

Cookridge Court Limited

Cookridge Court

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Inadequate 

Summary of findings

Overall summary

About the service

Cookridge court is a care home which provides personal care to people. At the time of the inspection the home was providing personal care to 65 people.

People's experience of using this service:

The service delivered at Cookridge Court has been rated Requires Improvement or Inadequate for the past five inspections, which shows a lack of improvement over a sustained amount of time. For the last four inspections the provider has been in breach of Regulation 17.

The provider failed to assess, monitor and improve the quality of the service and maintain accurate and robust care records. We found shortfalls in recordings; for example, repositioning charts, care plans and audits were not always updated or maintained correctly.

People living in the home were not always protected from possible harm. The provider had not followed their fire policy as staff had not carried out evacuations to ensure people could be evacuated safely from the home.

Risk assessments did not always reflect people's needs. We found assessments had not been updated when there was documentation to suggest a risk was present.

Care plans were in place but not always updated to reflect peoples' current needs and related risks. Appropriate action had not always been taken to follow up on deterioration in people's health.

The providers rota's were not clear and the dependency tool used to calculate how many staff were required was at times inaccurate. Recruitment checks were completed on new staff to ensure they were suitable to support people who used the service.

Staff were not always up to date with training the provider made mandatory. Staff were provided with regular supervisions and annual appraisals had been completed to support staff development and any new employees completed an induction programme.

The service was not appropriately decorated or designed to meet all people's needs. There was no signage, tactile simulation or décor which met the needs of people living with dementia.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People and their relatives told us the staff were kind caring and treated them with respect.

People told us they enjoyed the food and were offered choices. We saw people being offered refreshments on the days we inspected. People took part in activities within the home although activities outside of the home were limited.

People told us they were supported to be as independent as possible. Some people received end of life care and relatives provided positive feedback about the care their relatives received.

People living in the home said they felt safe and there were systems in place to reduce the risk of abuse. Medicines were stored, administered and recorded appropriately.

Meetings took place in the home. Staff told us the management team were honest and supportive. Complaints were managed effectively.

We found four breaches of regulation.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was requires improvement (published 22 November 2018) and there were three breaches of regulation. We issued requirement notices, for regulation 11 consent, 12 safe care and treatment and for regulation 17 good governance.

At this inspection the service had improved their medicines management and MCA. However, the provider had not improved their governance systems and records which meant they were still in breach of these regulations.

Why we inspected

The inspection was prompted in part due to concerns received about overall care quality and an unexpected death. A decision was made to bring the planned comprehensive inspection of this home forward to allow us to inspect and examine those risks.

This inspection was also carried out to follow up on action we told the provider to take at the last inspection.

We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Cookridge court on our website at www.cqc.org.uk.

Enforcement

We have identified breaches in relation to person-centred care, safe care and treatment (risk management), staffing and good governance.

Please see the action we have told the provider to take at the end of this report.

Information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will request an updated action plan to understand what they will do to improve the standards of quality and safety. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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 was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service caring?

The service was caring.

Details are in our caring findings below.

Good ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate ●

Cookridge Court

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team

The inspection team consisted of three inspectors, one specialist advisor 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.

Service and service type

Cookridge court is a 'care home'. 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

The first day of this inspection was unannounced.

Inspection activity started on 12 June 2019 and ended on 13 June 2019.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, professionals who work with the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan our inspection. The provider was not

asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection

We spoke with six people who used the service, and four relatives of people who used the service. We also spoke with seven staff members, two deputy managers, the health and safety lead and the registered manager. We reviewed eight people's care and medicines records.

After the inspection

We continued to seek clarification from the provider to validate evidence found and asked for additional information to be sent to us.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm. Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

- People with specific health conditions did not have the relevant risk assessments in place to inform staff of possible risks and how to manage or mitigate these risks.
- Another person had a Waterlow score of 16 indicating there was a risk of skin damage. A total Waterlow score greater than 10 indicates risk for pressure ulcers. Bruising was noted on the persons arm. There was no evidence or record that an investigation had been carried out to identify how the bruise occurred or what support staff would provide to promote healing or action to reduce risk of recurrence.
- Fire safety and emergency evacuation procedures had not been adequately considered or implemented. There had been no evacuations practiced and staff told us they were not assured they could safely evacuate the premises in an emergency. This concern was supported by a lack of adequate training provided to staff. Risk assessments in relation to this were incomplete or lacked detail. This included assessments of risk specific to individuals, locations and / or the premises as a whole.
- Personal Emergency Evacuation Plans (PEEPs) were recorded, although details were missing or inaccurately recorded for staff to know how to support individuals. For example, one person required a hoist to move with two staff to support with their mobility. The PEEP stated, 'One carer to assist [Name] into a wheelchair using there Zimmer frame. One carer to operate wheelchair.'
- The fire risk assessment for the premises had not been updated since 2017. This did not follow the providers policy which said the fire risk assessment should be reviewed annually.

We found systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded immediately during and after the inspection. They confirmed a new fire risk assessment would be completed and a simulated evacuation carried out with staff. We also spoke with the West Yorkshire fire service who planned a visit to the home.

- There were systems and processes in place to review, investigate and monitor accidents or incidents

within the home to use as learning opportunities to improve practice.

Staffing and recruitment

- We observed people having to wait for staff to assist them with their personal needs.
- People and relatives provided mixed reviews about staffing levels. Comments included, "There are two or three on at night and you have to wait if you want anything", "Yes there is enough staff. I don't have to wait a long time if I ask for help" and "I think we need a few more."
- Staff rota's were not clear. We looked at the rotas, allocation sheets and pay roll information which did not correlate with each other therefore it was difficult to determine which staff worked on each unit. The provider responded immediately during the inspection. They confirmed a new rota would be put in place to avoid confusion.
- The Chess tool used to determine what staffing levels were needed was not effective as information inputted onto this was not accurate. This created a risk there would not always be enough staff to meet people's needs. For example, one person was rated medium for Skin Integrity which gave them a score of 2. We looked at the persons care file which indicated they had a pressure sore, stage four, which indicated a high risk.
- We observed people being left unattended for periods of time without staff support or interaction. For example, one person had been left in a bathroom however, when they needed support from staff to leave there was no staff available. We heard the person shouting and asked staff to attend to their needs. This was undignified as the person had to wait for staff and opened the bathroom room to shout which meant other people may have seen them on the toilet. We immediately informed staff of this so the person could be supported.
- Our observations showed communal areas being unsupervised and staff having minimal interactions with people. For example, one person was left in a chair in the corridor with minimal interaction from staff. We saw another person entering a person's room and no staff to support them. The person was in bed, became distressed and had asked the person to leave. We went to find staff to support this person.

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

- People were supported by staff who had been recruited safely.

Preventing and controlling infection

- Some areas of the home were not clean. We found some toilet seats and hoists which had stains on. We discussed this with the registered manager who took immediate action and on day two of the inspection had ordered new toilet seats for those that were needed.
- Staff received training in infection control. Staff wore gloves and aprons when supporting people with personal care.

Systems and processes to safeguard people from the risk of abuse

- People told us they felt safe. One person said, "I feel safe. I'd know who to talk to if I didn't."
- Staff demonstrated a good awareness of safeguarding procedures and knew who to inform if they witnessed or had an allegation of abuse reported to them.

Using medicines safely

- Medicines were stored, administered and recorded appropriately.
- Staff had received appropriate medicines training and their competency had been assessed.
- Some people had medicine prescribed for as and when needed (PRN). We found that PRN protocols

contained enough details for staff to follow.

- Medicine audits demonstrated that discrepancies were identified and rectified in a timely way.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated requires improvement. At this inspection the key question remains requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff were not always up to date with training the provider made mandatory. For example, 61% of staff had not completed their fire safety training, 45% had not completed moving and handling and 50% of staff had not completed Mental Capacity Act training. We discussed this with the registered manager who told us they were in the process of using a new system to monitor training for staff and agreed that any outstanding training would be arranged.
- Staff completed a comprehensive induction and staff told us they received regular supervisions and appraisals to develop their practice.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support

- Appropriate action had not always been taken to follow up on deterioration in people's health. For example, one monthly review recorded the possibility of a person having cancer. There was no record of this being followed up or checked to ensure the person's physical wellbeing. We discussed this with the registered manager who did not provide any further information as to whether this had been followed up.
- Some people living in the home required regular monitoring due to being on high risk medicines. There was no evidence to demonstrate that these checks had been carried out by health professionals. This additional information is required to make sure that people receive the correct monitoring and blood tests and to support staff to identify when a person needs referring to a healthcare professional.
- People told us they had access to health care professionals when required. One person said, "The staff arrange for the doctor to come."

Adapting service, design, decoration to meet people's needs

- We saw people had boxes outside of their rooms which included memorable information about the person and helped people to find their bedrooms. People living in the home were encouraged to bring in personal items to decorate their room and make it personalised to them.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- The provider assessed people's needs prior to living in the home. One relative said, "They know her really well. They know what she wants and what she likes." However, some care plans and risk assessments did not have enough details to demonstrate people's needs had been fully assessed.

- We saw evidence people's choices and views had been incorporated into care planning.
- The service was not consistently delivering care in line with legal requirements as we identified four breaches of regulation during this inspection.

Supporting people to eat and drink enough to maintain a balanced diet

- People were supported to ensure they ate and drank enough. People's weights and appropriate monitoring charts were in place for those that required this. For example, people that were underweight.
- People were provided with a variety of meals and refreshments throughout the day.
- People appeared to enjoy the meals on offer. One person said, "The food is good. There is too much for me. I get a choice."

Ensuring consent to care and treatment in line with law and guidance

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 to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

- At the last inspection the provider was in breach of Regulation 11 (Consent). At this inspection the provider had made improvements and Capacity assessments were completed within the home. People were involved in decisions made about their care and support needs. One person told us, "Staff explain what they are doing and ask my consent".
- Staff understood the principles of the Mental Capacity Act.
- DoL authorisations had been requested for people when required.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Respecting and promoting people's privacy, dignity and independence

- People and their relatives told us they were encouraged to be independent. One relative said, "They always support [Name] with their independence. They would encourage [Name] to have a bath when they could'." One person told us, "They always help me to do what I can."
- Staff respected people's privacy. One person said, "They always knock before they come into the room."
- The service ensured they maintained their responsibilities in line with the General Data Protection Regulation (GDPR). GDPR is a legal framework that sets guidelines for the collection and processing of personal information of individuals. Records were stored safely which maintained people's confidentiality.

Ensuring people are well treated and supported; respecting equality and diversity

- People and their relatives said staff were caring and treated them well. Comments included, "The staff are very nice" and "On the whole the staff are very good."
- The registered manager was keen to enhance everyone's awareness of promoting dignity. The home had enrolled in a research project relating to sex in care homes. Workshops took place focusing on how sexual relationships, needs or wishes should be respected and is acceptable.
- The provider had also arranged a LGBT training day to promote equality and diversity as part of their learning. The registered manager said they were hoping to do further training to ensure they identify people's needs.

Supporting people to express their views and be involved in making decisions about their care

- Most people told us they were involved in making decisions about their care and were included in their care planning. One person said, "I've seen my care plan. I was involved in writing it'.
- An advocate is a person who can support others to raise their views, if required. The registered manager told us that should anyone wish to have an advocate they would support people to find a local service.
- People were supported to maintain relationships with their family and friends.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires improvement.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Care plans and risk assessments lacked important details which meant staff had limited care directions.
- Care plans did not contain information about people's specific needs. One person had diabetes however, there was no care plan in place for this specific need. These additional care plans are required to make sure people receive the correct care and to support staff to identify when a person needs referring to a healthcare professional.
- Some people living in the home took medicines that required additional blood tests and monitoring. The provider did not have any care plans or risk assessments for people on 'higher risk' medicines.
- Care plans were not updated with information following changes in people's needs. One person had been seen by their GP and told that they may have cancer. There was no evidence to suggest this had been followed up. No information could be found to suggest there had been follow up to ensure the persons health needs were being met.
- Staff did not always understand people's specific care needs. For example, one person wore a stocking daily to prevent build up of fluid and swelling on their leg. We spoke with three staff on duty but only one staff could confirm that the person had the correct stocking on. This meant staff did not always follow the care plan.
- Care reviews with people were not always regularly carried out. For example, one person had their last care plan review carried out in 2017, no current reviews had been completed.
- We found staff had not been responsive to people's immediate needs. One person had a grade four pressure sore and was on hourly turns to prevent further deterioration of skin damage. The care plan for end of life care written on 18 April 2019 stated the person required turning every hour. However, turning charts from the 27 May 2019 to 07 June 2019 stated '[Name] to be turned every two hours.' The person only started on hourly turns from the 08 06 2019. This meant the care plan had not been followed therefore the person was put at risk.

Failure to assess people's needs effectively and plan for their care was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- We found activities took place within the home. People and relatives said, "I go for the music. I've not been on trips, but I know there have been" and "[Name] never really did activities. The activities workers knew they loved animals, so they brought in a pony and some kittens."
- Activities within the home and outside the home were organised, we spoke with one relative who said

their family member had been on two trips outside of the home within the last two years.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- Care plans identified people's communication needs and the registered manager told us information could be provided in different formats to ensure people understood their care.
- We found the activities sheet placed on a board in the main corridor was written in very small sized typeface which was difficult to read and may impact people's ability to know what activities were taking place. We discussed this with the provider during our inspection.

Improving care quality in response to complaints or concerns

- There was a complaints procedure in place which had been followed. Complaints were managed effectively, and actions taken to ensure lessons were learnt.
- There were mixed views from people on how to make a complaint. Comments included, "I've no complaints. I'm not sure who I would go to" and "I've never made a complaint, but I would know who to go to."

End of life care and support

- Some people were receiving end of life care. One relative said, "[Name] is receiving end of life care. They turn [Name] every hour, the McMillan nurses come in. The staff make sure [Name] is clean. They make sure I'm alright'.
- End of life care plans were in place for people on end of life care however, these lacked details about people's preferences and wishes. For example, one person's care plan included who to contact and their funeral directors' information but did not record any preferences or wishes the person may have had.
- Not all people living in the home had been asked about their preferences or wishes for end of life care. We discussed this with the registered manager, so this could be addressed.

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires improvement. At this inspection this key question has now deteriorated to Inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last four inspections the provider has failed to ensure effective governance arrangements were in place. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the provider had not made enough improvements and continued to be in breach of this regulation.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- The service delivered at Cookridge Court has been rated Requires Improvement or Inadequate for the past five inspections, which shows a lack of improvement over a sustained amount of time. For the last four inspections the provider has been in breach of Regulation 17.
- The provider failed to assess, monitor and improve the quality of the service and to maintain appropriate and contemporaneous records. We found there had been no improvements in quality monitoring in some areas or records management.
- We looked at one moving and handling risk assessment which said no staff support was required but staff and other care plans within the care file stated two staff were needed to support the person with their mobility. This information was inaccurate and had not been identified in the audit.
- Care plan audits did not always record when actions had been completed and we looked at one audit which had no details of who's care plan had been audited, by whom and dates for when this took place.
- Quality indicators used to monitor and have oversight of the service had highlighted concerns, but actions had not always been taken. For example, we looked at Quality indicator action plans from October 2018 to April 2019 which showed a consistent decline in staff fire safety training from October 2018 to April 2019. No actions had been taken to address this and this had decreased to 39% during our inspection.
- There were gaps and inaccurate recording in care plans and risk assessments. This meant the service did not have an accurate, complete and contemporaneous record in respect of each person.
- One care plan said, '[Name] has a close relationship with a male – both families aware and happy about this. Care plan states relationship should be closely monitored.' The care plan did not record how staff should monitor this relationship to ensure people's safety. The registered manager said the gentleman referred to in the care plan no longer lived in the home and agreed the care plan was not current.
- Personal care diaries had not always recorded when people had received a shower or bath. For example, in May 2019 it recorded that two people had one shower within the month and another person had only two

showers.

- There was a lack of effective quality monitoring taking place to ensure the service was working to the registered providers expected standards. When checks were completed they were not always effective, or robust and did not always identify the concerns we had raised as part of this inspection.
- Since January 2017 the provider has been in breach of Regulation 17 which has meant significant improvements have not been made within this time.
- At previous inspections the provider has breached in several Regulations which has shown a continued failure to maintain a good standard of care.

Failure to assess, monitor and improve the quality of the service and maintain appropriate and contemporaneous records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- People told us they were not aware of who the current registered manager was. We spoke with six people living in the home. Five of these people did not know who the current registered manager was, and some said they had not met the registered manager.
- Staff told us the management team were honest and supportive. Staff felt concerns would be effectively managed.
- Meetings took place with people living in the home but not all people were aware of these. Comments included, "I've not heard about any meetings" and "No (didn't realise meetings took place)."
- Relatives told us they were kept informed of any changes within the home. One person said, "I attend relatives' meetings and any special events."
- Some staff had been given specific champion roles within the home to drive improvement. This included a medicines and care planning champion. These roles were not always effective as additional training had not always been provided to guide staff. For example, we found improvements were required within care plans.

Working in partnership with other

- The registered manager worked collaboratively with different organisations to support improvement of care within the home. Some of these included links with the local authority and universities.
- The home worked in partnership with people, relatives and health professionals.