Crossbind Limited

Cosham Court Nursing 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

We carried out an unannounced inspection of this home on 24 August 2016. The home is registered to provide accommodation, nursing and personal care for up to 47 older people, some of whom live with dementia. Accommodation is arranged over two floors with lift access to the second floor. At the time of our inspection 39 people lived at the home and the provider told us they had used several of the accommodation rooms to provide additional recreational facilities for people who lived at the home. This meant the home always accommodated less people than they were registered to support.

A registered manager was in post. 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. The registered manager was on holiday at the time of this inspection.

People were supported by staff who had a good understanding of how to keep them safe, identify signs of abuse and report these appropriately. Robust processes to check the suitability of staff to work with people were in place. There were sufficient staff available to meet the needs of people and they received appropriate training and support to ensure people were cared for in line with their needs and preferences.

Medicines were administered, stored and ordered in a safe and effective way. We have made a recommendation about how records are kept for medicines which are given as required or in a varied dose.

Risk assessments in place informed plans of care for people to ensure their safety and welfare, and staff had a good awareness of these. Incidents and accidents were clearly documented and investigated. Actions and learning were identified from these and shared with all staff.

People were encouraged and supported to make decisions about their care and welfare. Where people were unable to consent to their care the provider was guided by the Mental Capacity Act 2005. Where people were legally deprived of their liberty to ensure their safety, appropriate guidance had been followed.

People received a wide variety of nutritious meals in line with their needs and preferences. People had access to fresh fruit and snacks throughout the day and were encouraged to take fluids especially in the hot weather. Those who required specific dietary requirements for a health need were supported to manage these.

People's privacy and dignity was maintained and staff were caring and considerate as they supported people. Staff involved people and their relatives in the planning of their care.

Care plans in place for people reflected their identified needs and the associated risks. Staff were caring and compassionate and knew people in the home very well. External health and social care professionals were

involved in the care of people and care plans reflected this.

Effective systems were in place to monitor and evaluate any concerns or complaints received and to ensure learning outcomes or improvements were identified from these. Staff encouraged people and their relatives to share their concerns and experiences with them.

The service had a good staffing structure which provided support, guidance and stability for people, staff and their relatives. Relatives spoke highly of all staff.

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.

Risk assessments were in place to support staff in mitigating the risks associated with people's care.

Staff had been assessed during recruitment as to their suitability to work with people and they knew how to keep people safe. There were sufficient staff available to meet people's needs.

Medicines were managed in a safe and effective manner. We have made a recommendation about the documentation of some medicines.

Is the service effective?

Good

The service was effective.

People were supported effectively to make decisions about the care and support they received. Where people could not consent to their care the provider was guided by the Mental Capacity Act 2005.

Staff had received training to enable them to meet the needs of people. They knew people well and could demonstrate how to meet people's individual needs.

People a wide variety of nutritious food in line with their needs and preferences.

Is the service caring?

Good

The service was caring.

People's privacy and dignity was maintained and staff were caring and considerate as they supported people. People were valued and respected as individuals and were happy and content in the home.

People and their relatives were involved in the planning of their care.

Is the service responsive?

Good

The service was responsive.

Care plans reflected the identified needs of people and the risks associated with these needs.

People were supported to participate in events and activities of their choice and were encouraged to remain independent.

Systems were in place to allow people to express any concerns they may have and complaints were recorded and responded to in a timely way.

Is the service well-led?

Good

The service was well led.

People spoke highly of all staff. Staff felt very well supported in their roles.

Robust audits and systems were in place to ensure the safety and welfare of people in the home.

Cosham Court Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Three inspectors and an expert by experience completed this unannounced inspection on 24 August 2016. 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 our inspection we reviewed the information we held about the home, including previous inspection reports. We reviewed notifications of incidents the registered provider had sent to us since the last inspection. A notification is information about important events which the service is required to send us by law. In February 2016, the registered 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 for this home.

We spoke with seven people who lived at the home however others were not always able to talk with us about the care they received. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We observed care and support being delivered by staff and their interactions with people in communal areas of the home including at a mealtime. We spoke with two visitors and seven members of staff, including the nominated individual for the registered provider (referred to as the provider throughout the report), deputy manager, two registered nurses, the administrator and two care staff. We spoke with two health and social care professionals who supported people who lived at the home.

We looked at care plans and associated records for seven people. We reviewed the medicines

administration records for 39 people. We looked at a range of records relating to the management of the service including records of complaints, accidents and incidents, quality assurance documents, five staff recruitment files and policies and procedures.

We last visited this service in April 2014 and found no concerns in the service.

Good

Is the service safe?

Our findings

People were safe in the home and were supported by staff who knew them very well and understood how to support them to maintain their own safety. A relative told us their loved one was safe and was supported by staff who understood their needs very well. Two health and social care professionals said they felt people were safe and well cared for at the home by staff who had a very good understanding of people's needs.

Risks associated with people's nursing and care needs had been assessed and informed plans of care to ensure their safety. These included risk assessments for maintenance of skin integrity, nutrition, dependency and mobility. Wound care plans were completed and updated to reflect the nursing care people needed to maintain their skin integrity. For people who were at risk of falls, risk assessments had been completed and used to informed care plans about their mobility and how to avoid the risks of falling around the home. A log of falls was recorded in each person's care records and was used to monitor and identify any patterns in their falls. For people who were at risk of falls from bed, a review of this need and the risks associated with this for the person had been completed. Assessments for additional equipment such as a bed which could be lowered to floor level to reduce the risks of injury should a person fall from bed, or a mattress on the floor next to a bed where bed rails were not always used had also been completed. Where required this equipment was in place.

Risks associated with people's health conditions had been identified and appropriate plans of care were in place to mitigate these risks. For example, for people who lived with diabetes, epilepsy or breathing difficulties, clear risk assessments and plans of care gave staff information on how these risks should be managed. For people who displayed behaviours that might present a risk to the person or others, the behaviours and triggers to these had been identified. Staff knew people very well and demonstrated a good understanding of their needs and how to support them. Care records reflected actions staff had taken to support people should they become distressed or agitated and care plans had been updated when required to reflect changes in people's needs. During our inspection one member of staff identified how they would support one person should they become agitated and distressed. They told us this person could become aggressive towards staff and that they may put their hand on the person's hand gently to help calm them. This action was not identified in this person's care plan or risk assessment as a means of supporting them. We identified to the registered provider that this may be considered a form of restraint and they told us they would look into this.

Incidents and accidents were reported, recorded and investigated in a way which ensured any actions or learning from these was completed and shared with staff. A log of incidents and accidents was recorded and the registered manager monitored this for patterns and trends to ensure they were reviewed and addressed.

For example, the registered manager had identified during the months of June and July 2016 an increase in number of skin tears or bruises for nine people. Following this review information had been shared with all registered nurses to alert them to the need for a complete a review of risk assessments relating to the care for these people and how these wounds may have been occurring. This work was being completed at the

time of our inspection. The training coordinator told us the manual handling training for staff, which the registered manager had been delivering, was being updated to reflect the actions required following a review of these incidents and accidents where people had bruising or skin damage of an unknown origin. Moving and handling techniques were to be reviewed as well as the use of all equipment to support people with mobility. This showed the home was responsive to identified changes which were required as a result of audits and investigations in the service.

We had received information of concern about the management of an injury to a person following a serious fall. The registered manager held clear records of all incidents of falls and the subsequent actions staff had taken to ensure the safety and welfare of people. Any learning from incidents had been identified and shared with staff at meetings and individual discussions with the manager and other health and social care professionals. The registered provider had a 'Falls Prevention and Management Policy' which had been updated following learning from a recent incident at the home.

Personal evacuation plans were in place and available in the event of any emergency. A robust business continuity plan and emergency evacuation plan were in place to ensure people were safe in the event of fire or other utilities breakdown such as a power failure.

Safeguarding policies and procedures were in place to protect people from abuse and avoidable harm. Staff had received training on safeguarding and had a good understanding of these policies, types of abuse they may witness and how to report this both in the service and externally to the local authority and CQC. The registered manager held clear records on any concerns which had been raised with them, or which they had identified. These had then been reported to the local authority and information on the investigation of any concerns and the learning from these was clearly recorded and shared in the service. Staff were confident any concerns they raised would be dealt with swiftly by the registered manager and they were aware of the registered provider's whistleblowing policy.

There were safe and efficient methods of recruitment of staff in place. Recruitment records included proof of identity, two references and an application form. Criminal Record Bureau (CRB) checks and Disclosure and Barring Service (DBS) checks were in place for all staff. These help employers make safer recruitment decisions to minimise the risk of unsuitable people working with people who use care and support services. Staff did not start work until all recruitment checks had been completed.

During our inspection two members of staff told us there were not always enough staff available to meet the needs of people, particularly at weekends. However, two other members of staff told us there were always enough staff to meet the needs of people and the home did not very often employ external agency staff. We spoke with the registered provider and the deputy manager about this. They told us when staff went sick from work they worked closely with all current staff and four other external agencies to ensure sufficient staff were available to meet the needs of people.

The staff rotas showed there were consistent numbers of staff available each day and on occasions where staff had been absent from work through sickness these duties had been supported by other members of staff. The registered provider told us the registered manager had a very good understanding of the dependency of the people who lived at the home and how to monitor this. As the registered manager was on leave we were unable to review the tool used.

People told us there were sufficient staff to meet their needs and our observations confirmed this. Call bells were answered in a timely manner and during mealtimes we saw sufficient staff available to support people in the main dining area and also to support those who chose to remain in their rooms. The registered

manager monitored and audited call bell waiting times to ensure people received a timely response to their requests for support.

Medicines were administered by registered nurses who wore a red tabard during the medicines administration round to identify to people they were not to be disturbed at this time. Medicines were stored and administered safely. A system of audit was in place to monitor the administration, storage and disposal of medicines. A recent audit had identified the lack of storage space for controlled medicines in one nursing station. A new medicines storage system had been ordered and was awaiting fitting.

People received their medicines in a safe and effective way. There were no gaps in the recordings of medicines given on the medicines administration records (MAR). For medicines which were prescribed as required (PRN) we saw staff recorded when these medicines were given and for what reason. Whilst care records identified the effectiveness of these medicines, the MAR did not always reflect this. For some medicines with a variable dose, such as one or two tablets, the MAR was not always clear as to the number of medicines which had been administered.

We recommend the registered manager seeks further guidance on how to provide consistent documentation of variable and as required medicines and take action to update their practices accordingly.

We had received information of concern relating to the risks associated with the care people received who received anticoagulant medicines. These medicines thin the blood and people who take them are at increased risk of bleeding or clotting if the medicines are not managed appropriately. Information relating to all of the people at the home who received an anticoagulant medicine was clearly visible for all staff. Staff were aware of the potential risks for people and care plans reflected these risks. MAR held clear information on the dose and the frequency of blood tests for these people.

Good

Is the service effective?

Our findings

Staff knew how to meet people's needs effectively and offered them choice whilst respecting their wishes. They took time to allow people to make decisions. A health and social care professional said people were encouraged to make choices and staff understood when they needed to support people with choice and decisions and get other people involved in this process.

Where people had the mental capacity to consent to their treatment, staff sought their consent before care or treatment was offered and encouraged people to remain independent. Care records showed staff always respected people's choice when receiving care. For example, if people did not always want to have support with personal care staff would respect this wish and then return to the person later and ask if they needed any support. For one person, who chose to sleep in their chair as they found their bed uncomfortable, staff encouraged the person to change position whenever possible to ensure their safety and welfare but respected their wishes.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Where people lacked the mental capacity to make decisions the home was guided by the principles of the MCA. The deputy manager and staff had a good understanding of the processes required to ensure decisions were made in the best interests of people.

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 application procedure for this in care homes is called the Deprivation of Liberty Safeguards. For several people who lived at the home an application had been made to the local authority with regard to them remaining at the home to receive all care or leaving the home unescorted. We found the home to be meeting the requirements of the Deprivation of Liberty Safeguards.

A program of supervision sessions, induction and training was in place for staff. This ensured people received care and support from staff with the appropriate training and skills to meet their needs. Staff felt supported through these sessions to provide safe and effective care for people.

The training coordinator visited the home once a week and supported the identification and management of training for staff. They explained how they worked with the registered manager to monitor the training which staff had completed and ensure they all had the required training to meet the needs of people. All staff had been encouraged to develop their skills through the use of external qualifications such as National Vocational Qualifications (NVQ) and Care Diplomas. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. The training coordinator had also provided resources and support for people to access the Care Certificate. This certificate is an identified set of standards that care staff adheres

to in their daily working life and gives people confidence that staff have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

Staff had a good understanding of their role in the home and the management structure which was present to support them and people who lived at the home. The registered manager and their deputy provided senior leadership in the home and were supported by a team of registered nurses who provided clinical leadership in the day to day running of the home. An administrator provided support in the home for all clerical duties and all staff appeared calm and unflustered as they went about their duties.

People enjoyed a variety of freshly prepared foods of their choice. Menus were well presented daily to offer people a choice of main meals and teas. We saw people were offered choice daily as to their preferred food option for the day and alternatives were available. For example, for one person who did not wish to have the roast chicken dinner of the day, they requested a pasty. We saw they received this. The cook told us this person regularly wanted a pasty but that they always offered them other choices as well to encourage them to have a varied diet.

Special diets such as those for people who lived with diabetes, required pureed or soft diet and vegetarians were catered for. There was a plentiful variety of foods available for people to snack on throughout the day in communal areas and in snack boxes in people's rooms. These included crisps, biscuits and fresh fruit and these supplies were refreshed through the day. For people who required their daily intake to be monitored we saw this happened and people were monitored to ensure they had an adequate nutritional intake.

On the day of our inspection the weather was very hot and we saw staff had been given prompts to remind them of the importance of increased fluids for people at this time. Cold drinks were readily available for people in communal areas of the home and in their rooms. We saw staff offered people a choice of cold and hot drinks and encouraged them to drink fluids.

Care plans identified specific dietary needs, likes and dislikes of people and the cook was aware of these. People's weights were monitored regularly and action taken should any significant changes be noted. For people who were at risk of choking, information in care records and displayed in people's rooms clearly identified the need for staff to thicken fluids to reduce this risk.

Mealtimes were a calm time when people received the support they required to enjoy their meal. People were allowed time to enjoy their meals without staff interrupting them. One person told us, "I know I am slow, but they don't hurry me. It's lovely [food]."

Records showed health and social care professionals visited the service as and when required. Care records held feedback from GP's, speech and language therapists, social workers and a tissue viability nurse. Staff identified people's needs and involved health and social care professionals appropriately. The home worked closely with a local GP practice to support the medical needs of people. A GP visited the home for emergency calls but also had a regular visit once per week to review any medical needs for people and ensure care received was in line with their medical needs. The deputy manager told us this meant they did not have to call the GP unnecessarily as they could proactively identify any change in medicines or other needs and discuss these with the GP during this weekly visit.

Good

Is the service caring?

Our findings

People were valued and respected as individuals and were happy and content in the home. They were cared for by staff who understood their needs and who provided a calm, caring and happy environment for people to live in. Health and social care professionals said people were well cared for and happy in the home.

Staff knew people well and demonstrated a regard for each person as an individual. They addressed people by their preferred name and took time to converse with them in a way which was meaningful and supportive for them. For example, for one person who became confused and disorientated as to where they were, we saw staff sat with them in a communal area and reassured them by speaking calmly and providing them information as to where they were. For another person who chose to watch television in their room we saw staff interacted with them in a friendly way and encouraged them to come down for their meal and join in some activities in the afternoon.

The atmosphere in the home was calm and very friendly although at times there were limited interactions between people who lived at the home. Communal spaces inside and outside the home were well utilised to allow people the opportunity to spend time in different environments around the home with staff available to support them should they require this.

People's privacy and dignity was maintained and staff had a good understanding of the need to ensure people were treated with respect at all times. Doors remained closed to people's rooms when they were being supported with personal care and a sign was displayed on the door to ensure people did not enter without knocking and gaining consent. We saw staff knocked and waited for a response before entering people's rooms. Staff had a good understanding of how to ensure people's dignity was maintained.

People were able to express their views and be actively involved in making decisions about their care. Meetings were held quarterly for people who lived in the home and their relatives. Minutes from these meetings showed people were offered opportunities to discuss any changes at the home including any new activities, new members of staff were introduced and updates for people on renovations or decoration around the home. We saw the activities coordinator ensured information was shared with people who were not able to attend these meetings.

The registered manager used many different ideas to share information with people and relatives including; a monthly newsletter, displays of information, photographs and notices showed people's experiences were celebrated and any communications about activities or events in the home were shared. The monthly newsletter shared information of upcoming events and reminders for people about important information in the home such as the need for good infection control.

Good

Is the service responsive?

Our findings

People were able to express their views and be actively involved in making decisions about their care. They were encouraged to be active and healthy in the home and were supported by staff who knew them very well.

People were assessed prior to their admission to the home and these assessments helped to inform care plans. People's preferences, their personal history and any specific health or care needs they may have were documented. This allowed all staff to have a clear understanding of the person's needs and how they wanted to be cared for. Information was available in each person's care records to identify specific likes and dislikes and the personal abilities of people to manage their own care. They also noted people who were important to them and who needed to be involved in their lives and in helping them to make decisions.

Staff had a good understanding of the need for clear and accurate care plans which reflected people's needs. Care plans in place gave clear information for staff to meet the needs of people with specific health conditions such as diabetes, epilepsy and other long term health conditions.

An activities coordinator worked at the home for 31 hours per week to support the coordination and management of activities for people. They told us of the very wide range of activities they supported for people which included links to local groups and services such as the local church and local school. A large activities board in a communal area of the home identified daily activities for people to engage with including games, reminiscence therapies and music. We saw people were encouraged to help plan and choose these activities for the week and interacted well with the activities coordinator when doing so.

External entertainers visited the home regularly and included musicians, singers, visiting pets and animals. For people who preferred to remain in bed for their care the activities coordinator told us how they encouraged visiting singers to enter the central courtyard of the home to ensure people who remained in their beds could hear them. Visiting pets also went into people's room at their request to ensure people were not isolated from activities which were going on in the home.

Regular social activities such as parties to celebrate birthdays, special events (recently the Queen's birthday), barbecues and raffles to raise funds for activities were held. People told us of a recent barbecue which had been held in the central forecourt of the home. They had enjoyed music and good food in a very relaxed and friendly environment. Two outside areas of the home were well maintained and provided safe garden environments in which people could relax and enjoy good weather. Another area of the home was being converted into a coffee shop in which people would be able to socialise.

The activities coordinator had worked closely with a local hospice movement to develop a programme of relaxing and reflective therapies for people who lived at the home, especially those who were not always able to communicate their emotions or express their wishes clearly. This was called a Namaste programme. A quiet relaxation room and area was designated for this activity which supported a small group of people or individuals, depending on their preferences. The activities coordinator also supported people who

remained in their rooms with Namaste activities of relaxation and reflection through use of a mobile trolley for Namaste therapy. The activities coordinator told us they had introduced this therapy as, "We needed to find a way to enrich service user's lives who stayed in their room or who have limited communication." They told us the registered provider and manager had been very supportive of the introduction of this therapy and people were benefitting greatly from the relaxing and therapeutic benefits of this therapy. Care records reflected people's enjoyment of these activities.

A system of "Resident of the week" was in place to promote the care and wellbeing of an individual resident each week. During this time the person would be able to choose an activity specific to their interests and needs including a one to one visit to local shops, cinema, special areas of interest or family. The person's care plans would be reviewed to ensure they were in line with their needs and preferences and their room would be deep cleaned and any maintenance carried out. This gave people the opportunity to participate in activities which they enjoyed in a more personalised way and were specific to their needs.

The complaints policy was displayed in the entrance to the home. The registered manager also provided other means of communicating concerns for people and visitors including a 'Comments and Niggles Book' placed in the entrance to the home. We saw visitors used this means of communication with the registered manager and home. The registered manager and provider had effective systems in place to monitor and evaluate any concerns or complaints and ensure learning outcomes or improvements were identified from these. We saw any concerns or complaints were investigated and actions from these were implemented. Staff were encouraged to have a proactive approach to dealing with concerns before they became complaints. Staff welcomed visitors in a warm and friendly way and encouraged them to express any views about the service their relatives received.

Good

Is the service well-led?

Our findings

People felt the service was well led and spoke highly of all the staff at the home. Health and social care professionals said the service was well led and they received a good response from all staff who knew people very well.

A staffing structure in place at the home provided a strong support network for staff. The registered provider had clear systems and processes in place to ensure the safety and welfare of people. They visited the service regularly. The registered manager and their deputy provided a stable senior management team in the home. An administrator in the home supported with all clerical duties, whilst registered nurses within the service supported the clinical day to day running of the home. Staff felt able to speak with registered nurses or the registered manager about any concerns they may have and felt these would be addressed promptly and effectively.

Staff felt supported through supervision, appraisals and team meetings. These were used to encourage the sharing of information such as learning from incidents and new training and development opportunities. A short daily meeting called "Ten at Ten Meeting" had been introduced by the registered manager for all members of staff working in the home on the day including kitchen, domestic, care and nursing staff. The aim of these meetings was to facilitate good communication between all groups of staff working at the home. Staff told us these helped them to work better as a team and not individual sections of the home.

A system of employee of the month had been introduced to the home and staff were commended for their contributions in the work place. This was displayed in monthly newsletters for people and their visitors to see. The registered manager promoted an open and honest culture for working which was fair and supportive to all staff.

A robust program of audits was in place at the home to ensure the safety and welfare of people, this included external audit of the service. An audit completed in May 2016 from an external service identified some minor actions for implementation by the registered manager. We saw this was being completed.

Audits to ensure the safety and welfare of people included: medicines, infection control, bed mattresses, call bells, activities, environment, equipment checks and fire records. The registered manager had a system of nominated staff members to ensure these audits were complete and they monitored the effectiveness of these. For example, an audit of mattresses in the home had identified one mattress needed to be sent to laundry and another to be replaced. We saw this was completed. Audits were in place to review and monitor the effectiveness of care plans and records randomly by the registered manager. A 'Resident's Needs Assessment' was completed 6 monthly with people to ensure any changes to their needs were recorded and updated. Care records were reviewed monthly or more frequently as required.

People, their relatives and external health and social care professionals were asked for their views of the service and the quality of the care delivered at the home. A survey of people's views was carried out in March 2016 and showed people were very happy with the care delivery at the home.