were recorded on the MAR. Protocols were in place when people needed to be given medicines when needed. These described the rationale for giving the medicine, for instance pain, and the maximum dose allowed to be given.

Good

Is the service effective?

Our findings

People were supported by staff who had the opportunity to acquire the skills and understanding to meet their needs. New staff completed an induction programme which included the care certificate for staff new to care. The care certificate is a set of national standards that health and social care workers adhere to in their daily working life. This also included training considered mandatory by the provider such as first aid, moving and handling, fire and infection control. Staff were supported to develop professionally completing the Diploma in Health and Social Care and participating in the Dementia Link Worker programme. Training specific to people's needs included dementia and behaviour management support. The registered manager was a trainer and able to deliver custom-made training to staff in addition to open learning and external training. Staff were supported to reflect on their roles, responsibilities and training needs through individual support meetings with the registered manager and annual appraisals. The registered manager also carried out observations of staff carrying out their roles enabling them to provide constructive feedback in areas such as medicines administration and dignity and respect. Staff said they felt really supported in their roles. They understood people's needs and confirmed they communicated really well as a team.

People's capacity to make decisions about their care and support had been assessed when needed. Best interest decisions, for the administration of medicines, providing personal care or restrictions to keep people safe, had been discussed with health care professionals and relatives. Where people had a lasting power of attorney this had been verified. Where a lasting power of attorney was appointed they had the authority to make specific best interests' decisions on behalf to that person, if they were unable to make the decisions for themselves. People had a do not attempt cardiopulmonary resuscitation (DNACPR) order in place which had been authorised by their GP and discussed with either them or their relatives. DNACPR orders are a decision made in advance should a person suffer a cardiac or respiratory arrest about whether they wish to be resuscitated.

People were observed making choices about their day to day lives. Staff discussed how they planned to review care plans for people who had been assessed as unable to make decisions about their care support to reflect any choices they were able to make for themselves. For example, one person's care plan stated, whilst they were unable to consent to the provision of personal care they could make a choice about what they wished to wear. Staff were observed enabling people to make a decision about their meal choice by showing them the plated meals.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). When people's liberty was restricted DoLS had been applied for and there was evidence further DoLS had been requested when these had expired.

People were supported to stay healthy and well. Their dietary needs were considered and when needed a soft fork mashable meal was provided. People who needed help to eat their meals were supported at their own pace. People and staff ate their meals together which encouraged people to eat. People's weights were

monitored when necessary and their food was fortified if they were at risk of malnutrition. People at risk of obesity were also supported to eat healthily. People's cultural needs were considered when offering meals, ensuring spices, herbs and other options were available which reflected their personal choices. People had access to health care professionals and were supported to attend out-patient appointments. Health care professionals said staff liaised with them closely and "acted on any suggestions made".

The needs of people living with dementia had been taken into consideration when designing their environment. Corridors displayed memory provoking pictures and photographs. There were plans to create corridors which reflected the garden and to redesign the area where food was served to represent a restaurant. Toilet and bathroom doors were painted in a bright colour and the toilets had brightly coloured seats so people could easily recognise them. People's bedroom doors had signs with their names and photographs or pictures of personal interest to them.

Good

Is the service caring?

Our findings

People were treated with kindness and compassion. Relatives said, "She is being very well cared for" and "Staff are kind and helpful." Staff were observed responding attentively to people, giving them attention and taking time to be with them. Staff had developed ways of encouraging people to participate in activities of daily living. Music was used to communicate in many different ways with people. For example, staff were observed singing with people encouraging them to walk around the home. Staff also sang with people as they prompted them with activities. The atmosphere was light hearted and jovial. Staff were passionate about the care they provided and knew people's preferences and history well. People and their relatives had completed a "This is me" booklet which provided information about their past and their lifestyle choices.

People's religious, cultural and spiritual needs were considered alongside their individual disabilities. People were supported to join in with religious and cultural celebrations as well as attending a religious service at the home each month. People's human rights were respected. People were supported to maintain contact with family and friends who told us they were "made to feel welcome" and "welcoming every visit". People's personal information was kept confidential. People's diversity and equal rights were acknowledged. Their preferences for the gender of staff providing personal care were highlighted in their care records. People were encouraged to maintain their independence and to participate in age appropriate activities.

People and those important to them were involved in making decisions about their care and support. They were involved in the admission and assessment process providing information about people's day to day lifestyles and backgrounds. People and their relatives were involved in annual reviews of the care and support provided. Each person had a keyworker who kept in touch with relatives. A relative confirmed, "They keep us informed of what's going on."

People benefited from information which was accessible and could be produced in a variety of formats. Information displayed around the home had been produced in an easy to read format using large print and photographs or pictures. Large easy wipe boards displayed information about meals. Notice boards in the reception area displayed information about activities and the services provided. People had information about advocacy. People had been visited by an Independent Mental Capacity Advocate (IMCA) as part of the process to assess them for a deprivation of liberty safeguard. Staff were observed talking with one person in the dialect of the country of their birth.

People's dignity and privacy was respected. People were observed being discreetly asked if they needed help or support. Relatives commented, "Staff treat them with great humanity", "They treat him with dignity and compassion" and "Staff have a selfless and caring attitude." Staff had signed up to be Dignity Champions as part of the national Dignity in Care campaign to challenge poor care and to act as good role models.

Good

Is the service responsive?

Our findings

People received individualised care which reflected their personal wishes, needs and routines important to them. Each person had been assessed to make sure their needs could be met by the service. The registered manager said, "A thorough pre-admission assessment is completed. It is important people fit in with others already living here." Care records were developed as staff got to know people starting with a basic care plan and developing into an individualised account of how people wished to be supported.

People's changing needs were responded to appropriately. Their care plans were kept under review and it was evident any changes were reflected in their care records. For example, after increasing falls people were referred to their GP, a physiotherapist and an occupational therapist for an assessment with their mobility. Their care records were amended to reflect when they needed two members of staff to help them and any additional equipment which had been provided. As people's dementia altered their care records had been updated to reflect any changes to their care and support. For instance, if they had a sleepless night consideration was given to whether they wanted to sleep in the next morning or to have an earlier bedtime the following day. Staff described the techniques they used to support people with sundowning (this describes the period of the day, late afternoon or early evening, when people living with dementia might become anxious or agitated). For example, distracting them or providing an afternoon activity.

People had access to a range of meaningful activities. An activities co-ordinator was employed who provided activities and co-ordinated external providers. People were offered one to one activity time or personal time to chat and to have individual attention. The activity co-ordinator said they tried to provide this daily to people. This ranged from reading the newspaper together, having a manicure or singing along together. People had access to twiddle muffs, rummage boxes, dolls and fluffy animals to engage with if they wished. Group activities included games, arts and craft, cooking, poetry, gentle exercise and reminiscence. External providers were engaged for fitness with music, pet therapy and gospel singing. Children's schools visited the home and people also had trips out to places of interests and were going on a boat trip. Relatives commented, "Activities are excellent" and "Appropriate activities take place."

People and their relatives had access to a complaints procedure. Complaints information was displayed in the reception area. People and their relatives were also asked for feedback about their care and support as part of the review of their care, at residents' and relatives' meetings and as part of the annual survey. A person told us, "I would talk to staff if I had any concerns." Relatives said they had no concerns and would talk with staff or the registered manager if needed. Three complaints had been received in 2017 and one complainant had commented on the how impressed they were with the "speedy response". A copy of each complaint was kept along with a full report of the outcome and any action taken in response. The Provider Information Return stated, "We view all complaints as an opportunity for learning and improving the service."

Good

Is the service well-led?

Our findings

A range of quality assurance audits were in place to monitor areas such as health and safety, medicines, care records, infection control and staff support. The registered manager described improvements they had planned to make such as reviewing care records to make sure they reflected people's individual needs. This review would ensure that where people's care records highlighted they were at risk of choking then a corresponding risk assessment would also be in place. The registered manager had responded positively to discussions with us about suggested changes to improve the systems in place. They confirmed improvements would be made in a timely manner and that they were motivated to improve the service.

The registered manager discussed how they monitored accident and incidents, identifying any developing trends and ensuring appropriate action had been taken in response. The directors of the home visited each month producing a monthly report highlighting any actions. These were followed up at the next visit. For example, improving the management of the laundry to make sure people's clothes were not being ruined in the wash. Reviews on a national care home website were positive and the home had been scored 9.7 out of 10 for feedback from 28 people in 2017.

People's views and those of their relatives and staff were sought to make improvements to the service. There were a variety of ways in which they could give feedback. This included an annual survey, residents' and relatives' meetings, staff meetings and the complaints process. Staff spoke positively about the ethos in the home. They said, "We make decisions as a team" and "Our opinions count; we feel valued." Relatives commented, "It is very good all round", "Everything in Cavendish, is to me, excellent, outstanding" and "Standards in all areas have been constantly improving."

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was registered with CQC in July 2017 and had been working in the home prior to this as a training manager. The registered manager spoke about their vision for the service to provide "a person centred approach." The Provider Information Return confirmed this stating there "is a strong vision to promote personalised good quality care". We observed individualised care and support being provided. This was confirmed by comments from a health care professional who said, "I have found the care very person centred and have been impressed to see the manager actually working on the floor with the team to enable her to know the residents well." The registered manager also said they were a "hands on manager" who would never ask staff "to do something, I wouldn't do myself." Staff confirmed they appreciated the accessibility and openness of the registered manager.

The registered manager recognised the challenges of keeping up to date with changes to dementia strategies and supporting staff in line with these. They were able to ensure the delivery of care reflected current guidance through membership of a local care providers' association, completing a registered manager's course with the local authority and attending local skills for care events. Staff said they felt valued

and their individual and team achievements had been recognised by a local care awards 'unsung hero' award in 2016 as well as the annual care awards scheme in 2017. Three awards had been won for care catering, activities and outstanding contribution (manager) as well as a runner up award for carer of the year. In addition staff had signed up to the national social care commitment to provide people with high quality personalised care. Policies and procedures were kept up to date through registration with a national care management package. The registered manager worked closely with the local authority, commissioners of care and the care home support team.