Cuerden Developments Ltd

Cuerden Developments Limited - Cuerden Grange Residential Home

Inspection report

Cuerden Grange Residential Home
414 Station Road, Bamber Bridge
Preston
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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

Cuerden Grange Residential Home provides accommodation and personal care for up to 67 older people. Accommodation is provided on two floors. A passenger lift provides access to both floors. At the time of the inspection there were 57 people accommodated in the home. This unannounced inspection took place on 27 November 2017, and the service was rated 'Good' in all areas: "Good" overall.

The service had a registered manager. 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.

At the last inspection in April 2015, the service was judged to be in breach of the Regulations for infection control and recruitment. The home had made improvements since our inspection in April 2015. We had previously identified concerns which posed a risk of infection, for instance the kitchen on the first floor was in a poor state of repair and people were sharing hoist slings. These issues had been addressed. New kitchen surfaces had been provided or thoroughly cleaned, people no longer shared slings. This meant the risk of cross infection was reduced.

We also found that improvements had been made in relation to safe staff recruitment practices. The policies and procedures were now up to date, and recent recruitment had been undertaken in accordance with the Regulations.

Staff received supervision and appraisals were on-going, providing them with appropriate support to carry out their roles. Training records showed that staff had received training in a range of areas that reflected their job roles. The provider operated safe and effective recruitment procedures. Medicines were stored and administered safely.

The provider had systems in place to respond and manage safeguarding matters and make sure that safeguarding alerts were raised with other agencies. People said that they felt safe in the home and if they had any concerns they were confident these would be quickly addressed by the staff or manager.

Assessments were in place to identify risks that may be involved when meeting people's needs. Staff were aware of people's individual risks and were knowledgeable about strategies in place to keep people safe. There were sufficient numbers of qualified, skilled and experienced staff deployed to meet people's needs. Staff were not hurried or rushed and when people requested care or support this was delivered quickly.

Where people lacked the mental capacity to make decisions the home was guided by the principles of the Mental Capacity Act 2005 to ensure any decisions were made in the person's best interests.

People and where appropriate their relatives were involved in their care planning, Staff supported people

with health care appointments and visits from health care professionals. Care plans were amended to show any changes, and care plans were routinely reviewed to check they were up to date.

People were treated with kindness. Staff were patient and encouraged people to do what they could for themselves, whilst allowing people time for the support they needed.

People knew who to talk to if they had a complaint. Complaints were passed on to the registered manager and recorded to make sure prompt action was taken and lessons were learned which led to improvement in the service.

The registered manager was supported by the service provider who was regularly in the service and who carried out a programme of quality assurance audits to identify areas of risk, and areas to maintain performance and drive improvement. The service had an open culture where people had confidence to ask questions about their care and was encouraged to participate in conversations with staff. Staff interacted with people positively, displaying understanding, kindness and sensitivity.

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 has improved to Good.

There were sufficient numbers of staff to care for people in a safe way. Recruitment processes included checks so that only suitable staff were employed.

The service was clean and working practices were in place to minimise the spread of any infection.

Staff knew how to recognise any potential abuse to keep people safe.

Potential risks to people were identified and measures were in place to minimise them.

People received their medicines as prescribed.

Is the service effective?

Good

The service remains Good.

Is the service caring?

Good

The service remains Good.

Is the service responsive?

Good

The service remains Good.

Is the service well-led?

Good

The service remains Good.

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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.

The last inspection took place on 22 April 2015 and the service was rated 'Good' overall, but rated "Requires Improvement" in the safe domain. This unannounced inspection took place on 27 November 2017, and the service was rated 'Good' in all areas: "Good" overall.

Cuerden Grange Residential Home 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 inspection was carried out by one inspector, a Specialist Advisor and an Expert by Experience. A Specialist Advisor is a health and social care professional with particular expertise, who can advise on their findings during and following an inspection. In this case the Specialist Advisor was a nurse with expertise in the care of older people, and people experiencing mental health issues. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service, in this case older people and people living with dementia.

Before our inspection we contacted two visiting health and social care professionals in relation to the care provided at the home. During our inspection we spoke with the registered manager, nine members of staff, eleven people living at the home and five visiting relatives.

We looked at the provider's records. These included five people's care records, six staff files, a sample of audits, satisfaction surveys, staff attendance rotas policies and procedures.
We also checked the building to ensure it was clean, hygienic and a safe place for people to live.

We asked the provider to complete a Provider Information Return (PIR) before our inspection. 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.

Some people were not able to verbally communicate their views with us or answer our direct questions. 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.

Good

Is the service safe?

Our findings

People told us they felt safe and their visitors confirmed this. People answered, "Yes" when we asked if they felt safe and, "I feel safe and well cared for here". One relative said, "She is safe" when they were asked if their family member was. Another visitor told us, "I believe she is safe and is cared for".

At the last inspection in April 2015, the service was judged to be in breach of the Regulations for infection control and recruitment. The home had made improvements since our inspection in April 2015. We had previously identified concerns which posed a risk of infection, for instance the kitchen on the first floor was in a poor state of repair and people were sharing hoist slings. These issues had been addressed. New kitchen surfaces had been provided or thoroughly cleaned, people no longer shared slings. This meant the risk of cross infection was reduced.

We also noted at the previous inspection gaps in employment had not been recorded for one staff member, and the service's policies and procedures did not reflect the current Regulations governing staff recruitment and selection. We found that improvements had been made. The policies and procedures were now up to date, and recent recruitment had been undertaken in accordance with the Regulations.

Application forms had been completed and recorded the applicant's employment history, the names of two employment referees and any relevant training. There was also a statement that confirmed the person did not have any criminal convictions that might make them unsuitable for the post. A Disclosure and Barring Service (DBS) check had been obtained by the provider before people commenced work at the home. The Disclosure and Barring Service carry out checks on individuals who intend to work with vulnerable children and adults, to help employers make safer recruitment decisions.

However, it was noted that the current registered manager of the home had provided a character reference for a staff member, in their capacity as their previous manager in a different service. Although this did not pose a problem in terms of potential breaches of Regulation, we did suggest that the registered manager consider if it was appropriate for her to supply references to staff that she was then to manage. The registered manager agreed that she would not do this in future, and seek alternative referees from applicants, so as to reduce the possibility of any conflict of interests.

The PIR told us and we saw people were kept safe because they were supported by staff who understood and recognised signs of abuse. One member of staff told us they would, "Report to the management" if they had concerns, and added that they knew who to speak to outside of the service, if they had concerns about the manager or members of the management team. All staff agreed action would be taken by management if concerns about safety were raised. And again, if for some reason it was not followed up they all knew about external bodies they could raise concerns with e.g. Adults safeguarding, the CQC.

Any safety issues were reviewed and investigated by the registered manager or the service provider, and if any external agencies such as social services needed to be involved, then the registered manager welcomed their input and involvement. If there were any lessons to be learnt from an incident, e.g. a fall, then staff

meetings took place, and care plans were reviewed in order that staff were fully aware of any changes needed to keep people safe.

People were kept safe and their independence was promoted because risks were managed well. One member of staff said, "We are always risk assessing, and this is documented in people's care files". Each person had risk assessments in place including possible skin damage, mobility, risk of falls, risks associated with medicines. These identified the risks and how to mitigate them.

We observed that people were supported by staff during transfers with appropriate equipment so they were kept safe. For example, one person who was becoming anxious prior to using a wheelchair was reassured by staff. They said, "I don't trust you" to the staff. In response, the two members of staff remained kind and calm. One of the staff offered to hold the person's hand during the process for reassurance. When it was clear the person was not ready they calmly told them they would try again later.

We saw that people were supported by enough staff to meet their needs and wishes. People said, "Yes I think there are enough staff day and night, they come to help fast enough and I always feel I can ask for help" and "Yes there are enough staff". One relative told us, "They [meaning the staff] would respond as quickly as they could". Staff told us that they were busy at times, but there were enough staff working at the home. We saw call bells were responded to in a timely manner.

People's medicines were safely managed and administered by staff who had received appropriate training. There was a clear medicines policy and procedure in place to guide staff on obtaining, recording, handling, using, safe-keeping, dispensing, safe administration and disposal of medicines. People's medicine was stored securely in a medicine cabinet that was secured to the wall. There were systems to audit medication practices and clear records were kept to show when medicines had been administered or refused. When there had been a medicine error these were managed well.

Environmental risk assessments had been completed. Hazards were identified and the risk to people removed or reduced. Checks were made of the moving and handling equipment to ensure these were working correctly. Routine checks were also made of the passenger lift, electrical and gas appliances. Certificates and records were maintained of these checks. Staff had a good awareness of risks and knew what action to take to ensure people's safety. There were arrangements in place to deal with foreseeable emergencies. Personal Emergency Evacuation Plans (PEEPS) were kept on file with copies available at the entrance to the home to guide staff on the safest way to evacuate people in an emergency situation.

There was a clear system in place to ensure that the building, and the equipment used within it was regularly cleaned, and procedures in place to reduce the risk of the spread of infection. Cleaning rotas were followed, staff were seen to wash their hands correctly before the after personal care, hand sanitizer was correctly used, and the laundry facilities were appropriate for the type of home.

Good

Is the service effective?

Our findings

The home continued to provide an effective service to people. One person living at the home said, "I think the staff work well as a team. They seem to be well coordinated, and that helps when I need help. They all know me well, and my needs." A visiting relative said, "I think the staff team is quite stable, and this helps with making sure my [relative] receives a consistent approach to their care. All the staff know my [relative] very well, and in my opinion, I feel they are well trained and focused."

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

We noted documentation in a number of care files that showed that people had been assessed as having capacity, but that they then had best interest meetings to determine if they should take part in an activity. For example, people with capacity had documentation to show that it was in their best interests to sit out in the garden, and enjoy the good weather during the summer months. The registered manager explained that these documents had been completed on advice from the Local Authority Safeguarding Team. We explained that as people had been deemed to have capacity to make decisions, then a risk assessment regarding the warm weather would have been more appropriate, rather than a best interests decision. The registered manager agreed and said that she would cease this practice, and only undertake best interest meetings when it was appropriate to do so.

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 MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider had a policy and procedure to support staff in this area. People who lacked capacity had DoLS applied for when staff recognised there had been restrictions made to keep them safe. There was a system in place to ensure that appropriate action could be taken when DoLS were due to expire.

We saw that people were supported by staff who had received enough training to meet their needs and wishes. Staff said, "Training feels like it's never ending" and "You think you complete it all and then it starts again". Staff were supported in their role and had been through the provider's own induction programme. This involved attending training sessions and shadowing other staff. There was an on-going programme of development to make sure that all staff were up to date with required training subjects. Training included health and safety, dementia awareness, moving and handling, emergency first aid, infection control and safeguarding.

All staff confirmed they had regular supervisions from a more senior member of staff. One member of staff told us, "Senior staff observe the care team to make sure they provide good quality care". Another staff member said, "Staff observations also provide an opportunity to ensure they are transferring people safely

in line with the training they had received".

When people moved into the home who had a small appetite staff would find ways of encouraging them to eat. People told us the food was good. Some people said, "We do have food choices and I like the food" and "Food is pretty good". When people expressed a preference for food this was met.

At each meal there was a choice of two options for the main meal and a pudding option. However, two people suggested that the food was sometimes "on the cold side", and expressed the opinion that they would like it "to be a little hotter." We spoke to the staff about this, and they explained that the food was prepared off site, in a building next to the home, and that it was transported over to the home in heated trollies. The registered manager said that no one had expressed any dissatisfaction to her regarding the food temperature, but she agreed that she would monitor the situation, and if changes were required then she would see that they were made.

We also noted that one person who required a softened diet was given food that did not look particularly appetising. The meal on the day of our visit was chicken pie, mashed potatoes and peas with gravy. The meal presented to the person consisted of 2 mounds of food, both looking like the other. We could not make distinguish which was the chicken pie and which was the mashed potato. No peas were served, and no gravy. Although the person ate the meal, they did so in a slow manner, and they did not appear to show that they particularly enjoyed the experience. We were unable to obtain an opinion from the person regarding the quality of the food. We asked the staff and they said that they had supplied the person with the meal that had been sent via the kitchen, and that there weren't any other meals available. Again we passed this onto the registered manager who said that she would look into the issue, but was surprised about our observations, as her recent audits relating to mealtimes were positive.

People had access to a range of health and social care professionals to meet their needs. People told us, "My chiropodist comes regularly" and "My doctor would be sent for if I needed seeing for anything". The home was part of a "tele-med" system where people in need of a medical opinion were supported to speak to a doctor via Skype. This was seen to be a good use of technology. Staff at the home said that it was a useful tool as it quickened up the process when people needed to see a doctor, and if any further action was needed then the "tele-med" doctor would make suggestions. One person who had used the system said, "It was a bit strange at first, but then I got used to it. It was just like talking to someone on the TV."

The registered manager told us they used evidence from health and social care professionals involved in people's care to plan care effectively. This was evidenced in the care files. For example, care plans contained guidance from people's GPs and other health professionals who had been involved in their care. The local GP practice employed a Nurse Prescriber, who visited the home on a weekly basis. When spoken to she said that the home was well organised in ensuring that those people who needed to be assessed were done so, and when changes to their care and treatment were made, then these were recorded and acted upon.

We saw that people were able to personalise their bedrooms how they wanted. We saw that people had brought their ornaments and photographs of family and friends or other pictures for their walls. This personalised their space and supported people to orientate themselves. We did however see that there was some signage within the home that could be confusing. For example, one door had both a sign for "the bathroom" on it, and a sign for "storage room". We explained that this needed to be changed as it could be confusing to people. The registered manager agreed, and the signs were removed.

Good

Is the service caring?

Our findings

People spoken with indicated they were treated with kindness and compassion and all expressed satisfaction with the service. One person said, "They [the staff] look after me well" and their relative continued, "My [relative] loves all the carers. I think they look after people very well". One relative said, "The staff go out their way to give my [relative] personal attention".

We saw that people made choices and these were respected by staff. For example, one person was in bed and two staff went to see if they wanted to get up. The person said, "I can't be bothered". So the staff joked with them about the weather and wishing they could be in bed. The staff returned to the person later, and were able to support the person to get up. They respected the person's wishes and said they would come back later. We observed that people were listened to by staff when they expressed choices about the care they received. One person said, "I think the care is good and they do listen".

Some people were living with mild confusion or dementia. When they were unable to verbally communicate their own choices their relatives were consulted. This was then recorded in people's care files. One relative said, "The care staff regularly speak to me about care needs and wishes. If there were any changes they tell me." Other people who were not able to express themselves and lacked family were provided with information on advocacy services. The registered manager explained that if people needed assistance to contact the advocacy service, then the staff would do this on their behalf.

We observed that staff demonstrated a good understanding of respect and dignity issues, and were observed providing care which maintained people's dignity. We observed staff being discreet when asking people if they wanted to use the toilet. People told us staff always sought consent and provided personal care in a manner which ensured their dignity was maintained. We observed people spending time in the privacy of their own rooms and in different areas of the home. Staff were seen to ensure that people were appropriately dressed, and staff supported people to maintain their personal appearance.

We saw that the staff encouraged people to carry out tasks for themselves such as washing, dressing and eating, and gave people the time and support to do so. Some people required items of equipment such as mobility aids or adapted crockery to support them to be independent. We observed that the staff on duty knew the items people needed and ensured these were provided as they required. People's rights to privacy and dignity were discussed during staff meetings to help ensure the staff had a sound understanding of these issues.

Good

Is the service responsive?

Our findings

We looked to see how people received personalised care that was responsive to their needs. We saw that people received consistent and personalised care and support. Once the service agreed to support a person, an initial assessment took place. Staff made efforts to empower the person to be actively involved in the whole process. Evidence was gathered about the person's medical history, family life and previous occupation and hobbies. Consideration was given to people who were thinking about living at the home to ensure existing people and new people would all get on, and it was the right environment for them. Feedback we received from people at the home on a recent move was positive. One person said, "The care was customer focused, they were listened to me and my family, and the care I receive meets my requirements. I think it's great."

We reviewed people's care plans and saw that they were well-organised and provided staff with detailed information on how to respond to each person's individual needs and preferences. Staff had a good understanding about person-centred care. One member of staff said person-centred care was when you, "Put the resident in the centre; consider needs, wants, choices." Another member of staff explained that people, "Have different care needs and you give care the way they want it." Staff said it was important to know people's likes and dislikes. One member of staff said the best way to do this was to, "Get to know the resident and their families." They then said, "This takes time and patience." The care plans contained detailed plans for areas of the person's life including personal care, medicines, cognition, nutrition, communication, safety and wellbeing.

We looked at what arrangements the service had taken to identify record and meet communication and support needs of people with a disability, impairment or sensory loss. Care plans seen confirmed the service's assessment procedures identified information about whether the person had communication needs, and if people needed extra support, then this would be offered. One person had been identified as being hard of hearing, and although they used hearing aids, the staff explained that they still had difficulty hearing. To ry and over come this, the staff explained that they often wrote things down for the person so that they could understand better, and this was recorded in the person's care plan as an action the staff should take to respond to the person's support needs.

Members of staff we spoke with were able to describe the different activities that people enjoyed such as music and movement, quizzes, bingo and coffee mornings. One member of staff told us, "There is always something going on activity wise so we encourage people to take part. We ask people what they like to do and let them know when that activity or something similar is planned so that they have the opportunity to join in." There were activity programmes displayed in each of the communal corridors and in the entrance hallway so people and their relatives knew the activities that were on offer or any future events that were planned. During our inspection we saw a number of people join the planned activities on offer. We also saw staff engaging people in social conversation and completing individual activities with people as opportunities arose.

We looked to see how people's concerns and complaints were listened and responded to and used to

improve the quality of care. People we spoke with knew how to report any concerns. Comments included, "I have no concerns, but if I had any, I would say to them and they would act" and "All the staff are very good, there's no problem at all with the carers. I have no concerns." We looked at records to show how complaints had been responded to. In each case we were able to see appropriate action had been taken to resolve matters.

For example, one person had complained about how their food had been presented, the quality of the food, and the temperature of their drinks. We found that the registered manager had met with the chef and the complainant, and had discussed the menus with them, and recorded further information about their likes and dislikes. A kettle, tea and coffee were placed in the person's room to allow them to make their own drink. The person was very happy with the response. Staff confirmed that following a complaint, details were discussed at staff meetings and handovers, so that any changes to the way care and support was offered were communicated, so that a consistent approach was offered.

We looked to see how people were supported at the end of their life to have a comfortable, dignified and pain-free death. We found that the wishes of individual's about dying and terminal care and the arrangements they wanted after death had been discussed in a sensitive manner and added to people's care plans. Some had given a lot of detail, whereas others had not. The registered manager said that for some people, the thought of discussing death and funerals was just not for them, and that the staff would return to this discussion at a later date, when the person was ready. The registered manager explained that if people wanted to stay at the home as they approached their passing, then every effort would be made to support them to do this through discussion with the local GP, nurse practitioner and district nursing team. If people need specific pain relief, then external healthcare staff would organise this in conjunction with the home's own medicine trained staff.

Good

Is the service well-led?

Our findings

The home continued to be well-led. There was a registered manager in place. 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'.

Staff and relatives told us that they thought the home was well-led. One person told us, "The manager does a good job." A relative who was visiting told us, "The home is well run and my relative is very happy living here". They went on to say they would recommend the home to others. A visiting healthcare professional told us, "I believe the manager is open and honest about any concerns she has regarding residents, and is happy to contact other professionals such as myself as and when required. She is open to accepting advice and suggestions in an attempt to support residents".

The registered manager was supported by the service provider who regularly visited the service and who carried out a programme of quality assurance audits to identify areas to maintain performance and drive improvement. We saw documentary evidence to support this.

Staff told us there was good communication within the team and they worked well together. Staff, people and relatives told us the registered manager and service provider were visible in the home, and they created a warm, supportive and non-judgemental environment in which people felt comfortable.

The service had an open culture where people had confidence to ask questions about their care and was encouraged to participate in conversations with staff. Staff interacted with people positively, displaying understanding, kindness and sensitivity. Staff spoke to people in a kind and friendly way.

The provider sought the views of people, staff, relatives and health and social care professionals through questionnaires, health and social care professionals consistently noted the service was "Good", and feedback from relatives was complimentary.

Staff told us that team meetings took place regularly and they were encouraged to share their views. They found that suggestions were welcomed and were used to review and improve the service. We looked at staff meeting records which confirmed that staff views were sought and that staff consistently reflected on their practices and how these could be improved. Staff told us they felt comfortable raising concerns with the registered manager and found them to be responsive in dealing with any concerns raised.