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Claydon Lodge Care Home

Inspection report

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Date of inspection visit:
25 February 2016

Date of publication:
06 July 2016

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection was unannounced and took place on 25 February 2016.

Claydon Lodge provides accommodation and personal care for up to 45 older adults, including people who may be living with dementia. At the time of our visit, there were 36 people living in the home. There was a registered manager at this service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection in August 2014, people were not always protected from receiving unsafe care. This was because there were not always sufficient staff and the home was not always kept clean and hygienic. Following that inspection, the provider told us what action they were going to take. At this inspection we found that the required improvements had been made to ensure sufficient staffing and they had mostly been made to establish safe systems of cleanliness and hygiene at the service. Further minor improvements required were assured by the manager through their revised management checks and related action plan for this. This showed that equipment and systems improvements help to protect people from any risk of infection through cross contamination.

People felt safe in the home and they were protected from the risk of harm and abuse. The provider's arrangements for staff recruitment and deployment at the service helped to ensure people's safety in care.

Robust needs assessment and care planning approaches helped to mitigate risks to people's safety associated with their health conditions, equipment used for their care and their medicines.

Staff were trained and supported to understand and deliver their role and responsibilities for people's care. People received effective care from staff who monitored their care and nutritional needs associated with their health conditions.

People were supported to access external health professionals when they needed to and staff followed health professionals' instructions for people's care when required. Shared health plans helped to promote a consistent and co-ordinated approach to people's care and their related wishes and choices when they moved between services.

Staff followed the Mental Capacity Act 2005 (MCA). People's consent or appropriate authorisation was obtained for their care when required, which helped to ensure their rights and best interests.

Staff were kind and caring and understood the importance of ensuring people's rights and choices in care. People were treated with respect by staff who promoted their dignity, privacy, choice and independence. People and their relatives were appropriately involved and informed in the care provided.

Staff understood peoples' communicate needs but did not always supported people to participate in home life or engage in activities in a way that was personalised and meaningful to them. Staff were usually visible and they often responded promptly when people needed assistance, although this was not consistently achieved.

Relevant adaptations and adjustments were not consistently considered in relation to people's diverse needs associated with their dementia and sensory care requirements.

People and relatives were confident to raise concerns about their care or make any complaints but the provider's complaints procedure did not fully inform them how to do this. Complaints received by the registered manager were investigated, handled appropriately and used to inform care and service improvements.

The service was well managed and people using the service, relatives and visiting professionals were confident of this. The provider kept us informed and took appropriate action for any important events that happened at the service.

The quality and safety of people's care, was regularly checked and analysed and used to inform service improvements.

Staff understood their roles and responsibilities for people's care. Further improvements were being proactively sought in relation to people's dementia care experience.

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.

Improvements were made to ensure sufficient staffing and for environmental cleanliness and hygiene at the service.

People felt safe and they were protected from the risk of harm and abuse.

Robust care planning approaches helped to mitigate risks to people's safety from their health conditions. Equipment used for people's care and their medicines were safely managed.

Is the service effective?

Good

The service was effective.

People's consent or appropriate authorisation was obtained for their care to ensure their rights and best interests.

People received care from staff who were trained, supported and understood people's care and nutritional needs.

A co-ordinated approach to people's care, in consultation with external health professionals when required, helped to ensure people's health and related care needs were consistently met.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff who ensured their dignity and rights in care.

People's care accounted for their known preferences and wishes and was appropriately informed by others who knew them well.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care was often not always personalised. People were

not consistently supported to participate in home life and engage in activities that were meaningful to them.

People's diverse needs were not always recognised, considered or responded to in relation to their dementia or sensory care requirements.

People and their representatives were confident but not fully informed how to make a complaint about the service. Complaints were appropriately responded to and used to inform care and service improvements.

Is the service well-led?

Good

The service was well led.

The service was well managed and run and staff understood their roles and responsibilities.

Significant improvements had been made to the quality and safety of people's care, which was regularly monitored and evaluated. Service development planning helped to ensure continuous improvement in relation to people's care experience.

Claydon Lodge 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.

We visited the home on 25 February 2016. Our visit was unannounced and the inspection team consisted of two inspectors.

Before this inspection we looked at all of the key information we held about the service. This included notifications the provider had sent us. A notification is information about important events, which the provider is required to send us by law. For example, a notification of a management changes. We also spoke with local authority care commissioners and Healthwatch Derbyshire who are an independent organisation that represents people who use health and social care services.

During our inspection we spoke with eight people who lived at the home and two people's relatives. We spoke with eight care staff including the registered manager, deputy manager and a senior and four care staff. We also spoke with a cook and a visiting medical professional. We observed how staff provided people's care and support in communal areas and we looked at eight people's care records and other records relating to how the home was managed. For example, medicines records, staff rotas, training records and checks of quality and safety.

As many people were living with significant dementia at Claydon Lodge, we also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

Good

Is the service safe?

Our findings

At our last inspection in August 2014, people were not always protected from receiving unsafe care. This was because there were not always sufficient staff and the home was not always kept clean and hygienic. Following that inspection, the provider told us what action they were going to take. At this inspection we found that the required improvements had been made to ensure sufficient staffing and mostly to establish safe systems of cleanliness and hygiene at the service.

We found that the premises were mostly clean and well maintained. Two people we spoke with were satisfied with cleanliness in general and particularly their own rooms. One of them said, "The rooms are kept nice in clean."

The registered manager told us about the action they had taken since our last inspection to improve standards of cleanliness and hygiene at the service, which we observed. This included revised cleaning procedures and the provision of equipment to reduce the risk of infection through cross contamination. For example, we saw that suitable waste bins and hand washing and drying facilities were provided. We also found that the premises were mostly clean and well maintained but saw that some furnishings in two communal areas were not always clean and kept free from stains, dust or spillages. However, records of the registered manager's checks also found the same and showed the action they were taking to address this.

Following our last inspection the provider told us they had introduced a staffing tool to regularly inform their staff planning and deployment arrangements. They also advised that their staffing levels increased following that inspection and were being regularly reviewed to help meet people's changing care needs.

At this inspection people, relatives and visiting professionals said there were enough staff available when they needed them. A regular visiting health professional told us, "There's always enough staff when I'm here – well organised and visible." Overall we observed that staff were visible and readily available to people when they needed assistance. Staffing levels were under review to ensure they were sufficient following changes in two people's health status relating to their end of life care needs.

Staff said that staff planning arrangements took account of absences, including holidays and sickness. We also found that recognised recruitment procedures were followed to check that staff, were fit to work in the home before they commenced their employment. For example, relevant employment checks were obtained. This helped to make sure that staffing arrangements were safe and sufficient to meet people's care needs.

People said they felt safe at the service and relatives felt they were safe there. One person told us, "Staff behave properly, it's a nice place; I feel safe here." Information was displayed to inform people about how keep safe. This included information about what to do if they witnessed or suspected abuse of any person receiving care at the home. Staff knew how to recognise and report abuse and they were provided with regular training and appropriate procedures to follow in any event. This helped to protect people from the risk of harm and abuse.

We saw that staff supported people safely when they provided care. For example, helping people to eat and drink, with their medicines and to move safely. Staff wore and used personal protective clothing when required such as disposable gloves and aprons to help prevent the spread of infection through cross contamination. We also saw that people were provided with the equipment they needed to keep them safe and that staff understood how to use this safely. For example, pressure relieving equipment to help prevent skin sores or hoist equipment to help people to move who were unable to do so themselves. Records showed that equipment used for people's care was regularly checked and serviced for safe use.

Risks to people's safety, such as risks from falls or from malnutrition because of a reduced appetite, were assessed before they received care and regularly reviewed. People's care plans showed the actions that staff needed to follow to mitigate those risks. For example, if bed rails were needed to help prevent a person from accidentally falling out of bed, staff consulted with a relevant external health professional to make sure this was the safest way to manage that risk. This helped to make sure that people were safely supported.

People's medicines were safely managed. A visiting health professional told us, "They are very good at managing medicines; staff follow instructions and ensure a safe system." They also told us about a recent audit of people's medicines at the service by local health care commissioners, which found the same.

People who were able to tell us felt they received their medicines when they needed them. We observed that staff gave people their medicines safely and in a way that met with recognised practice. Records kept of medicines received into the home and given to people showed that they received their medicines in a safe and consistent way.

Staff responsible for people's medicines told us they had received medicines training, which included an assessment of their individual competency. Staff training records also showed that all relevant staff received this. The provider's medicines policy was subject to a periodic review and provided comprehensive guidance for staff to follow for the management and administration of medicines. This helped to make sure that people's medicines were safely managed.

Good

Is the service effective?

Our findings

People were happy with their care and they, relatives and visiting health and adult social care professionals felt that people's needs were being met. We received many positive comments from them about this, particularly in relation to staff member's understanding of people with dementia and their related care needs. One person said, "Staff are good and helpful; they understand me." Another person told us, "Staff have sense; they understand what people need and always make sure I'm properly looked after." A visiting health professional said, "Staff know how to approach people; they understand people, their behaviour and what they need, which is important, as many can't say directly."

Staff understood people's health needs and supported them to access external health professionals when they needed to. For example, for specialist or routine health screening, such as eye care or diabetes screening. People's care plan records showed that staff followed related advice and instructions from health professionals when required. A visiting medical professional told us, "Staff are very organised; their knowledge of people's health care needs is very good."

The registered manager and senior care staff provided us with a comprehensive account of people's care needs and associated care requirements when we spoke with them about this. Staff understood and followed instructions from external health professionals for people's care. This included what to observe for that may show a change in people's health status and how and when to refer to them. This information was also shown in people's written care plans. For example, care staff told us about one person's care relating to their mental health and dementia care needs. They understood how the person's health condition affected them and what helped. They knew what changes to observe that may trigger the person's referral to relevant external health professionals and how to support the person in the least restrictive way possible. A visiting health professional said, "Staff manage him very well; they know his needs and how to approach him."

Staff recognised the importance of working closely with external health professionals concerned with people's care. For example, one senior care staff told us in relation to this, "Making sure we work closely as a multi-disciplinary team is key to maintaining and improving people's health."

We saw that each person had a shared health plan, known as a 'joint care plan.' This is an agreed care plan that was shared and accessed by staff at the service and relevant medical and health professionals concerned with the person's care. The plan was subject to regular joint review by the service and person's GP and provided a concise summary of information about the person's health condition(s), medicines and related care needs. This included, people's known choices, wishes and consent to their care. A copy of the plan was provided to go with the person if they needed to transfer to another health service provider. For example, in the event of their hospital admission. This helped to promote a consistent and co-ordinated approach to people's care and to make sure that their wishes and choices were recognised and shared when they moved between services.

People were provided with personal care in line with legislation and guidance in relation to consent. 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.

Staff had received training and they were aware of the key principles of the MCA. Many people were not always able to consent to their care or make important decisions about their care and treatment because of their health conditions. People's care plans showed an appropriate assessment of their mental capacity and a record of any decisions about their care and treatment made in their best interests and any consultation with their relatives and relevant health professionals where required.

Some people's freedom was being restricted in a way that was necessary to keep them safe, known as a Deprivation of Liberty Safeguard (DoLS). For example, they were not able to independently choose whether or not to live at the home. Records showed that DoLS were either formally authorised by or requested from the relevant local authority, which the provider had notified us of as authorised. This showed that people were protected from the risks of receiving care without appropriate consent or authorisation because

Staff received a formal introduction to their role, which met with recognised national standards for this. Each staff member received regular one to one supervision from a senior staff member to support their role and development. The Care Certificate was also introduced for new care staff to complete. This identifies a set of care standards and introductory skills that non regulated health and social care workers should consistently adhere to. They aim to provide those staff with the same skills, knowledge and behaviours to support the consistent provision of compassionate, safe and high quality care.

Staff told us they received the training and support they needed to provide people's care. Training records reflected this and showed that staff received regular training updates. We saw that information was provided for staff about planned training sessions. For example, the staff notice board showed forthcoming training updates for safeguarding vulnerable adults and staff due to attend. One staff member said, "Training is pretty good here; it covers what we need ; we can request any relevant additional training if we think we need it." Staff lead roles were also established to champion care practice in the home against recognised national standards. For example in relation to medicines management, nutrition and end of life care. This showed that staff were trained and supported to perform their role and responsibilities.

People's nutritional needs were being met and they received a balanced diet. Food menus showed a balanced diet, although did not match the meal provided on the day of our visit. However, the cook spoke with people before their meals to inform them and check their meal choice with them. People said they were generally satisfied with their meals. One person said, "We get enough to eat and drink; I enjoy my warm milky drink at night." Another person told us, "The food is good, especially when it's a good stew that I like; I get plenty of cups of tea." One person said, "The breakfasts are good; I had an excellent breakfast - bacon and egg this morning."

People's care plans showed that staff consulted with people, others who knew them well and external health professionals when required about people's meal choices and nutritional requirements. At lunchtime were saw that tables were properly set and people were offered a choice of drinks with their meal. Most people ate their meal in the main dining room, where they sat in small groups, who were served their meals together at the same time. Lunchtime was sociable and relaxed and staff provided people with the support they needed to eat and drink.

We saw that a jug of drinking water and a glass was provided in all people's rooms. Staff regularly replenished the water to ensure it was fresh. A few people choose to eat in their own rooms, or were supported there because of their health conditions and associated frailty and care needs. Some people were at risk of malnutrition because of their health conditions. Staff monitored and recorded some people's nutritional and dietary intake and they regularly checked people's body weight to help monitor this. Staff knew people's dietary needs and requirements and followed instructions from relevant health professionals for this. For example, staff made sure that people were provided with the correct type and consistency of food or drinks, where risks were identified to their safety such as risks from choking, due to swallowing difficulties. This showed that people were effectively supported to eat and drink.

Good

Is the service caring?

Our findings

People and relatives said that staff were patient, kind and caring and treated them with respect. One person said, "Staff treat people well; I have always been treated with respect." Another person told us, "Staff are patient and give me time; they know it takes me some time to get going in a morning and what helps." A third person said, "Staff make sure we are looked after; they are kind and treat me well."

We observed that staff treated people in a caring manner. They took time with people when they provided care and were gentle and patient in their approach. For example, we observed staff support one person to eat and drink through gently encouragement. They told us later, "It's really important to make sure that someone is actually eating their food and not just put the plate in front of them; they often need time, encouragement and gentle support, sometimes with every mouthful.

All of the staff were spoke with were able to describe what they felt was important when they provided people's care. This included ensuring their dignity, privacy, choice and independence.
We also observed that staff took time to do this. For example, by helping people to make choices about their care, such as what to eat and drink and where to spend their time.

We found that staff were patient, kind and explained what they were going to do before they provided care and support to people. One person said, "Staff are calm and kind – they don't rush you." We observed that staff promoted people's privacy, dignity and independence when they provided care. For example, when one person needed to have their prescribed skin creams applied, staff reminded them about this in a discreet manner and supported them to move to the privacy of their own room for this. Staff also made sure, if people needed equipment such as walking frames or special seat cushions, to help them to move independently or for their comfort, that this was within easy reach or available to them. This showed that staff were respectful and promoted people's rights when they provided care.

Many people were unable to communicate how they felt verbally. Staff took time with people and made sure they approached them calmly, particularly if they became upset or anxious in relation to their dementia experience. For example, staff used gentle verbal tones and touch to re-orientate one person who was distressed because of their confusion.

People's care plans showed their individual needs, choices and preferred daily living routines. They also showed people's involvement and the contact information of family or friends who were important to them.

Requires Improvement

Is the service responsive?

Our findings

People were often, but not always supported to participate in home life and engage in activities in a way that was personalised and meaningful to them. One person told us, "The staff are very good, but there is not always much to do." Another person said, "I am an artist; I'd love to be able to paint or draw again; it's not offered." Another person said, "We don't go outside much; I like to sit near the window to feel the sunshine." Another person told us, "I'd like to in a garden with plants and trees; this garden here is bland; just grass.

People said there were sometimes activities and entertainments they could engage in. One person told us they regularly went out with their relative, which they very much enjoyed. Staff said that they often organised activities to support people's engagement and participation in home life. For example, they told us about one person who particularly liked singing and baking, which they were regularly supported to do. We saw that some information was provided about 'Daily Activities' on a notice board. This showed that daily activities were planned in the home, such as reminiscence, film shows, singing, baking, chair based exercises, unspecified 'one to one' activities or 'residents choice of activity.' There was a reminiscence lounge, which contained some items relating to the past; that may help to invoke people's memories of times gone by. This included literature, pictures and an afternoon tea set up. However, the room and items there were dusty and unused. This showed that people were not consistently supported to engage in social and recreational activities that met with their known preferences and choice or that were meaningful to them.

We observed that staff did not always support people's engagement in home life. During the morning staff served teas, coffee and biscuits to people in communal areas or their own rooms. This included some people who were sitting alone at dining tables and a group of ladies who staff had supported to sit together beforehand in a small semi-circle nearby. Most people were not able to communicate with each other because of the dementia. We saw that staff did not engage with people once their drinks were served and subsequently left the room for a considerable time period. They did so after switching on loud music from a radio nearby and did not consult with people about their wishes or preferences for this. People openly commented they did not like the music and wished for it to be turned off. The inspector obliged when one person said, "We are trying to turn it off, it's awful." Another person also became visibly distressed during this time, until another person sitting nearby moved closer and attempted to comfort them and help with their drink. Eventually staff returned to clear away people's empty cups. In this instance, staff had not ensured that people were supported in a personalised way.

We observed staff were often visible and they mostly acted promptly to support people or respond to their requests for assistance when needed. For example, at lunchtime care staff acted promptly when one person was struggling to eat independently. They took time and made sure that the person was encouraged and appropriately supported to eat and drink sufficient amounts at their own pace. However, in another dining room at lunchtime we observed that tables were not provided with condiments for people to help themselves. Staff did not routinely offer condiments to people when they served the meals and ignored two people's person's request for this.

People, relatives and a visiting medical professional felt that staff were usually helpful and prompt to provide people with the assistance and support they needed in relation to their personal and health care. For example, when people needed assistance to eat and drink or if their health needs changed, staff acted promptly to engage external health professionals. One visiting medical professional told us, "Staff always refer people promptly when there are any changes to their health."

Staff told us how they supported one person who was not able to communicate directly how they felt because of their mental health condition. Staff understood the person's needs and how to communicate with them. A visiting health professional confirmed that the person could become angry and distressed because of their health condition and may subsequently behave in a way that was sometimes challenging to others. They told us that staff responded appropriately in a way that was meaningful to the person when this occurred, which helped to reduce the episodes of this behaviour and its impact on others. We saw that the person's related care plan was personalised to them and showed the steps that staff needed to take to support the person when this occurred. This showed that the person's care was personalised and provided when they needed it.

Most people were living with dementia and a few with sight impairments at the service. However, adaptations and adjustments to support people's diverse needs were not consistently considered or provided. For example, picture signs were provided on doors to help people recognise toilets and bathrooms, but other environmental aids that may assist people's orientation around the home were not. We observed on several occasions that staff guided people who needed help to find their own rooms or a communal lounge. Adapted dining crockery and chairs helped to ensure people's recognition and ease of use. However, the standard print food menus displayed did not aid people's recognition and did not match the lunchtime meals served at our visit.

People and their relatives said they would speak with the manager or senior care staff, if they were unhappy or had any concerns about people's care. They felt confident that this would be listened to and acted on, but were unsure how to contact the provider if required. The complaints procedure displayed in the home did not show the contact details of the registered providers, which meant that people were not fully informed if they needed to make or escalate a complaint to the registered provider if they needed to.

Records showed that two complaints were upheld following investigation by the registered manager. Changes were made as a result of the investigation findings, which helped to ensure appropriate oral care for people at the service and to improve the quality of meals provided. Records showed that positive feedback was subsequently obtained from people, relatives and visiting professionals, which showed that improvements were made.

Good

Is the service well-led?

Our findings

People, relatives, staff and a visiting professional described the registered and deputy managers as being always 'available,' 'helpful,' and 'approachable. One person said, "She's very nice; always helpful and listens to what you have to say." All felt they were listened to, that their voices were heard and were pleased that the service continued to improve. One person's relative said, "It has taken a positive direction since the registered manager came into post. All were confident about the management and running of the service.

Information we held from our inspections of the service and the registered manager's checks of the quality and safety of people's care, showed that significant service improvements had been made over the previous 18 months. This included improvements in management, cleanliness, record keeping, communication and staffing systems and improvements to people's care and nutrition. Further systems improvements were being progressed in relation to cleanliness and infection control and dementia care provision against nationally recognised practice standards. The registered manager told us, ""We firmly aim to continuously improve; our main priority over the next 12 months is to maintain this and to develop our dementia care standards."

Regular checks were made of complaints, accidents and incidents. Regular checks were made of people's health status, which included skin, infection, nutritional and weight status checks. The results were formally analysed by the registered manager to help identify any trends or patterns that may further inform improvements for people's care. This helped to ensure that people received safe and effective care.

Staff felt they were respected by management and said they were often asked for their views about people's care, which was discussed with them. Senior manager's held regular meetings with staff, which included group and one to one supervision meetings. Staff told us that these were helpful and used to inform staff about service development requirements, including any improvements needed and the reason why. Records of staff meetings that we looked at reflected this.

The provider usually sent the Care Quality Commission written notifications informing us of important events that had happened in the service when required. There was an unnecessary delay in sending one notification, which the provider did not send us until we asked them to. However, the notification showed they had taken appropriate action.

There were clear arrangements in place for the management and day to day running of the home. The registered partners, as providers of the service, regularly visited there. Records of their visits showed this helped to ensure the appropriate management and running of the service in relation to the quality and safety of people's care. Care staff had delegated lead roles and responsibilities relating to people's care. For example, for people's medicines and for their dignity in care.

Key worker roles were also allocated to care staff to help personalise people's care experience
Staff understood their roles and responsibilities and they were confident to raise any concerns about people's care. For example, by reporting accidents, incidents and safeguarding concerns. One staff member

told us, "There is a good reporting 'no blame' culture; nothing is hidden; we are supported to report anything untoward – if someone falls say, or we notice they have a bruise."

We saw that relevant policies and procedures were in place for staff to follow in such events. They included a whistle blowing procedure if serious concerns about people's care need to be reported to relevant outside bodies to protect people from harm or abuse. Whistle blowing is formally known as making a disclosure in the public interest. This showed the provider promoted an open and transparent culture.