Contemplation Homes Limited

Crossways Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service: Crossways is a nursing and residential care home. It is registered to provide care for up to 30 people. The management of the home are making plans to reduce this number as they eventually plan to stop providing double occupancy rooms. Crossways provides personal care and nursing care for adults.

People's experience of using this service: One person told us, "I tell staff if I feel unwell, they ask if I need a tablet and then say we'll keep an eye on you. They do and then call the doctor if they think best."

One person's relative also told us their views of the home, "The staff seem to work together as a team. There's always people about and the manager is always about. I am always made welcome. It's bright and airy in here, some of the areas could do with an update. I can get [relative] out into the garden in their wheelchair but I think others have difficulty getting out."

People received a good standard of nursing care at the home. We were told by relatives how their relatives' health had significantly improved since they moved to Crossways. When people were unwell or needed more specialist health support, referrals were made to these professionals in a timely way. Actions were then taken in the meantime to promote people's physical health.

People had good risk assessments in place and received their medicines as prescribed. There were good levels of staff to meet people's physical care and nursing needs. However, some people and their relatives felt that staff worked too long and too many shifts and were tired. The management team had not reviewed the potential impact this had on the quality of care delivery.

There were various safety checks completed in relation to the building to ensure people were safe. Safe staff recruitment checks were in place. Staff had a good understanding about what potential harm or abuse could look like. But they lacked the knowledge of how to share concerns outside the service.

Staff including the nurses received regular competency checks and training. Staff felt supported in their role and comfortable approaching the registered manager and one another for support.

Good systems were in place to respond and support people who were at risk of choking when eating and for those who needed to gain weight. However, people did not always have a positive dining experience, especially those who stayed in their rooms. Choice for people who were living with dementia was not promoted in relation to their food and drinks. The management team had not meaningfully assessed this aspect of people's day to day life. We saw some poor practices in relation to staff assisting people to eat in their rooms.

People spoke positively about the staff. Referring to them as caring and kind. We saw some kind interactions from staff during the inspection. However, we also found that staff practice was not always personable to people. There was not a culture of staff spending time with people, talking with them, checking they were

comfortable, or promoting their social wellbeing.

People told us that they enjoyed the activities that took place. We saw an activity co-ordinator spending time with some people during the inspection. However, there were people who spent all their time in their bed or bedrooms. There was little consideration given to these people. The management team had not completed any checks and in a meaningful way to see if people were okay with spending all their time in their bedrooms, or if they wanted more from their daily experience. We found that there were missed opportunities during our inspection of staff engaging with people or trying to improve their experience at the home.

People, their relatives, and we noticed that the environment of the home looked tired. There was a renovation plan in place, which was slowly being completed. The registered manager told us that the work will have finished by Christmas 2019.

The management team were completing audits and checks on elements of the care delivery. However, they had not fully considered people's daily experiences living at the home, and if this could be improved upon. The registered manager was responsive to all the issues we raised. However, the registered manager and the provider's own quality monitoring systems had not identified these shortfalls and they had not taken action to try and correct them.

There were breaches of the Health and Social Care Act 2008.

Rating at last inspection: Good (this report was published on 13 October 2016)

Why we inspected: This was a scheduled and planned inspection based on previous rating.

Follow up: We have asked for an action plan and will return to the home to check for improvements.

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

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 safe Details are in our Safe findings below.	**Good**
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 always well-led Details are in our Well-Led findings below.	**Requires Improvement**

Crossways Nursing Home

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. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
The inspection was completed by two Inspectors and an Expert by Experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. This Expert by Experience has expertise in dementia care.

Service and service type:
Crossways is a 'care home'. People in care homes receive accommodation and nursing or personal care as a 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:
No notice was given.

What we did:
Before the inspection we asked the local authority, who commissioned this service for their views. We checked statutory notifications which the provider must send us by law. We also reviewed the most recent provider information report. This is a report the service does telling us about what the service does well and improvements it plans to make. During the inspection we spoke with eight people who used the service, and four people's relatives. We also spoke with five members of staff, and the registered manager. We completed observations. We looked at nine people's care records, and three staff recruitment files. We also looked at safety checks relating to the building, medicines and medicines records.

Good

Is the service safe?

Our findings

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

People were safe and protected from avoidable harm. Legal requirements were met.

Assessing risk, safety monitoring and management
- People had good risk assessments in place. These explored the risks which people faced in detail. Such as risks around people's mobility, malnutrition and the risk of choking.
- Some people were at risk of a breakdown to their skin. Safe monitoring systems were in place for these people.
- Various fire safety checks were taking place. People had emergency evacuation plans. There were regular fire drills, and the safety of the building had been assessed.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
- People told us that they felt safe living at the home and being around staff. One person said, "I do feel safe because of all the arrangements in place and all the staff who are always good and helpful."
- Another person said, "I definitely feel safe because the staff are good with me. I have to call them sometimes and I don't wait long."
- A person's relative told us, "I think [relative] must feel safe and happy because of the way the home is run and the staff."
- There had been a recent safeguarding event. When this was raised, the management team took appropriate action. This event had highlighted a shortfall in the knowledge of some staff at the home. Timely action had been taken to address this.
- We found staff had a good understanding of what harm or potential abuse could look like. Staff said, they would report concerns to the registered manager and other outside agencies such as the local authority. But they were not clear about how they would contact these agencies. The registered manager told us they would correct this issue.

Using medicines safely
- We completed a check of some people's medicines. We found that the correct amount of medicines had been administered for these people.
- Medicine audits were completed on a regular basis. We saw that action was taken when recording errors were identified.
- Some concerns with how people's prescribed topical creams and medicines were stored were quickly dealt with by the registered manager.
- Medicines were being stored at the correct temperature ranges. However, we noted that when the weather was hot the current arrangement for storage may not be sufficient. We spoke with the registered manager about these issues. We were later sent an action plan responding to these issues.

Preventing and controlling infection

● We found the home was clean.
● We had identified some potential infection control risks. Chipped furniture and baths, dents in paint work, and stained carpets in two rooms. However, the registered manager showed us a renovation plan for the home. We could see some work was completed and planned. The registered manager said these remaining works will be completed in six months' time.

Staffing and recruitment
● Safe recruitment checks were in place for the sample of staff files we looked at. New staff had Disclosure and Barring Service (DBS) checks before they started working at the home. Staff references were sought and checked.

Requires Improvement

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

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

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

● People said they had enough to eat and drink. One person said, "We get plenty of drinks and snacks. They supply us with chopped up fruit between meals. I've had 3 cups of tea already and another here. You can ask anyone passing for a cup of tea and they always bring it back, or a cup of hot chocolate."

● But we had some negative views about the food. One person said, "I had the gammon with pineapple which was nice, but the chips were cold. That does happen sometimes. I didn't eat the lettuce because I get fed up with the lettuce all the time. I'm quite happy with the food on the whole."

● One person told us that staff always bring them squash to drink, but they never drank it as they did not like squash.

● Some people had made complaints about the food. The registered manager told us what action was being taken to respond to this.

● We saw staff supporting people to eat and drink in the lounge. Staff supported these people to eat at their own pace and encouraged people to drink.

● Some people needed encouragement to eat and drink. We saw this happened in the lounge, but this did not happen for people who ate alone in their bedrooms. We saw one member of staff give a person their meal. When they returned, and the person had not eaten their food, this member of staff did not ask why or offer an alternative meal or any assistance.

● For some people who were living with memory difficulties, staff did not use best practice guidelines to prompt choice or check they were still happy with the choice they had made earlier in the day. Staff did not check if people were still happy with their previous choice.

●We saw one person being offered two plated up meals to choose from. However, others also living with dementia were not supported in this way. From looking at these people's care assessments, they would have benefited from this support.

● People were also served their pudding with their main meal. Two people who were living with dementia were seen to be intermittently eating from the two meals at the same time.

● When people lacked an appetite, people's favourite food and where they wanted to eat their meals was not being considered.

● People's dining experience was not being reviewed by the management team, especially if they were in their rooms.

● We spoke with the registered manager about this. They created an action plan about addressing these issues.

● There was a system in place to monitor weight loss. For people who were at risk of this, timely action was taken to refer them to specialist professionals. There was a plan in place to promote weight gain while they

awaited this input.

Adapting service, design, decoration to meet people's needs
● The home looked tired in parts and in people's rooms. People and their relatives commented on this issue. There was a plan in place to address this.
● We were told people could access the outside space with the support of staff. Although this was not encouraged when we inspected, despite it being a warm and bright day.

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 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.
● We found that people had capacity assessments but these lacked details about how the assessor had reached their decision.
● We also saw that staff did not always promote choice when they were supporting people.
● The registered manager later sent us an action plan about addressing these issues.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● People's relatives spoke positively about this. One relative said, "[Name of relative] has progressed so well, they had been bedridden in hospital till we came here. Now they are sitting up in the lounge, eating well, putting on weight. The dementia is still there obviously but their health is much improved."
● Records confirmed that people had regular interventions from GPs when they were unwell and for general health checks.
● Nurses also responded when people showed signs of being unwell. Observations took place and referrals to specialist health professionals were made.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● We saw that people's needs were assessed before they moved to the home. We were told how best practice guidance was followed when training staff. There were systems in place to respond to a change in a person's health needs.

Staff support: induction, training, skills and experience
● Staff spoke well of their induction to their work. New staff said they shadowed more experienced staff for a few days and then continued to work with their colleagues until they felt confident.
● Staff and nurses said they felt supported by their colleagues and the registered manager.
● Staff and nurses had up to date training in key areas of their work.
● Staff and nurses had regular competency checks to test their abilities to complete their work.
● The registered manager showed us the system they used to ensure the nurses employed had current registrations to practice.

Good

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

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- People spoke positively about the staff who supported them. One person said, "I find on the whole the staff are very caring. After my care this morning staff asked if I would like another cup of tea and brought it straight back. I've only ever seen staff being caring to all the residents. I find everyone lovely."
- Another person said, "I find all the staff caring but I do have two favourites."
- A person's relative told us, "I think the staff are lovely with [relative]. I get the feeling they treat [relative] with dignity and kindness. They knock when [relative's] door is closed. They are friendly, polite and genuinely caring."
- We saw staff treating people in a kind way.
- Staff had a good understanding about how to promote people's privacy and dignity. They gave us examples of how they did this.
- We saw staff speaking with people in the lounge in a polite way.
- Staff told us how they encouraged people to be as independent as they could be when supporting them with personal care.

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

- People told us that they were involved in planning their care. We saw that people's care plans had details of what gender staff they liked to receive support from. Information about their daily care showed this was respected.
- People also made other choices about their lives. For example, people were asked if they wanted the lights off or on in their bedrooms during the night and the doors open or closed.

Requires Improvement

Is the service responsive?

Our findings

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

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● People had assessments in place explaining their health and care needs. Some information had been gathered about their backgrounds and interests. However, this lacked details. For example, it was recorded if people liked watching TV and reading magazines, but not what types of programmes and magazines people liked. People's wider interests, past achievements and experiences were not captured in these assessments and then explored in their experiences at the home.

● Some people spent all their time in their rooms, with limited stimulation. The management team was not checking if more could be done to improve these people's experiences. People told us that staff did not have time to have a chat with them or engage in some kind of activity. One person said, "The staff are too pushed for time to stop to talk." We observed this to be the case during the inspection. When we asked staff about the people they supported, they were unable to give us information to show they had in fact got to know them and formed a relationship with them.

●The registered manager told us that the service operated a key worker scheme. This is a scheme to help staff to get to know people. However, staff had not heard of this scheme or if they had been assigned certain individuals.

● We did see an activity co-ordinator supporting people with some activities. However, this was for a limited time and the service did not have an activity person daily.

● A member of staff said to one person, "We could take you out in the garden tomorrow." This person said, "That will be nice." Both said this, whilst looking out to the garden as it was a warm, dry and bright day. This member of staff did not ask this person if they wanted to go outside that day. Other people were not asked this.

● People said they only went out if their relative took them.

● In terms of staff responding to people's needs, we observed a mixture of responses from staff. On two occasions, we saw a member of staff talking with two different people in their language of origin. These people responded well to these conversations.

● We also saw one person being supported to eat in their room. There was no conversation taking place. When we asked to enter the room the member of staff then started talking to the person. We observed staff giving people food in their rooms without speaking with them. On one occasion, a member of staff showed the person a fork and spoon and said, "Fork or spoon." This was the sum total of this interaction.

● One person chose to sit near the window in the lounge. Staff commented how they liked to watch the birds. But they did not have a good view of the garden, because of how staff had positioned their chair.

● We saw staff routinely go around to people in the lounge putting their leg raisers up and down, adjusting their clothes, without checking with the person if it was okay to do this and explain what they were doing.

● Napkins were placed on people with no conversation. We saw that one member of staff gently throwing a napkin at one person to land on their chest. Another person eventually threw their napkin off after a member of staff had put in on their chest.

● A person we spoke with said staff did not always help them or ask them if they were comfortable, after they had supported them. They said, "They plonk me down and then I feel uncomfortable. I do feel safe with all the staff, just those two are not as careful."
● People were not regularly having a purposeful review of their care. The service was not involving others in this process to gain their views.
● We found that staff chatting to people, offering to take people out, or completing an activity together was not part of the general culture or practice of the home.
● We spoke with the registered manager about these interactions. We concluded that the registered manager needed to review this and consider staffing levels, deployment of staff, and support for staff get to know people and be more personable with them.

The lack of personalised care meant that this was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

End of life care and support
● People had an end of life plan in place and we could see that the registered manager had recorded having conversations with relatives about this support. However, the plans did not show if particular wishes relevant to the person were explored with them.
● We spoke with the registered manager who said they would review these with people.
● We found that nursing staff received training and worked with other professionals to meet people's needs at the end of their life.

Improving care quality in response to complaints or concerns
● Relatives told us that the registered manager responded well to any issues raised by them.
● There was a complaints process in place. No one had made a formal complaint.

Requires Improvement

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Regulations may not have been met.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements;

- Staff did not always respond to people in a person-centred way. Staff did not know how to communicate with some people and there were missed opportunities to promote people's wellbeing and experience at the home.
- Some work was being completed to gain people's views of aspects of their care and review the activities provided. However, elements of people's daily experiences were not being reviewed to see if improvements could be made or more could be done for people. For example people's dining experiences and assistance with helping people to make an informed choice with their meals.
- Effective management systems were not always in place to monitor and review people's experiences at the home. The registered manager did not consider if there was enough social stimulation for those who spent all day in bed or in their bedroom or if this part of people's lives could be improved upon.
- Staff shortfalls in communicating and engaging with people had not been identified as part of the managements quality audits. Consideration was not given if staff had the time and skills to meet people's social needs.
- It was positive that when we raised issues, the registered manager considered these and created an action plan with time scales to have completed these by. However, the provider's and registered manager's own audits had not identified these shortfalls.

The lack of effective quality monitoring systems meant that shortfalls in people's care had not been identified and action had not been taken to address this. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We found people were supported well to promote their physical health and staff respond quickly to a change in their health needs. Relatives reported how their relative's physical health had improved during their time at the home.
- The management had completed effective checks on this aspect of the service. In terms of the safety of care provided, understanding people's physical health needs, and taking action to promote this.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics;

- There was a lack of meaningful engagement with people to gain their views of their care and involve them in the development of the home.

Continuous learning and improving care

● The management team had learnt from a previous shortfall in staff practice. They were also responsive to the issues we identified at this inspection.

Working in partnership with others

● We saw that the service worked with other professional agencies and individuals to promote people's health and good care delivery in terms of people's physical care needs. However, there was no partnership working or involving other organisations to look at other aspects of people's day to day experience.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (RA) Regulations 2014: Person-centred care. There was a lack of effective systems to ensure quality care was always provided. Regulation 9 (a) (b) and (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Regulation 17 HSCA 2008 (RA) Regulations 2014: Well Led. There was a lack of effective systems to ensure quality care was always provided. Regulation 17 (1) and (2) (a) (e)