Barchester Healthcare Homes Limited

Cubbington Mill

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 inspected Cubbington Mill on 14 July 2016. The inspection visit was unannounced.

Cubbington Mill House is divided into two separate floors and provides personal and nursing care for up to 56 older people, including people living with dementia. There were 50 people living at the home when we inspected the service, supported by 40 care and nursing staff.

At our last inspection in July 2014, the provider was meeting the requirements of the HSCA 2008 (Regulated Activities) Regulations.

A requirement of the service's registration is that they have 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 and associated Regulations about how the service is run. There was a registered manager in post at the time of our inspection. We refer to the registered manager as the manager in the body of this report.

People were protected against the risk of abuse as the provider took appropriate steps to recruit staff of good character, and staff knew how to protect people from harm. Safeguarding concerns were investigated and responded to in a timely way to ensure people were supported safely.

Care and nursing staff knew people well and could describe people's care and support needs. Staff treated people with respect and dignity, and supported people to maintain their privacy and independence. People made choices about who visited them at the home. This helped people maintain personal relationships with people that were important to them.

The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Decisions were made in people's 'best interests' where they could not make decisions for themselves.

People were supported to access healthcare from a range of professionals inside and outside the home and received support with their nutritional needs. This assisted them to maintain their health. Medicines were stored and managed safely.

People had interests and hobbies offered to them that met their needs and their personal preferences. People were involved in deciding how they wanted their care and support to be delivered and care records reflected the support people received.

People knew how to make a complaint if they needed to. Complaints received were fully investigated and analysed so that the provider could learn from them. People who used the service and their relatives were

given the opportunity to share their views about how the service was run. Quality assurance procedures identified where the service needed to make changes, and where issues had been identified the manager took action to continuously improve the service.

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.

People felt safe living at the home. People were protected from the risk of abuse because staff knew how to safeguard people from potential abuse. There were enough staff available to care for them safely. The provider recruited staff of good character to support people at the home. Medicines were stored safely and people received their medicines as directed.

Is the service effective?

Good

The service was effective.

Staff completed induction and training so they had the skills they needed to effectively meet the needs of people at the home. Where people could not make decisions for themselves, people's rights were protected. Important decisions were made in their 'best interests' in consultation with family members and health professionals. People received food and drink that met their preferences and supported them to maintain their health.

Is the service caring?

Good

The service was caring.

Care staff treated people with respect and kindness and knew people well. People had their privacy and dignity respected and staff supported people to maintain their independence. People were involved in making decisions about their care, and were consulted about their preferences with regard to care at the end of their lives. This was recorded in a care plan so relevant people would be aware of their wishes.

Is the service responsive?

Good

The service was responsive.

People were supported to take part in social activities in accordance with their interests and hobbies. Care records described the care people needed and how staff should support them, in accordance with their wishes. People were able to raise

complaints and provide feedback about the service. Complaints were analysed so that action could be taken to make improvements.

Is the service well-led?

Good

The service was well led.

The management team was approachable and there was a clear management structure to support staff. The manager was accessible to people who used the service, their relatives, and members of staff. People were asked for their feedback on how the service should be run, and feedback was acted upon. Quality assurance procedures identified areas where the service could improve, and the manager took action to improve the service.

Cubbington Mill

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 14 July 2016. The inspection was unannounced and was conducted by two inspectors, an expert by experience and a specialist advisor. An expert by experience is someone who has experience of caring for a person who uses this type of service. A specialist advisor is someone who has current and up to date practice in a specific area. The specialist advisor who supported us had experience and knowledge in nursing care.

We reviewed information received about the service, for example the statutory notifications the service had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We also contacted the local authority commissioners to find out their views of the service. These are people who contract care and support services paid for by the local authority. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We found the PIR reflected the service provided.

We spoke with seven people who lived at the home and two people's visitors or relatives. We spoke with three nurses (one of whom was the clinical development nurse), five care staff, the chef, the registered manager and the regional director.

We looked at a range of records about people's care including seven care files. We also looked at other records relating to people's care such as medicine records and fluid charts that showed what drinks people had consumed. This was to assess whether the care people needed was being provided.

We reviewed records of the checks the manager and the provider made to assure themselves people received a quality service. We also looked at personnel files for two members of staff to check that safe recruitment procedures were in operation, and that staff received appropriate support to continue their

professional development.

Good

Is the service safe?

Our findings

All the people we spoke with told us they felt safe at the home. People's comments included; "I feel very safe and comfortable, I'm in safe hands", "We have been here since March last year. We are very safe here", "I trust them to lock the front door and the windows. I've never known anyone to be rude to me and that is a big thing", "Oh yes, definitely safe. I would recommend this home to anyone."

The provider protected people against the risk of abuse and safeguarded people from harm. The provider notified us when they made referrals to the local authority safeguarding team where an investigation was required to safeguard people from harm. They kept us informed with the outcome of the referral and actions they had taken. Staff attended safeguarding training regularly which included information about how staff could raise issues of concern with the provider.

All the staff knew and understood their responsibilities to keep people safe and protect them from harm. One staff member explained the different type of abuse they needed to be aware of saying, "There are different types, financial, physical, neglect, sexual, racial and verbal. I would report it. People aren't here to be abused. I would take it to the nurse and the manager would get involved." Staff consistently told us their training assisted them in identifying the different types of abuse and they would not hesitate to inform a senior member of staff or the manager if they had any concerns about anyone. Staff said they would be observant of people to ensure their wellbeing. When asked what would give them cause for concern responses included: "Bruising, black eyes or marks or also if they became very nervous all of a sudden, their mood changed, they were depressed or they stopped interacting with people." Staff were confident the manager would act appropriately to protect people.

Staff told us and records confirmed, people were protected from the risk of unsuitable staff working at the home because the provider checked the character and suitability of staff prior to them starting work. For example, criminal record checks, identification checks and references were sought before staff were employed to support people.

The manager had identified potential risks relating to each person who used the service, and care plans had been written to instruct staff how to manage and reduce potential risks to each person. Risk assessments were detailed and reviewed regularly. Risk assessments gave staff clear instructions about how to minimise risks to people's health and wellbeing. For example, both care and nursing staff undertook checks of people's skin where it had been identified the person was at risk of developing skin damage. People had the equipment they needed, such as specialist mattresses to minimise the risks of damage to their skin. Staff we spoke with had a good understanding of the risks related to each person's care.

The provider had taken measures to minimise the impact of some unexpected events happening at the home. For example, emergencies such as fire and flood were planned for so that any disruption to people's care and support was reduced. There were clear instructions for staff to follow in the event of emergencies. This was to minimise the risk of people's support being provided inconsistently.

People told us they received their medicines as they should, comments included; "I take medicine, for pain in my arms, every night", "I take a lot of medicine, it's usually on time." We observed medicines being administered by the nurses who had received specialised training in how to administer medicines. Their competence to administer medicines safely was checked regularly by the manager or their deputy. Each person at the home had a medicine administration record (MAR) that documented the medicines they were prescribed. MAR records contained a photograph of the person so that staff could ensure the right person received their medicines. This was important as the home could use staff to administer medicines who might not be familiar with the people who lived there. Administration records were signed by nursing staff to state people received their medicines as prescribed.

There were protocols for the administration of 'as required' medicines, such as pain relief medicines to direct nursing staff when the medicine should be administered. For example, information was provided to staff on the signs people might display when they were in pain. This made sure, as much as possible, people were offered pain relief when it was needed.
However, a system was not in place to ensure people received their 'as required' medicine with an appropriate time gap between doses. For example, some people required a four hour gap to be left between each dose. A gap between some medicines is important to prevent people receiving too much medicine. Nursing staff did not record the time people were given their medicine. This meant they could not ensure an appropriate time gap was observed. For example, we saw the morning medicines round did not finish until after 10.45am. The next medicines round was scheduled to start at approximately 1.00pm. We were concerned that if a different member of nursing staff conducted the next medicine round, they would not know when each the person had received their medicine, or when the person could receive their next dose of pain relief.

We brought this issue to the attention of the manager during our inspection visit. Following our visit the manager confirmed, "We are now recording the time of when 'as required' medication is given to ensure people receive their medicines at the right time, and with an appropriate gap between their medicines."

People told us there were enough staff available to care for them safely and meet people's care and support needs. Comments from people included; "There seems to be enough staff. I've not seen a short staff situation", "I always think they seem to work hard but I'm happy with the service", "There always seems adequate staff. [Name] is always ready when I come. They are always busy but give attention when you ask."

Staff gave mixed responses when we asked whether there were enough staff to care for people. Some said there were enough staff and they had time to respond to call bells. However, other staff said they were very busy. Comments included; "There are enough staff according to the planned staffing levels but to me there are not enough. It can be difficult if something untoward happens. It depends on the demands of people." When we asked if the staff levels were unsafe this staff member responded, "No, It is about having the time to give that little bit extra."

Most people told us staff responded to their call bells quickly. One person said, "For me there are plenty of staff. I rang the bell by mistake, they came in minutes." Another person said, "I use the bell occasionally. Once I waited fifteen minutes, no trouble otherwise." We observed how staff responded to people when they activated their call bells. On one occasion we saw one person waited for around four minutes before staff answered their call bell. We observed one person who asked to be assisted to go to the toilet. Staff were busy and reassured them two or three times that they would be with them soon, the person waited approximately 20 minutes before they were taken to the toilet. However, on other occasions we saw people were responded to almost immediately.

We observed there were enough staff during our inspection visit to care for people safely, although some people waited for staff to support them with their personal care. We saw activities with people at the home took place as scheduled and were supported by care staff, as there was a vacancy for an activities co-ordinator. This showed there were adequate numbers of staff to engage people in some meaningful interactions during the day. We saw that in addition to the nurse and care staff on shift, there was the manager and their deputy available to cover care duties at the home when needed. In addition other staff members worked alongside care staff, such as housekeeping and kitchen staff. This meant care staff could concentrate on providing care support to people who lived at the home.

Although we observed there were enough staff to care for people safely, staff told us they would enjoy having more time to spend with people at the home. We asked the manager how they ensured there were enough staff to meet people's needs safely. They told us staffing levels were determined by the number of people at the home, their knowledge of the home, people's needs and their dependency level. We saw each person had a completed dependency tool in their care records. This assessed how much care and support they required. The manager used this information to determine the numbers of staff that were needed to care for people on each shift.

Good

Is the service effective?

Our findings

People told us staff had the skills they needed to support them effectively. One person said, "Staff are very good." A second person said, "They know exactly what they are doing." Another person commented, "Staff are friendly and professional."

Staff told us they received an induction to their job role when they started employment at the home. This included working alongside an experienced member of staff, and training courses tailored to meet the needs of people who lived at Cubbington Mill. A member of staff gave us examples of the types of training they had completed, these included catheter care, choking and training in how to support people who have swallowing difficulties. Another member of staff told us about their induction saying, "It was good. It was done the first week I was here. I shadowed for a week. If I didn't know what I was doing or I needed someone to help me there was always someone there." The induction training was based on the 'Skills for Care' standards and provided staff with a recognised 'Care Certificate' at the end of the induction period. Skills for Care are an organisation that sets standards for the training of care workers in the UK. This demonstrated the provider was acting according to recognised guidelines around the correct induction procedures.

Staff said they received regular training to refresh their skills so they could meet the needs of the people who lived at Cubbington Mill. The provider maintained a record of the training staff attended, so they could identify when staff needed to refresh their skills. Staff told us that each member of staff received an individual training programme tailored to their specific job role. For example, nursing staff received specialist training in medicine administration. One member of staff told us, "The training is on-going. Every year we have to do health and safety, food safety and manual handling." They added, "I have also been on a dementia care course."

We observed staff used their skills effectively to assist people at the home. For example, staff used their manual handling skills to assist people to move safely. Staff used the correct equipment for each person, and people's privacy and dignity was protected. One person described how they were transferred into the bath and said they felt safe when staff used the hoist to transfer them.

Staff told us they were supported with regular meetings with their manager to discuss their role and any training or staff development needs. One member of staff said, "I have meetings every three months." They added, ""It is useful because it helps you to pick up the things you are not doing properly. The last meeting I had, I did take something from it and what I could do to improve." They also had yearly performance appraisals to assess if they were carrying out their role to the standards expected by the provider.

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 when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called

the Deprivation of Liberty Safeguards (DoLS).

We checked whether the manager was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager was able to explain to us the principles of MCA and DoLS, which showed they had a good understanding of the legislation. Mental capacity assessments were completed when people could not make decisions for themselves. In these cases records confirmed important decisions had been made in their 'best interests' in consultation with family members and health care professionals. The manager reviewed each person's care needs to assess whether people were being deprived of their liberties. Several people had a DoLS in place, and their care was being managed in accordance with the MCA.

Staff demonstrated they understood the principles of the MCA and DoLS. They gave examples of applying these principles to protect people's rights, for example, asking people for their consent and respecting people's decisions to refuse care where they had the capacity to do so. One staff member said, "The majority of people here have capacity, for those who don't, any major decisions would need a member of the family involved." One staff member described how they supported people who lacked the capacity to make all of their own decisions saying, "We give them as much choice as we can. If they can't make choices, you make the best choice you can for them on their behalf." They added, "When families come in we ask the families what they like. We always try to make sure what they are having is what they like."

People's dietary needs were being met. People we spoke with told us they enjoyed the food on offer at the home and could make choices each day about what they wanted to eat. Comments included; "The food is very nice and enjoyable, plenty of it. I get a choice of two meals every day", "The food is usually quite good and ample. There are two savouries at lunchtime. Mealtimes are very nice", "[Name] enjoys the food", "[Staff] come in the morning and go through the choices."

A daily menu of the food on offer was displayed in reception and on the noticeboard outside the dining room. People were able to choose from a range of food options and staff asked people for their food choices before their meal was served. Where people were unable to make decisions themselves, staff made choices based on the individual's likes and dislikes. These were recorded in the care records we reviewed. We saw people were consulted about the food on offer at the home. Each week the chef walked around the home to ask people for their feedback about the food, to discuss what their food preferences were, and whether the menu was meeting their needs. This information was reviewed when new menus were drawn up. The menu was changed every four to five weeks and included seasonal and vegetarian choices.

People told us they were offered drinks and snacks throughout the day. One person told us, "They offer tea and biscuits. You get three choices of drink at bedtime." Drinks were available in people's bedrooms and were in easy reach. We saw there were plenty of side tables around in the lounge area, so that drinks could be put in easy reach of people. We observed staff prompting people to drink their drinks as they moved through communal areas. One person told us, "I have enough to drink, it is always important to have a drink." During the morning, we observed the hostess ask people what they wanted to eat. They clearly knew people well because when asking one person what they wanted they said, "Is it your usual egg sandwich tonight or would you like something different?" When offering someone a drink in the morning they said, "Your pink wafers my dear and your black tea."

We observed people having lunch. Dining tables were laid with table clothes, condiments, cutlery and flowers to make the mealtime experience enjoyable. The dining room was calm and there was a relaxed atmosphere. One person commented, "The mealtimes are a very nice occasion. Today was the same as usual." Where people needed assistance to eat their meal, staff assisted people at their own pace and

waited for people to finish before offering them more food. One person confirmed this was usual saying, "It's a nice environment. They never rush us." Other people told us they could ask for an alternative if the meal they chose did not suit them, one person said, "They make me something else if needed."

Prior to admission, people's dietary needs were assessed to ensure the home met their needs. Some people required their food and fluid intake to be monitored to maintain their health. We found that where people required this support, records were kept up to date and regularly reviewed to ensure people were having enough to eat and drink. Kitchen staff knew the dietary needs of people who lived at the home and ensured they were given meals which met those needs. For example, some people were on a soft food diet or fortified diets (where extra calories are added such as cream or butter). Information on people's dietary needs was kept up to date and included people's likes and dislikes. The chef told us, "Every month we hold a meeting to discuss people's health changes, to see whether we can provide any specialist support."

Staff were able to respond to how people were feeling and to their changing health or care needs because they had up to date information about each person from daily staff 'handover' meetings. These are meetings where staff from one shift handover information to staff who are starting a new shift. Records showed these were attended by the nurse on duty and information was transferred to care staff. We asked care staff what communication was like between them and nursing staff about changes in people's needs. One care staff member said, "If we have any concerns, we hand it over to the nurses." Another member of staff commented, "Great, we have a good relationship. Everybody listens to everybody. As the nurses say we are with the residents a lot more of the time than they are."

Nursing staff and people told us the provider worked in partnership with other health and social care professionals to support people's needs. Records confirmed people had been seen by their GP, a speech and language therapist, mental health practitioner, optician and dentist where a need had been identified. Comments from people included; "We have a chiropodist every few weeks. We get an optician from time to time…..they have a visiting dentist", "[Name] sees the doctor from time to time because of water infections, they manage it well. They have seen the home's dentist", "One of the nurses had to call the doctor last week, I was chesty. They are very kind and helpful, no problems whatsoever." The manager told us the doctor and other health professionals visited the home when needed. We found people were referred to see health professionals in a timely way to address their healthcare needs. For example, one person had been identified as being at risk of malnutrition, they were referred to the dietician and records showed staff had followed their advice. The person had gained weight as a result.

Good

Is the service caring?

Our findings

People told us care staff were kind and caring. Comments from people included; "The carers and nurses are quite caring", "Oh yes they are very helpful and caring", "They are all lovely. I have no complaints about the staff at all", "I am happy enough here and I'm well looked after" "They treat [Name] very well, they wouldn't be here otherwise."

Staff told us they thought the home was a caring environment. One staff member told us, "I ask myself would I put any of my family members in here and I would. I care for people how I would want to be cared for." They added, "Everyone has a caring nature here."

We observed staff took time to engage with people as they walked through communal areas. They also chatted with people as they carried out care tasks. For example, when giving people drinks and biscuits in the morning the hostess chatted away to people about the music that was playing, favourite singers etc. People were offered biscuits off a plate so they could choose their own.

We observed staff interacting with people at the home in a respectful and caring way using people's preferred names. We observed one interaction where the staff member prompted a person to wear their sunglasses in the garden to protect their eyes. The member of staff went and got the sunglasses and helped [Name] put them on before helping them into the garden. Staff communicated with people effectively using different techniques. We observed staff touching people lightly on their arms or hands to provide them with reassurance and comfort. Staff assisted people by talking to them at eye level and altering their tone of voice to help people understand them. People laughed and smiled with staff and enjoyed their interactions.

People told us they made everyday choices about how they spent their time. One person told us, "I like to spend time in my room, which the staff respect." We saw most people at the home spent time in their room according to their preference, rather than in the communal areas of the home. We saw people had breakfast and other meals in their room.

Staff promoted people's independence by encouraging them to do things for themselves, where possible and to make everyday choices for themselves. For example, staff encouraged people to stand and move around with assistance rather than being hoisted or assisted to move fully by care staff, which was supported by relevant risk assessments. Staff encouraged people to dress and do everyday tasks themselves, where they could. One person said, "I'm quite independent here, I do what I like."

People told us their dignity and privacy was respected by staff. We observed care staff respected people's privacy and knocked on people's doors before entering, and announced themselves. One person told us, "They always knock; it's as private as I want it." Another person commented, "If I want my door closed, I do it myself. I prefer it open."

There were a number of rooms, in addition to bedrooms, where people could meet with friends and relatives in private if they wished. People made choices about who visited them at the home and were

supported to maintain links with friends and family. The manager confirmed, "Visitors can come in without any restrictions." We saw people and their visitors were offered drinks and snacks and used communal areas of the home which helped to make them feel welcome.

People and their relatives were involved in care planning where possible and people made decisions about how they were cared for and supported. For example, people had information recorded in their records about their religious beliefs and their personal history, so that staff could support people in accordance with their wishes. One person commented, "A lady came to my room and went through my care. I felt quite involved." Another person said, "They sit and update my care plan with me." A relative told us they had also been involved in their family member's care planning saying, "We had a meeting a few months ago to update their care plan."

Some people at the home had been consulted about their wishes at the end of their life. This was to provide good quality care to people nearing the end of their life, and to respect their cultural or religious beliefs. Plans showed people's wishes about who they wanted to be with them at this time and the medical interventions they agreed to. The manager confirmed that people made these choices in consultation with health professionals, their relatives and staff, so that their wishes could be met.

Good

Is the service responsive?

Our findings

People told us staff were responsive to their individual requests. One person told us, "Whatever I need, I ask for and I get it".

Staff responded to changes in people health in a timely way, ensuring they received the support they needed. For example, we reviewed the wound care of one person who had a pressure ulcer. Pressure relieving equipment was in place, the person was being re-positioned regularly to assist with the maintenance of their skin. The wounds were regularly photographed and assessed to make sure they were healing. Involvement and support was sought from a Tissue Viability Nurse. There was evidence that the wounds were improving and healing, which showed the person was receiving the correct treatment.

Staff told us that care records were kept up to date and provided them with the information they needed to support people effectively. Care records were available for each person who lived at the home. The records we reviewed gave staff clear information about how people wanted their care and support to be delivered. For example, care plans included information on maintaining the person's health, nursing needs (where relevant), their support needs and information about how they wished their care to be provided. The PIR stated care planning was undertaken with the person, their loved ones and family members. Care reviews took place monthly to ensure people's records were kept up to date.

Staff we spoke with had a good in-depth knowledge of the needs, preferences, likes and dislikes of the people they supported. This was because care records gave them the information they needed, and staff took time to get to know people. For example, they could describe people's preferences in detail and information about their lives before they came to live at Cubbington Mill.

Each person had an individual record of activities, interests and hobbies that they might enjoy. Activities were regularly evaluated to ensure they met people's social needs and were fulfilling for the people who participated. They were evaluated under a number of headings including interaction, communication, engagement and wellbeing. People were provided with a sheet that listed all the activities planned for the coming week so they were aware of them. Recent activities included a sherry afternoon, games morning, flower arranging, gardening, quizzes and exercise classes. People's religious needs were met through a monthly bible class and regular church services. One person said, "A list of activities is circulated. We were told that one person has left and a new activities co-ordinator will be taking over next week. The activities list is issued weekly; we do movements, choir and a band. We take part in what appeals."

We asked people whether they enjoyed the activities and events on offer at the home. People told us they did. Comments to us included; "I do like to go to the activities. Today I haven't been because it is bingo. I'm never bored. I do have a paper every day. If there is a trip I always look to go on it. They do work hard here to keep us occupied", "My friend takes me out once a fortnight. My daughter takes me out when she comes. I went out down the street with other residents a few weeks ago, staff took us."

We saw one person enjoyed gardening and other people enjoyed sitting in the garden area. The home had a

large garden which was filled with flower beds and traditional flowers which encouraged people to spend time outdoors. We observed people sitting in the garden and in the communal areas of the home listening to music. We saw other people chatting with their relatives and friends in their bedrooms which they enjoyed. We watched the game of bingo in the dining room. It was well attended by 16 people and most people took part. There was a lot of chatter between people and it was clearly enjoyed by them.

Some people told us that although there were regular activities and events on offer at the home, they chose not to participate in these. This demonstrated staff respected people's choices about what they wanted to do. One person commented, "They tell me about the activities, I would rather read, do puzzles and my own thing."

We spoke with the manager and provider regarding the number of staff employed to offer people activities. They explained there was usually one member of staff employed to provide people with activities, interests and hobbies that met their individual needs. However, they currently had a vacancy; a new member of staff was due to start work at the home within the next two weeks. In the meantime activities were being organised by care staff at the home. People we spoke with confirmed they knew about the changes in staff. One relative said, "They do activities every day. The current lady left recently, they have recruited a new lady. They do keep fit, bingo, maypole, dancers, crafts."

There was information about how to make a complaint and provide feedback on the quality of the service in the reception area of the home and in people's bedrooms. People and their relatives told us they knew how to raise concerns with staff members or the manager if they needed to. One person told us, "I have no concerns, if I did I know who to tell." Another person said, "I would ask for a nurse and tell her my problem (If I did not feel safe)."

People told us although they knew how to make a complaint, they had not needed to. One person commented, "If there was a real concern, I would raise it. So far, none at all." Another person said, "I haven't needed to complain." In the complaints log we saw that previous complaints had been investigated and responded to in a timely way. The provider had acted on the feedback they received in complaints to improve the quality of their service.

Good

Is the service well-led?

Our findings

There was a registered manager at the service. People and staff told us the manager was approachable and the home was well-led. The manager operated an 'open door policy' and encouraged staff and visitors to approach them in their office. People told us they were confident in approaching them and other staff at the home. One person told us, "The manager walks around and says hello." Other comments included; "They are very pleasant and approachable", "The staff have asked if I'm happy. Nothing is too much for them, they are very approachable." All of the people we spoke with rated the home between 8 and 10. A typical comment was, "It's got to be 9/10, it's all very good."

There was a clear management structure within Cubbington Mill to support staff. The registered manager was part of a management team which included a deputy manager and a designated member of staff responsible for each floor. Nurses were also available to support staff on each shift and on each floor. Staff told us they received regular support and advice from managers and nurses to enable them to do their work. For example, there was always an 'on call' telephone number they could ring outside office hours to speak with a manager if they needed to.

Most of the staff we spoke with told us the manager was approachable and they felt they could talk to them. Staff told us they would not hesitate to raise issues or concerns with the manager if they needed to. Comments from staff included; "[Manager] is fine. They have an open door policy. If you have any problems you can go and talk to them", "[Manager] is good at what they do. I find them easy to approach", "If I didn't think it was well managed I wouldn't be working here." Staff also told us they enjoyed working at the home saying, "It is a nice environment to work in, it is a nice place to work."

The manager told us the provider was supportive and offered regular feedback and assistance to support them in their role. For example, the provider visited the service every month to hold meetings with them. They discussed issues around quality assurance procedures and areas for improvement at the home including the ongoing refurbishment programme. The manager said, "The provider is very good, they are really supportive." They added, "They are very responsive, I can pick up the phone and speak to a senior manager any time."

Staff told us their contribution at Cubbington Mill was recognised by the manager, as they had recently introduced an employee of the month scheme to recognise good care. The PIR stated this was to recognise the valuable contribution that our staff make to enhancing the lives of people. The provider also recognised their staff with their annual care awards scheme, to recognise staff who consistently delivered excellent care.

Staff had regular team meetings with the manager and other senior team members, to discuss the daily running of the home. Daily meetings were held with each department manager to keep all staff up to date on the running of the home. Meetings were also held with staff in each department to update them and discuss how things could be improved at the home. Staff meetings were held within teams. For example, nursing staff met to discuss clinical information. An agenda was drawn up before each meeting and staff were able to contribute their suggestions for discussion. A recent meeting record showed staff had

discussed being paid for breaks during the night shift which had been implemented. Staff told us they had an opportunity to raise any concerns they had, or provide feedback about how the service could be improved. Where staff had made suggestions, the manager had acted to implement improvements.

People could provide feedback about how the service was run and their comments were acted on by the provider. The manager told us they encouraged feedback from people, visitors and relatives by holding regular meetings at the home. People told us they were invited to attend the meetings saying, "We are sent a circular about residents meetings. We have been to them, they are useful." The manager also asked for people's suggestions in a comment book that was placed in reception for everyone to access. They also carried out annual quality satisfaction surveys to gather feedback. We reviewed the information from the most recent satisfaction survey which showed people were satisfied with the care they received.

The provider completed regular checks on the quality of the service they provided. The provider visited the home to conduct unannounced quality inspections. A regional audit was carried out on a quarterly basis by the regional director which included an audit of medicines administration and care plans. The provider also directed the manager to conduct regular checks on the service they provided. Checks included weekly and monthly checks such as premises maintenance, medicine administration, care records, clinical governance and infection control procedures. For example, each month three care plans were picked and audited to check they covered people's needs and continued to provide staff with the information they needed to meet any changes in need.
The manager produced reports into how the home was performing using the information they gathered for the provider. This included a report each month on clinical governance, showing key indicators to track how well people's nursing needs were being met. Where checks had highlighted any areas of improvement, action plans were drawn up to make changes. Action plans were monitored for their completion by the provider. This demonstrated the provider took action to continuously improve the quality of the service provided at the home.

The provider had sent statutory notifications to us about important events and incidents that occurred at the home. They also shared information with local authorities and other regulators when required. They had kept us informed of the progress and the outcomes of investigations they carried out. For example investigations in response to accidents, incidents or safeguarding alerts, the manager completed an investigation to learn from these incidents. The investigations showed the manager made improvements to minimise the chance of them happening again.