Care Quality Commission

Mrs Lynette Hollick & Mr Antony Hollick

Clayfield Care Home

Inspection report

3-4 Clayfield Villas, Victoria Road, Barnstaple.
EX32 8NP
Tel: 01271374066

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection visits took place on 29 April and 13 May 2015 and were unannounced.

At the last inspection of 10 May 2013 we found the service was meeting all the legal requirements and regulations associated with the Health and Social Care Act 2008 (HSCA).

Clayfield Care Home is registered to provide accommodation for 16 older people who require personal care. The home was full on both our inspection visits.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the HSCA and associated regulations about how the service is run.

Management and staff had a varied understanding of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS). Where people lacked capacity, staff did not always understand the law which underpinned people's rights and the appropriate; DoLS authorisations and best interest decisions had not always been made.

People's assessments of risk and plans of care were not always up to date and did not contain all the information necessary as to how their care and support needs were to be met. In-house activities were provided.

Summary of findings

Improvements were needed to ensure people received their right medicines at the right time.

Not all staff employed had all the necessary checks made before they started work.

There was not always enough care staff on duty in both numbers and deployment. Whilst overall staffing levels had recently improved with the employment of a cook and a housekeeper, people still had the potential to be at risk due to the numbers of care staff on duty at certain times of the day.

People enjoyed the varied and appetising food served but the lunchtime experience was not always relaxed for some people.

There was a homely atmosphere at Clayfield and people said they enjoyed living there. People said they felt safe and were given choices in their everyday lives. People and relatives were very complimentary of the care and support provided by staff. Relatives and visitors were encouraged to visit and made to feel welcome at all times.

People felt safe and told us they were treated with dignity and respect by kind and caring staff.

The registered manager promoted a culture which valued people and staff. People, relatives and staff said the home was well run and they had confidence in the registered manager.

Staff received the necessary training they required to allow them to do their jobs properly. They felt supported in their jobs; they were motivated and enthusiastic.

The home had quality monitoring systems in place but improvements to these were required to identify any shortfalls in practice and drive continuous improvement. Views were sought from people and their relatives from regular feedback including a quality assurance survey sent out yearly.

People benefitted from a plan of continuous investment and on-going maintenance programme to make Clayfield a more pleasant and comfortable home for them to live in.

We identified six breaches of regulations at this inspection. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

Some aspects of the service were not safe.

Not all risks to people had been identified and systems put in place to reduce the risk.

Medicines were not managed safely to ensure people got their right medicines at the right time.

People were not fully protected from the risk of staff who had not had the full recruitment checks undertaken before they started work.

People were not supported by enough staff on duty at all times.

Staff had a good knowledge of how to recognise abuse and knew the correct procedures to follow if abuse was suspected.

Accidents and incidents were recorded and analysed to monitor for any trends or patterns.

The service had an on-going maintenance programme with a planned schedule of improvements.

Is the service effective?

Requires improvement

Some aspects of the service were not effective.

Some staff had a better understanding of the Mental Capacity Act and the Deprivation of Liberty Safeguards (DoLS) than others. Where people may be deprived of their liberty, the service had not taken the appropriate action.

People enjoyed varied and appetising food served but the lunchtime experience was not always relaxed for some people.

Staff felt supported in their jobs; they were motivated and enthusiastic. They received the necessary training to do their jobs properly.

Staff understood the importance of offering choice and this was offered in people's daily lives.

People were complimentary about the care they received and had access to healthcare services when they required it.

Is the service caring?

Good

The service was caring.

People and relatives said there was a homely atmosphere and liked living at the home.

Staff respected people's privacy and dignity.

Summary of findings

Relatives and friends were encouraged to visit and were made to feel welcome.

Staff were kind and caring towards people and treated them with respect and compassion.

Is the service responsive?

Requires improvement 

Some aspects of the service were not responsive.

People's care records were not up to date and did not contain all the information necessary as to how their care and support needs were to be met.

A variety of in-house activities were offered.

Staff knew people well and cared for them as individuals.

People felt confident to raise concerns. Any concerns were listened to and addressed.

Is the service well-led?

Requires improvement 

Some aspects of the service were not well led.

Some quality assurance systems were in place to monitor the effectiveness of the service provided. However, these did not always identify the shortfalls in record keeping.

There was a registered manager in post and the culture was open, friendly and welcoming.

People, relatives and staff expressed confidence in the management and said the service was well run.

Regular satisfaction surveys to people, family members, visitors and health and social care professionals were sent out to gain their views of the service.

Staff were positive about working at Clayfield. They felt supported valued, supported and motivated in their work.

Clayfield Care Home

Detailed findings

Background to this inspection

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

The inspection took place on 29 April and 13 May 2015 and was unannounced. The inspection team consisted of one inspector and an expert-by-experience on the first visit and two inspectors on the second visit. An 'expert-by-experience' is a person who has personal experience of using or caring for someone who uses this type of care service. The evidence within the report relates to our findings on both days of inspection.

All information known about the service was reviewed before the inspection such as previous inspection reports, contact with the provider and notifications. A notification is information about important events which the service is required by law to tell us about.

During our visits, we saw all of the people using the service and spoke with 11 of them. Nine relatives told us their experiences and views of the service. We spoke with eight staff, the registered manager and the registered providers. We also spoke with seven health and social care professionals, including three GP's, three community nurses and one member of the community rehabilitation team.

We looked at the care records of five people, their medicine records, three staff recruitment records, all staff training records, copies of the staff rota, the complaints record and the provider's other quality monitoring systems.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not comment directly on the care they experienced.

Following the inspection, the providers sent us some further information we required and their plans to continually improve the service.

Requires improvement

Is the service safe?

Our findings

People were not always protected from unnecessary risk. Assessments of people's risks had been carried out in the care records we looked at which included mobility, safe handling and moving and falls. However, four of the five did not reflect all of the current or increased risks to people. Information was difficult to follow, inconsistent and not up to date. For example, in one care record staff had recorded one person had been assessed as having increased mobility needs and "when moving requires hoist". Staff were then asked to "refer to the moving and handling assessment". This assessment said the person had been assessed as "low risk" and was "independent."

We discussed this information relating to individual risk assessments on the days of our inspection which were shown to the registered manager who assured us these would be updated and include all the information required.

Systems and practices for the management of medicines were not always safe. Where people had been prescribed PRN (when needed) medicines, it was not clear from the Medicine Administration Record (MAR) whether these had been offered. For example, the MAR charts were completely blank for one person who had been prescribed pain relief tablets and there was no record if this had been offered, accepted or declined. Also, another person had been prescribed a PRN medicine for anxiety. This medicine had been given continuously three times a day for three weeks. There was no plan or guidance in place as to direct staff when the person needed this medicine, such as the level or the length of time of their anxiety.

Where people had developed skin conditions for which their GP had prescribed a cream to be regularly used, staff had not signed on the MAR to show they had been applied. Two staff members, responsible for giving out medicines, said if creams were applied they would not be recorded anywhere else but on the MAR chart. This meant staff could not be sure people had received their prescribed cream.

The home used a monitored dosage system (MDS) designed to reduce risks of incorrect medicine being given. One person's MDS had five tablets removed from the pack, despite the MDS only being started the previous day. The person had only had two prescribed doses signed for on the MAR chart. On another MAR chart the pre-printed dates on the top of the record had been changed. This made it difficult for staff to read and follow when medicines should be given. As a result, one medicine which had been added to the MAR chart was signed for as being given twice. It was unclear whether the medicine had been given twice or if this was a recording error.

The room temperature where medicines were stored was not monitored. This meant people were at risk of having medicines which had not been kept at the temperature recommended by the supplier. Bottles of open medicine in the medicine trolley had not been marked with an 'opening' or 'expiry' date which meant staff could not be sure how long it had been opened for and when it should be disposed of. Out of date and medicines no longer in use were still held in the home dating back to September 2014.

An audit had been carried out by the supplying pharmacist on 26 February 2015. This found some concerns, for example concerns with not writing opening dates on bottles and not regularly monitoring medicines which required more stringent control. Audits of medicines had been carried out, but these had not fully addressed the concerns.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were several policies and procedures in place relating to medicine management.

Records showed there was always a care worker who had been trained to give out medicines. Staff gave people their medicines safely and the medicines were secured when a staff member was not present. Staff were patient with people and explained the various medicines and stayed with the person until the medicine was taken safely. A medicine reference book was available to guide and assist staff what a medicine was used for.

Staffing had not always been maintained at safe levels. The service admitted people who required a higher level of care and support due to their complex needs, many related to a dementia type illness.

Two people needed assistance from two members of care staff at all times to meet their care needs, such as supporting all transfers and giving personal care. Between the hours of 8am to 10am and 6pm to 8pm, two care staff were on duty. During the two hour morning period, other staff were working at the service to assist if necessary, such

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Is the service safe?

as the registered manager, maintenance person or cook. However, during the two hour evening period, only the two care staff were working at the service. This meant there may be periods when both care workers were occupied with one person, which left people unattended or not monitored in other areas of the home.

The service had been without a cook and housekeeper for some time. The provider explained every morning it was decided and recorded which member of staff would do the cooking. Staff had been offered extra hours to do the housekeeping. Care staff had covered these absences as part of their normal working day. All the staff told us this was difficult at times for them to manage and two staff said "Whoever is on shift does the cooking." Another member of staff said "We did have a cook; they left a little while ago and have not been replaced. If we are busy X (registered manager) helps."

On our first visit, there was a rushed and stressful atmosphere at Clayfield. The provider explained this may have been due to the fact that the manager had returned from two weeks annual leave, one member of staff was on induction and outside training was taking place at the service.

There were times when staff were not present for varied lengths of time and people were not always safe, for example in the lounge and in the dining room. During these times we saw unrest and altercations on three occasions between people which staff were unaware of. On this visit, care staff felt there were enough on duty to meet people's care needs, but they did not have much time to spend with people chatting, doing activities or one to one time. One care worker said "We have to do a bit of everything." A new member of staff had worked at the home for two weeks; they said they were not sure of their role but thought it was to do the housekeeping and "lunches some days". As the building is on three floors, with two people choosing to stay in their bedrooms on the third floor all the time, two members of staff on duty was not sufficient to ensure people's safety at all times.

On our second visit, whilst there was a calmer atmosphere at Clayfield, we saw periods when people were left unattended. On one occasion there was an altercation between several people in the lounge with aggressive behaviour displayed. We saw one member of staff was now working solely as the cook and another member of staff was in the process of being employed for housekeeping and cleaning duties. Care staff said they felt more confident and relaxed in their roles on the second visit; they felt they could do their jobs better now. Comments included "It's different since the last visit, it's more relaxed and there's been lots of changes…more time now" and "It's improved. Have more time. It's calmer. We know what X's (cook's) role is now." However, the staff rota confirmed there were still times when only two care staff were on duty at key times of the day.

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

The registered manager said they were looking at staff's roles and responsibilities at the service. They had worked hard to recruit the right staff to work at the home. However, despite the staff vacancies, the registered manager felt the service was able to continue to admit people and continue to provide day care. No specific tool had been used to monitor or record the dependency of the people living in the home. The registered manager said they routinely reviewed staffing levels to take into account people's changing needs and determine whether any adjustments were needed; however, there was no record of how and when this was done.

People felt staff responded to their needs in a timely way. One person said "They (the staff) respond to me very well" and another said "Staff come when I call." Relative's opinions varied on whether staffing levels were adequate at the service. One said "There are enough staff; when my X needs help, they come straight away" whilst another said "There is not enough staff…there are a lot of staff issues." Three health care professionals said "...Would question whether fewer residents would give them (the staff) more space and time?", "Staff are always so busy" and "There is often a level of unrest and dispute going on between patients that is unsettling."

Adequate recruitment checks on prospective staff had not always been carried out. We looked at the last three staff employed. All the staff files contained an application form, proof of identity and a satisfactory Disclosure and Barring Service (DBS) check. A DBS check provides information about any criminal convictions a person may have. One of the files contained a record of the questions asked at interview and the prospective employee's replies; two did not. Two of the files contained two references; one file contained one. Gaps in employment history were not routinely recorded. The registered manager had

Requires improvement

Is the service safe?

acknowledged some information was missing from the staff files and had developed a "recruitment checklist" to assist them to identify which information they were still awaiting.

Incidents and accidents were reported by staff. The registered manager reviewed these and analysed the incidents. This ensured any patterns or trends were identified and managed accordingly. For example, one person agreed to a change of room on the ground floor due to the number of falls sustained. Systems ensured people were safe in the event of a fire. There was a fire risk assessment in place. Each person had an emergency evacuation plan which was held in the office; this gave clear guidance as to how they would need to be supported to leave the building in the event of an emergency.

The service protected people from abuse. Staff had received training on safeguarding adults and whistleblowing and understood what abuse was. They knew how to recognise it and, with the exception of one member of staff, knew the correct action to take if they needed to report any concerns. One staff member said "I would report it to higher management or the Care Quality Commission (CQC)" and another said "I would report it; go to a senior or the manager or the CQC or the safeguarding team." Safeguarding and whistleblowing policies procedures were in place. No recent safeguarding incidents had been raised with the local safeguarding team.

On our first visit, there was an obvious smell of urine in different areas, such as the library area, communal entrance and individual people's bedrooms. From feedback, two health care professionals said the home sometimes had an offensive odour when they visited.

The cleaning cupboard was very dirty, cluttered and contained cleaning equipment such as mop and buckets which were next to a hairdressing trolley. The laundry room was disorganised with dirty and clean laundry not clearly separated. There was no policy or procedure in place to guide staff of their roles and responsibilities in relation to infection control, for example the cleaning of commodes. On our visits, personal protection equipment (PPE), such as disposable aprons and gloves were not readily available for staff to use. However, the provider confirmed gloves and aprons were kept in communal toilets, bedrooms and a specific place on each floor.

Six dining room and lounge chairs were unclean and stained. Three pressure relieving cushions had an offensive odour. Bathrooms were cluttered and contained unnecessary equipment which was stored there such as a wheelchair, weighing scales and a mattress. A basket full of communal toiletries such as used shampoo, deodorant and soap were in use in the ground floor bathroom. Waste bins in the toilets and bathrooms were not suitable to prevent cross infection.

The kitchen had areas where there was a risk of cross infection such as the seals around the worktops and sink.

Cleaning rotas were in place for the service but these had not been kept up to date and did not cover all of the areas required.

We discussed our findings with the registered manager at the end of our first inspection visit. On our second visit, there had been significant improvements in the protecting of people from the prevention and control of infection and systems put in place. We saw an up to date infection control policy and PPE available for all staff. A new ordering system for supplies meant the service would not run out of disposable items such as toilet roll. Specialised cleaning fluids and sprays had been obtained and the registered manager was in the process of testing which ones were the most effective. The laundry room and cleaning cupboard were tidy, organised and clean.

As part of on-going maintenance at the service, the providers had identified and planned a schedule of improvements at the home for the following year. This included redecoration, replacement of some floor coverings and new furniture. On our second visit we saw how these improvements were progressing. Clayfield smelt fresh, walls had been painted and furniture had been cleaned or replaced. One bedroom carpet had been replaced with alternative flooring.

Requires improvement

Is the service effective?

Our findings

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. DoLS provide legal protection for those vulnerable people who are, or may become, deprived of their liberty. On our first inspection visit, the registered manager had made no authorisations to deprive a person of their liberty. On our second inspection visit, they had made one. Relevant authorisations had not been sought for people in the home who required it. For example, for those people who were restricted in their movement either by pressure mats (a pressure mat is a device used on the floor which people walk on; it connects to the call bell system to alert staff the person has moved), 'tipper' chairs (chairs which people cannot get out of due to the recline) or locked doors. This was discussed with the registered manager and providers on the second day of our visit who said they would send authorisations to the local authority for those people who required it.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager and deputy manager had received training in the Mental Capacity Act (2005) (MCA) and the Deprivation of Liberty Safeguards (DoLS) including how these applied to their practice. Some staff were in the process of completing an online course. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where appropriate.

Discussions with some staff showed an understanding of the MCA and DoLS. However, discussions with other staff showed they needed more support and guidance. For example, three staff members explained "Lots of people are not able to give consent; It's in the care plans. If they (people) don't like something, talk it through with the family" and "If they (people) refuse care, talk it through and give reasons why" and "The MCA means everyone is treated equal; no discrimination. We try hardest to get consent; there are lots of ladies here with no capacity." A further two were less confident what the MCA and DoLS meant and one commented "I'm not too sure what it means."

From care records, people's mental capacity had been briefly assessed by the registered manager. However, it was not always clear of the process which then took place when it had been confirmed people did not have capacity to make decisions. For example, one person's care records stated "Decisions made on X's behalf will be made in his best interest." The process of how these decisions took place, who took part and what decisions had been made were not recorded. In another care record, one person had a confirmed diagnosis of dementia. Staff confirmed this person did not have capacity to give their consent to personal care. No best interest's decisions, with the relevant people involved, had been recorded following their admission to the home. Staff said they asked the family to be involved if the person did not have capacity. Some people had a Power of Attorney (POA) (a person who acts in their best interests) who made some decisions; neither of these decisions were recorded. The registered manager said best interest's decisions were made but these were not always recorded.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Those people, who were able to express their opinions, told us staff always asked for their consent before giving any support or care. Throughout our visit, we saw staff asking people discreetly and gently for their consent before they gave care, for example one person was assisted to go to the toilet and another was asked if they would like to have some personal care.

A list in the kitchen detailed people's any specialised diets and their likes and dislikes. Meals served were attractive and appetising. People were offered hot or cold drinks and fresh fruit during the day. Food was ordered online from a large supermarket and a weekly delivery made.

All the people said they enjoyed the food served at Clayfield. Comments included "The food's nice, homely and good", "It's ordinary food; it's OK" and "Food's good; always very acceptable." A relative said "My X loves the food; X eats well; it's great." People had a choice of main meal and a variety of dishes were served including some homemade and some pre-prepared. A mix of fresh and frozen vegetables were used. One person said "Good plain food. If I don't fancy what they have they will find something else." The daily meal was displayed on the notice board in the hallway.

Requires improvement

Is the service effective?

The lunchtime experience in the dining room was not relaxed and enjoyable for everyone due to the unrest between some people. Other people ate their meals in their bedrooms. Staff took these on nicely laid out trays to their rooms. Staff assisted two people to eat in their bedrooms. This was done in an unhurried and calm manner, with staff helping them at a pace which suited the individual person. Both staff explained what the person was eating and enjoyed a short conversation with them whilst they ate their lunch.

Staff understood the importance of providing an adequate supply of drinks for people. Whilst drinks were not readily available for people to help themselves to, staff regularly asked people if they would like a drink during the day. Some people requested drinks on demand and these were also given. People had juice available in their bedrooms.

Staff received training in areas specific to their work, for example fire training, safeguarding and medicine management. Training was provided from the local care homes education team, outside trainers or online which staff completed at their own pace. Staff were supported to obtain nationally recognised care qualifications at different levels. Staff received supervision regularly when they discussed their training and performance needs; they said they found this very useful to help them in their work.

Staff received induction training when they began work to help them become familiar with people's needs and help them to work safely with people. New employees 'shadowed' experienced staff until they were confident to work on their own. The registered manager will shortly be introducing the 'Care Certificate' (a nationally recognised tool in social care training) which will support new staff in their induction period.

Training records showed staff had received training in dementia care. However, from our discussions with staff and from observation, not all staff showed confidence or a good understanding of how best to support people with dementia. For example, one person was trying to pick things up from the carpet and tables but this was discouraged by staff which made the person more anxious. A health care professional commented "Wonder whether staff need more training in looking after patients with dementia."

Appropriate referrals were made to health care professionals and staff acted upon their advice. One professional said "they (the staff) try hard for their patients" and another said "They (the staff) always take advice." One person said "I have physiotherapists who come to do exercises, now I can hobble around" and another said "If I need a doctor or a dentist, they will organise it. The optician comes here to sort out your glasses and the 'foot person' comes here every eight weeks." One person said their teeth did not fit which made eating their meals difficult; the registered manager had made a referral to the local community dentist and requested a visit for this person.

The service had a call bell system in place which was not totally reliable. However, this was scheduled to be replaced shortly with a complete new system installed.

Good

Is the service caring?

Our findings

People spoke positively about staff and said they were caring towards them. Comments included "The staff look after me. They are kind… I haven't found anybody that was unkind", "The staff are very pleasant … they are always kind …always gentle" and "Staff are kind and do all they can for us. This is a very nice place to be". One person said "I'm independent and a proud person….I've had more care and attention from the staff than I'm used to." Relatives said "My X is getting all the care I would expect", "I am positive that my X is getting all the care he needs. X gets on well with the staff and they treat X well" and "I can't see that they (the staff) can offer any more service than they give."

Health care professionals gave positive comments about the staff and these included "The care is fine. Staff are always friendly and helpful. They are always helpful and welcoming" and "Staff are caring and compassionate and they appear to try hard for their patients." Staff interactions were positive. For example, one person was crying in the afternoon and a care worker sat and held their hand in a kind and gentle way to soothe them.

Conversations between people and staff demonstrated familiarity and knowledge of people's preferences and interests. For example, we heard one care worker having a conversation with a person about their relatives visiting and we heard another talking about their animal interests.

People told us how important it was for them to maintain contact with their family and friends. Relatives said they received a warm welcome from staff and were offered refreshments. We saw several visitors enjoying private time with their relatives. Comments included "They (the staff) are welcoming when we visit…helpful…kind…they never refuse visitors", "This place is cosy…homely…we are welcomed in" and "Always welcomed…can come in any time." Relatives were invited to a 'buffet tea' when it was people's birthdays; to come in an "make it special"

Staff gave examples of how they maintained people's privacy and dignity and this was reflected in their interactions with people. We saw care staff help people to ensure their dignity was maintained when needed, for example when one person went unaccompanied to the toilet and did not shut the door and when another person came down the stairs in a state of undress in their pyjamas. Staff discreetly and sensitively asked if people needed the toilet or personal care. One care worker explained how they knew what one person wanted through non-verbal communication.

People said routines were flexible; they were offered choices about aspects of their care and about where they spent their time. For example, about what time they got up and when they went to bed and where they wanted to spend their time. One person said "Staff listen to you and meet our requests" and another said "The staff treat me with respect – everything is super." Another person said "I like to stay here on my own. I prefer to be alone…they (the staff) understand that…I don't feel isolated."

People said they liked living at Clayfield. Their comments included "This is a very nice place to be", "They (the staff) look after you really well, It's not home but it is homely" and "I'm very comfortable, they (the staff) look after us really well, nothing is too much trouble. Care staff felt the standard of care provided was good and they were able to demonstrate a commitment to giving as high a standard as possible to people they looked after. Comments' included "I would recommend my Nan to come here", "This is a lovely, cosy, homely place…people here get all they need to be happy" and "It's like a little family here."

Requires improvement

Is the service responsive?

Our findings

People's care and support needs were assessed by senior staff prior to them moving into the service, although this was not always possible if a person needed immediate care from the service. In these circumstances, the registered manager ensured they had enough information to meet their needs initially.

People were not always involved in developing or reviewing their care plans. Care plans are a tool used to inform and direct staff about people's health and social care needs. Some care plans had been signed by a relative to agree the plan of care but two relatives told us they had not been involved in its actual planning.

Care plans had been signed by staff to say they had been reviewed, but it was clear people's needs had changed and the plan of care had not been changed to reflect this. Five out of the six care plans we looked at, did not reflect those identified and recorded in the care plan. For example, when one person's general health had deteriorated and their assessment of risk had increased; their care plans had not been updated.

From discussions we had with staff, they had different ideas about how they would care for this person which did not match each other, nor what was written in the care plan. For example, how often and what they needed to do to monitor and reduce the risk of pressure damage to the person's skin. Staff had signed this person's care plan to confirm the care and support provided had been recently reviewed and updated; however, it was clear this did not reflect the person's care and support needs.

Another person's care plan showed they had been assessed as being "very confused and anxious". There was no plan in place in the care plan to inform staff what triggered this person's behaviour or how they should manage it, should it escalate. During our visits, we saw staff did not always identify and manage this behaviour. When we asked two care staff how they would do this, they both told us they would manage the behaviour "as best they could."

One care plan for a person who was staying at Clayfield on respite (short-term) care was much briefer than the other five. However, this contained more relevant and up to date information to guide staff how to care for this person. For example, how to meet their communication, mobility and personal hygiene needs.

A senior care worker said only senior staff updated the care plans; each member of staff had four care files each. One person had responsibility per shift to update the daily care records. These were written between 11am and 3pm. They said any information relating to the person after this time was not routinely recorded in the care files but on the staff allocation sheet or individual charts, such as fluids charts. However, the provider confirmed staff were instructed and encouraged to record all relevant information in the care files. Staff said they did not routinely look at care plans but used the three staff handovers each day to pass on important information.

We discussed the lack of up to date, incorrect and missing information from the care plans with both the registered manager and the providers. Following the inspection, they have informed us they intended to update the care plans to include all the information required.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's social, emotional and spiritual needs were taken into account when activities were planned but these were not always assessed and recorded in the care plans. Despite no regular programme of planned activities, a selection of in-house activities were available such as arts, crafts, board games, singing and the watching of movies. The provider confirmed the service had sensory items specifically designed for people with dementia such as "dementia mats" which provide a prompt for meaningful conversations and recollections for people.

The service had a library area off the main lounge which contained a large selection of large print books. Whilst the majority of people in the lounge were unable to choose a book and read it without assistance, the library provided a quiet and relaxing space for people and relatives to enjoy.

The activities which took place during our first inspection visit consisted of a brief balloon session in the lounge area with a staff member. People did seem to enjoy this. On our second visit we saw people had made mobiles prior to which were on display. During our visits, we saw people experiencing boredom at times, together with a lack of staff interaction in the communal areas.

People said they would like more activities and one said "Wish that staff could have more time to stop and talk or play a board game." All of the staff spoken with were clear with us they felt more activities for people at Clayfield were

Requires improvement

Is the service responsive?

needed. Comments included "Would like to see more activities; have more people involved in activities and more singing; more Church services", "There's no outside entertainers, no trips out, people don't go out" and "Would like more activities for people; keep people enthusiastic; they (the people) need more activities to do." Care staff undertook activities as part of their role but felt they did not always get the time to do this. Two relatives felt more activities were needed. Feedback from resident's meetings and surveys showed more activities were requested, for example hymn singing. Staff said this activity happened once a month but people had asked for it more often as they enjoyed taking part.

People knew how to make a complaint and felt they would be listened to and responded to by the registered manager. No complaints had been received since the last inspection. People, visitors and relatives were complimentary of the service and had no specific complaints. Comments included "If I had a problem I would tell the Head of Care. They would listen to me", "I've got no complaints but if I did they would tell the manager. I'm sure she would sort it out" and "No complaints about anything here but if I had a problem I would tell the manager". A relative commented "If I had a complaint I would go to the manager and then to Social Services but I'm sure that X (the registered manager) would listen." Two staff members said the registered manager always listens to their concerns and dealt with any problems.

As well as the formal complaints procedure, the service had a notebook which was kept on the entrance hall table for anyone to put helpful comments, suggestions or concerns in which the registered manager monitored. The registered manager also had a personal notebook which they carried in their pocket. They used this to write any issues highlighted whilst they were meeting people, relatives and visitors in the home so they could address and resolve them.

Requires improvement

Is the service well-led?

Our findings

Improvements were required to ensure quality assurance checks in place highlighted all the areas of the service or systems which required improvement. There were written monthly audits in place but these were not all effective. They had not picked up the shortfalls we found in several areas of poor record keeping during our visits. For example, people's risk assessments, care plans and best interest's decisions. Also a medicine audit had been completed by the supplying pharmacist who had required some improvements which had not yet been fully addressed. Some audits carried out by the registered manager had identified where records did need improvement, such as the staff recruitment and fire drill records. We discussed this with the registered manager during the inspection. They felt one of the reasons this had happened was the lack of detail written in the audits which had prevented them from identifying issues; they acknowledged this was an area which required improvement. They said they would address this as soon as possible, as it was essential for them to have effective audit systems in place to improve the service and care delivered.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in post. Staff spoke positively about communication and how the registered manager worked well with them, encouraged team working and an open culture. Regular staff meetings took place where staff were given an opportunity to bring up any concerns as well as keeping up to date with working practices. Staff commented "We all get on well together; staff work together; help each other out; it's a good atmosphere", "It's like a little family here; everyone gets on well together" and "I think this is a lovely, cosy homely place; staff get on well together; I like the atmosphere here". Staff also felt motivated and supported by the registered manager to do their job. One member of staff gave an example of a recent occasion when the registered manager had supported them confidentially with a personal matter. Staff comments included "X (the manager) is always there", "X is lovely, supportive and understanding", "The manager is approachable" and "X (the registered manager) is OK, approachable. Appreciated? I would like to think so." The registered manager was supported by the providers who were in daily contact with the service and visited every two to four weeks .

People's views and suggestions were taken into account to improve the service. For example, for the people who were able to, meetings took place where they could bring up any issues. Regular surveys of people using the service, their relatives and family members, together with surveys to health and social care professionals had been sent out. The last ones sent out in April and October 2014 showed any negative issues highlighted on the surveys had been addressed. For example, people had made requests for a more varied diet which had resulted in more food choices on the menu. The surveys were very complimentary of the service and comments included "Clayfield has consistently provided good, kindly and thoughtful care to my X over many years", "Thank you for the special care you gave to my X" and "X has a contentment and quality of life that would not have been possible without it (the care provided)." The registered manager was in the process of planning the next surveys to go out.

Regular relative meetings were also held; the next one was planned for June 2015. For those relatives who would not be able to attend the meeting, the registered manager had planned to meet with them informally when they visited the home in order to gain their views of the service and how they could improve. They had planned to put one week of their time "dedicated to meeting relatives".

Equipment and systems were maintained and serviced in line with their individual contracts such as the fire alarm, electrical testing, boiler and gas appliances.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not taken proper steps to protect service users by: - not assessing the risks to the health and safety of service users and doing all that is reasonably practicable to mitigate any such risks and: - not ensuring the proper and safe management of medicines Regulation 12 (1)(2)(a)(b)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered person had not taken proper steps to protect service users from risk by: - not ensuring sufficient numbers of staff were deployed Regulation 18 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person had not taken proper steps to protect service users from risk by: - not following the requirements of the Mental Capacity Act (2005) Regulation 11 (1)(2)(3)(4)(5)

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had not taken proper steps to protect people by: - depriving people of their liberty without lawful authority Regulation 13 (5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person had not taken proper steps to protect service users from risk by: - not providing person centred care to meet individual needs Regulation 9 (3)(a)(b)(c)(d)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had not taken proper steps to protect service users from risk by: - not having effective audit systems in place to continually improve the service Regulation 17 (1)(2)(a)(b)(c)(d)(f)