Kirklees Metropolitan Council

Claremont House

Inspection report

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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?	**Good**
Is the service well-led?	**Good**

Summary of findings

Overall summary

The inspection of Claremont House took place on 18 and 23 February 2016 and was unannounced. The service was last inspected on 19 March 2014 and met the Health and Social Care Act 2008 Regulations in operation at that time.

Claremont House is a registered care home situated in Heckmondwike in West Yorkshire. It provides accommodation and personal care for up to 40 people living with dementia. At the time of our inspection there were 26 people living there on a permanent basis and five people receiving temporary residential respite care.

There was a registered manager in post who had been registered since October 2015. 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.

Staff had received training in how to keep people safe. All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents.

The service had completed some risk assessments in detail and there were risk reduction plans in place, but we could not see the evidence that all risks had been identified and reduced. The systems for recording risks in people's files was not easy to follow and did not correlate between the risk index and other risk information in people's files.

Staff had recently undertaken refresher training in the management of medicines and were waiting for the results of their assessments. Competency assessments around medicines were not up to date. On the first day of our inspection we found errors in the management of medicines for one person. This was raised with the registered manager who acted immediately on this concern.

We found the environment to be maintained to a high standard and was extremely clean with good infection control practices in place. Staff were observed to follow good practice guidelines in the management and prevention of infections.

Staff received an induction and training to ensure they had the skills to meet the needs of the people who lived there. Staff were supported to continually develop by obtaining nationally recognised qualifications and by on-going supervision.

People were supported to eat their meals by care staff appropriately and sensitively and people told us how much they enjoyed their meals. People's nutritional and hydration needs were met, although we had concerns about one person which we addressed with registered manager. People were encouraged to drink throughout the day.

The home was compliant with the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and had applied for authorisations to the local authority and were awaiting the outcome for several requests. We did find relatives had consented on behalf of their relations when there was no evidence of the legal authority to do so. When this was brought to the attention of the management team they responded immediately to correct this error.

We found all the staff to be caring in their approach to the people who lived there and treated people with dignity and respect. Staff knew the people they supported very well and were keen for people to feel they were at home at Claremont House. We observed staff to be kind and compassionate throughout our inspection. Relatives spoke highly of the care at Claremont House and described it as 5 star and second to none.

Care provision was personalised and support plans were reviewed regularly to ensure they were relevant to the people who lived there. Families were invited to input into the reviews of their relative to ensure known preferences and views were incorporated into people's care plans.

Complaints were handled appropriately and people were happy that any concerns raised had been acted upon.

The home was well led and the management team encouraged an open and transparent culture where people were able to make suggestions for change and improve the quality of 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?

Requires Improvement

The service was not always safe

Staff we spoke with demonstrated a good understanding of how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents

Risk assessments were detailed to reduce some risks but not all risks had been identified with risk reduction plans in place to ensure risks were reduced to an acceptable level.

Medicines had not always been administered safely and although staff had undertaken medicines refresher training, their competencies had not been assessed.

Is the service effective?

Requires Improvement

The service was not always effective

Deprivation of Liberty Safeguards (DoLS) applications had been made appropriately to comply with the Mental Capacity Act 2005.

We found not all the mental capacity assessments complied with the Mental Capacity Act 2005 and consent from others had been sought without evidence of the legal authority.

People told us how much they enjoyed the food and they were offered choice at mealtimes. People's nutritional and hydration needs were monitored although we had concerns about one person's nutritional requirements

Is the service caring?

Good

The service was caring

We found staff to be caring and compassionate towards people using the service and they knew how to ensure privacy, dignity and confidentiality were protected at all times.

People were encouraged to maintain their independence around activities of daily living and with their mobility.

The service used formal advocacy service when required to ensure people had a voice.

Everyone we spoke with at the time of our inspection or following this spoke highly of the staff at the service and their attitude and approach to provide a caring service.

Is the service responsive?

Good

The service was responsive

People were supported by staff who knew them well and were keen to enhance people's well-being and quality of life.

People were involved in their care planning when appropriate and families consulted with to ensure preferences and views were considered when devising support plans.

People's care needs were regularly reviewed to ensure changing needs were identified and responded to.

Is the service well-led?

Good

The service was well led

There was a positive culture within the service. There were clear values that included compassion, dignity, and respect. The management team
provided strong leadership.

Staff were engaged with the changes at the service to drive up improvement to provide a quality service for the people living there.

We found all audits to be up to date and detailed, and all environmental checks had been completed.

Claremont House

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.'

This inspection took place on 18 and 23 February 2016 and was unannounced. The membership of the inspection team consisted of two adult social care inspectors. .

Before our inspection, we reviewed all the information we held about the home. The registered provided had not been asked to complete 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 contacted Healthwatch to see if they had undertaken a recent 'Enter and View' visit. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. They told us they had not undertaken a recent visit and they had not received any recent information relating to the service. We also contacted the local authority contracts department to gather recent information about this service to inform the inspection process.

We used a number of different methods to help us understand the experiences of people who lived in the home. We used the Short Observational Framework for Inspection (SOFI) to observe the lunch time meal experience in one of the communal dining areas. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the registered manager, the service manager, a team leader, an agency worker, two care workers and cook as part of our inspection process. We case tracked three people and reviewed the care files of six people in detail. We also spoke with nine people who used the service, two regular visitors and one relative. Following our inspection we spoke with a further three relatives to seek their views of the service provided at Claremont House.

We spoke with two visiting community nurses Claremont House and after the inspection we spoke with a social worker who had recent involvement at the home.

Requires Improvement

Is the service safe?

Our findings

Three people who used the service told us they were safe at Claremont House. One person said "I've always felt safe here." Another person told us "I would go to [name] in the big office If I wasn't happy and [name] would sort it out. The manager comes and sits a lot with us and asks us if we are alright." Another person told us "I occasionally press the buzzer if I need it. Staff are there straight away." All the relatives and visitors told us people were safe at Claremont House and they had no concerns about either the staff or the environment.

One member of staff we spoke with told us "People are safe here. We have automatic locks, and there are always staff around. Everybody has a sensor mat on their bed and this is linked to a pager, which all staff have so we can respond to people who cannot press a buzzer."

We asked staff about their understanding of safeguarding. All the staff we spoke with demonstrated they understood how to ensure people were safeguarded against abuse and they knew the procedure to follow to report any incidents. One member of staff we spoke with told us if they suspected any type of abuse was happening they would "report this straight to the team leader and if it was not acted upon, they would go to the manager, and if they didn't act on it, they would go to the higher manager." They gave us an example of a recent safeguarding incident they had been involved with and the outcome of this situation. They also described the signs of abuse such as "bruising, and people being afraid of staff." The registered manager told us they regularly observed staff during daily walk around the service, to see how staff interacted with people who might present with behaviours that could challenge others. They told us they observed to check that staff were reading people's positive behavioural support plans, followed these plans and recorded the activity.

The registered manager told us they used an electronic dependency tool which worked out the number of staff required to support the people using the service. They told us they inputted people's dependency needs on a weekly basis to ensure they always had the correct number of staff to meet the people's current care needs and the systemworked well in determining staffing levels. They demonstrated the dependency tool to us during our inspection and this detailed who required one to one care or two to one care and during which activities. The outcome of the dependency tool correlated with staffing levels at the home.

We asked staff whether they felt there was enough staff to ensure people were cared for safely. One person told us this was manageable at the moment because one unit was not fully occupied due to work on the kitchens but when a number of people require two people to assist them with personal care, this can often leave people without supervision, which was echoed in the relatives' survey. One of the relatives we spoke with told us they felt there were enough staff, but they could do with additional staff to ensure people were not left unsupervised in the communal areas. A member of staff told us, there were enough staff but that there was currently a high number of agency staff used because some staff had left and they had not yet recruited permanent replacement staff. This view was shared by a relative of a person who used the service, who told us permanent staff had been there for many years and knew their relative very well, but they had noted an increase in agency staff who did not have this in-depth knowledge. The area manager told us they

were actively recruiting to reduce the use of agency staff and would be holding a recruitment fair to encourage applications. They also told us they were aiming to implement a bank of casual staff in addition to permanent recruits to ensure people were cared for by staff they were familiar with.

The registered manager told us risks to people at the service were discussed at handover and during team meetings to ensure all staff were continually updated in relation to risks to the people using the service. They told us each person had a risk index in their file to identify the risks to the person which then led onto various risk reduction plans such as accessing the call bell, physical aggression, and verbal aggression. We reviewed this risk index in the six care files we looked and found the risks listed in the index did not correlate with risks listed in their care plans or those contained in the file. For example, in one person's care plan we found an entry in the care plan which recorded the person had a risk assessment in place for fire, skin and verbal aggression dated 18 October 2015 but in the risk index the only recorded risk was for physical aggression, verbal aggression, vulnerability, medical/health and non-compliance. In another person's care file the risks in relation to choking for a person on a liquidised diet had been stated but no specific instructions related to their positioning which had been specified by the SALT team had been implemented other than "fully supported" to eat and drink.

We also found there was a lack of risk assessment around the use of assistive equipment such as bath hoist, wheelchairs and commodes in all the files we looked at. We raised this with the registered manager who told us they were aware of this situation and were working on these risk assessments with one of the registered provider's other homes in the area which would be implemented in all the registered provider's homes.

We looked at three staff files and found all necessary recruitment checks had been made to ensure staff suitability to work in the home. This included a Disclosure and Barring Services (DBS) checks, reviews of people's employment history two references received for each person. The area manager told us they had a rigorous interview process to ensure only people with the right behaviours and skills were recruited to the home.

We asked staff how they would respond in an emergency. One member of staff said "if the fire alarm goes off all staff have to go to reception and the person in charge will direct staff to ensure people are moved to a safe zone. We found each person had an emergency evacuation plan which was held in the reception area and also included a photograph of the person on the form to aid recognition in an emergency situation, next of kin detail and how they required to be supported. This ensured people's needs were recorded to ensure they remained safe in an emergency situation.

We observed a team leader administering medication to people who lived at the home. All medication was supplied by a local pharmacy and the stock stored in the clinical room before being transferred to the medication trolleys. Prescribed drugs were dispensed in colour coded blister packs and non-scheduled solutions or tablets were kept on the trolley shelves. We saw that there were arrangements in place for ensuring hand hygiene and that the MAR charts had people's details and their ID photograph. We saw no protocols for 'as and when' (PRN) medicines nor any risk assessments for those people who lacked capacity to consent to this type of medication, although this was immediately actioned when it was discussed with the registered manager.

We had concerns about the safe administration of one person's medicines. For example, we observed one person's pain medication syrup was put in their nutritional supplement, which was given covertly, but there no authorities or protocols in place for this administration. The amount or rationale was not entered on the reverse Medication Administration Record sheet and because the person was non-compliant, they decided to leave the drink on this person's over bed table, so did not observe the person taking this medication. We

also found issues with stock control for one person. For example, one box of tablets we examined contained more tablets than were recorded on the MAR chart, but there was no means of determining the cause of the error. These examples demonstrated a breach in Regulation 12 of the Health and Social Care Act 2008 Regulations 2014

Medicines were stored in a locked clinical room The temperature of this room was not monitored although we did see there was a room thermometer. The drugs fridge temperature had been monitored. The overflow and anticipatory drugs were stored in locked cabinets. We checked the Controlled Drugs and found them in order and that there was a list of staff signatures to clearly record who had administered the medicines.

All staff had completed a recent refresher training programme, and was waiting the outcome of their assessment. We were told by staff that they had not had an annual competency checks and we confirmed this by checking the team leaders' files and found only two had had a recent assessment. However, by our second day of inspection all staff had been scheduled or were in the process of being scheduled for a competency check. We recommended the home utilised the current NICE guidelines to ensure their policies and procedures conformed to current best practice.

We observed that the home was well maintained and saw that they had an effective cleaning schedule. Hand washing facilities, sanitisers and waste disposal bins were readily available throughout the home. We examined the infection control audits and saw that the home had an external rating of 86% in July 2015 rising to 90% in September 2015. The home has appointed a Deputy Manager as the infection control lead and we saw that they had initiated a self-assessment audit and updated staff knowledge to ensure people remain safe from transferrable infection.

Requires Improvement

Is the service effective?

Our findings

People received care and support from staff who knew them well and who had the skills and training to meet their needs. One person who used the service told us "They are well trained. They know what they are doing. We don't have any problems." There was a strong emphasis on training and continuing professional development throughout the staff team. Staff confirmed they undertook a thorough induction when they first started working in the home which included agency staff. We spoke to an agency carer who told us they had worked at the home for the last 2 years and before they began work in the home they received a comprehensive induction as well as safeguarding and indemnity checks. The staff we spoke with all told us they had received a comprehensive induction and we saw this was evidenced in the three staff files we reviewed. This included training on an introduction to the local authority, fire safety, infection control, recording skills, moving and handling training, safeguarding training, dementia awareness, and medication training. The registered manager told us they were planning to use the Care Certificate for all new starters with no experience in care, but they had not used this with their latest recruit as they had previous experience in the care sector.

Relatives of people living there told us in their opinion staff were skilled and trained to be able to care for their relations. One person told us "Staff were brilliant" in caring for their relation. One of the professionals we spoke with described how impressed they were at the staff knowledge and skill in dealing with behaviours that challenge others and how they had worked hard to identify triggers to this behaviour and inputted appropriate monitoring charts. They praised how the staff worked with other professionals to find solutions to ensure positive outcomes for this resident but also to ensure the safety of other residents.

Records of training showed us a wide range of learning opportunities were provided for all staff and one of the deputy managers had the responsibility for ensuring all training was up to date. The service had a list of training required at each level and for each job role and how often this training was to be refreshed. This included training in safeguarding, Mental Capacity Act and the Deprivation of Liberty Safeguards, moving and handling of people, medication awareness, infection control and dementia awareness. The majority of training was up to date or booked in and the deputy manager could explain to us why some people had not completed training due to absence from work. The registered manager was currently undertaking an NVQ Level 5 in Management and staff had the opportunity to utilise the registered provider's in house training.

The registered manager told us staff received supervision every eight weeks. We reviewed the supervision records for two members of staff and found supervision sessions were comprehensive and reviewed the previous supervision notes. The records also recorded the training required for the role such as dementia training, safeguarding training, moving and handling, information governance and annual appraisal, when this had been completed and when it was booked. The sessions also covered the local authority "behaviour of the month", wellbeing of staff, safeguarding, the application of the registered provider's 'Mum's Test'(is this service good enough for my mum), policies and procedures and record keeping. Staff require supervision to be supported to develop in their roles and that any gaps in knowledge and skills can be identified through this process to ensure safe care delivery and we found the supervision provided to staff was meeting this objective.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS) We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection 18 applications for authorisations had been sent to the local authority, six had been approved and one had been withdrawn. In the care files we reviewed we checked whether any conditions on authorisation had been met, but there had been no conditions attached.

On the first day of our inspection we reviewed the capacity assessments in the care files of four people to ensure they were compliant with the MCA. In one person's file there was an incorrectly completed two stage capacity assessment which meant this person had been assessed as having capacity when it was clear this was not the case, and the staff member had then made decisions in the person's best interests. This did not meet the requirements of the MCA. This was raised with the registered manager at inspection, who advised us they would attend to this immediately.

We also found in three care files we reviewed that relatives had consented on behalf of people when there was no evidence of legal authority to do so either with a lasting power of attorney (LPA) or a Court of Protection authority. The registered manager told us they would ensure this was rectified immediately and by our second day of inspection, the service had completed applications to the Office of the Public Guardian to confirm who at the service had a registered Lasting Power of Attorney.

We observed one person had their medicines administered covertly during our inspection. The process for administering medicines covertly did not meet the requirements of the Mental Capacity Act 2005. There was no decision specific mental capacity assessment and we could find no evidence of a best interest meeting, or of advice being gained from a pharmacist. The registered manager told us two other people had their medicines administered covertly and they had followed the service procedure at that time which was to seek the GP's approval in writing for this type of administration. The registered manager agreed to follow the updated NICE guidelines on covert medicines to ensure the home followed best practice in this area.

We found the staff at the service we spoke with had a good understanding around mental capacity to consent to care and they could tell us how they supported decision making in everyday life to maximise people's understanding and choice in activities such as getting dressed. One member of staff told us if the person lacked capacity and they were supporting the person to dress, they would choose appropriate clothes for the person to show them the suitable options and support them to choose.

People using the service told us how much they enjoyed the food. One person said "Always nice, really good meals. You get a choice of what to eat. I love bananas. They get you everything you want." Another person said, "You can drink what you want. You can make your own drinks. There's Yorkshire Water over there (pointing to a water dispenser)." Visitors at the service also told us staff always offered them a drink when they were visiting, which they found a positive experience.

We observed lunch in two dining areas on the ground floor and found there were enough staff to ensure the lunchtime experience was positive for the people living at Claremont House. Domestic staff assisted during

meal times to ensure people were supported and prompted to eat. We observed people being offered a choice of main meal and were shown a plate of fish, or steak pie and if they did not want either they were offered vegetable soup. All the people seated at the tables enjoyed their meal and we heard comments such as "beautiful" as people ate their meals. Second helpings were offered for those people who had finished their meals.

We observed evidence of good practice on the four units in relation to nutrition and hydration and senior staff had compiled a Nutrition file detailing the nutritional requirements of each person. This contained a photograph of the person, their dietary requirements and preferences, and how they liked to be supported at meal times. This also included a monitoring chart for staff to record what people had eaten and had to drink each day.

However, this approach was not consistent. In one of the care files we noted, there had been a drastic weight loss over the previous 12 months. This person was now cared for in bed, and was resistive to all care provision and preferred to be left alone in bed. Their weight had been recorded on 06 January 2015 at 56.5Kg and their last recorded weight was 26 November 2015 45.2 kg. There was reference at this point to request the GP to discuss weight loss, but there were no records in the care file to detail the GP had visited or what the outcome of this visit had been. In December 2015 it was recorded "not to be weighed too distressing for [person] and on 7 January 2016 "not to be weighed due to be distressing. Appears to not have lost weight". There was no record of how this person's weight was being monitored as an alternative to the use of weighing scales or how this judgement had been made. In the daily record for the day prior to our inspection, this person had only had fortified drinks as they had declined food but there was no record of how much fortified drink the person should be having each day in their care record although staff were monitoring what they had taken to drink. There was no evidence the dietician had been contacted and we were concerned there was no specific risk assessment relating to this persons nutritional risk. We raised this with the registered manager who agreed to action this immediately and by the second day of our inspection the GP had visited and a referral had been made to the dietician.

In contrast to the concerns we had with the nutrition for one person, the home had recently been complimented on its recording of nutrition for another person. we saw a compliment in the compliments file in the office from the dietician dated 20 January 2016 which recorded "Documentation completed to the highest standard." And one of the care staff we spoke with told us how they were monitoring one person's intake of fibre to ensure their dietary requirements were met. We observed evidence of good practice on the four units in relation to nutrition and hydration and senior staff had complied detailing the dietary requirements of each person. This contained a photograph of each person, their dietary requirements and preferences, and how they liked to be supported at meal times. This also included a monitoring chart for staff to record what people had eaten and had to drink each day.

We saw they had access to other health care professionals for example, GP's, district nurses, dieticians, moving and handling team, dentist and optician. The registered manager told us they utilised the services of the Care Home Liaison Team for guidance and advice for individual people who used the service particularly around guidance on how to manager behaviour that challenges others. This showed people living at the home received additional support when required for meeting their care and treatment needs.

The environment had been purposely built and therefore met all requirements on accessibility. There were two units over two floors accessed via a lift and staircase and secured by electronic locks. We found signage

to be clear throughout the building. Consideration had been given to the toilet areas to ensure the toilet seat and grab rails were contrasting colours to improve recognition and each bedroom had en-suite bathrooms with level access showers. There were areas for people to sit in along the corridors that had been furnished as a home living environment and each communal living space had an ensuite kitchen area.

Good

Is the service caring?

Our findings

The atmosphere in the home was warm and welcoming and we found the interactions between people and staff were positive. All the people we spoke with told us the staff were caring. We asked them to explain how staff supported them with care and compassion. One person told us "They are caring. If they see you struggling they will help you. If you're having a problem, they sit and talk to you". Another person said "They come in at night to make sure you're ok." Relatives of people using the service spoke highly of the caring and compassionate staff. One person said "This service is 5 star. Staff are always attentive. They let me know if there are any issues and they put my mind at ease." Another relative told us "The care is second to none. That's the most important thing."

We asked care staff whether the service they were providing was caring. One member of staff told us "I look after people like they were my own mother and how I would like my mother to be looked after." They also said "I know people really well. I know them emotionally and physically and I can tell straight away if there were any changes." Another member of staff told us they had observed other staff giving a person who used the service a hug and spending time with this person to ensure they felt reassured and at ease.

Staff told us they always ensured privacy and dignity was maintained. The registered manager told us ensuring staff maintained people's privacy and dignity was high on their agenda and to encourage staff to understand how the staff behaviour can impact on people using the service; they had played a DVD recording at the latest staff meeting on this topic area. This showed a person being assisted to bathe and the care staff talking together and not with the person and the effect this type of behaviour can have on a person living at the service. After the DVD the registered manager told us they held a discussion amongst staff on the video to encourage respectful behaviours amongst the staff group.

One member of staff told us they always made sure toilet doors were shut and they made sure they did not talk about people unless necessary. They told us "I will make sure the door is shut when I shower people and I will knock on the door when I enter the room."

Staff told us they maximised people's independence by encouraging them to continue to undertake personal care tasks such as washing and dressing. One member of staff told us "I make sure they do as much as possible to maintain their independence and if they can't do I will help them. I will persuade one person to feed themselves." Three people who used the service told us they were encouraged to remain independent and liked to help out with laying the tables and with arranging flowers for the unit.

The registered manager told us they used advocacy services and had recently used an Independent Mental Capacity Advocate for one person who lives there as part of a best interest decision making process. This showed us the service was appropriately considering the use of advocacy services to ensure all the people living there were supported to express their views.

In two of the care plans we reviewed the patient information sheet had omitted the religious denomination,

although we found reference to the people's faith preferences in another part of the plan. We were also told that there is a church service every month at the home.

Care plans we looked at showed people were actively involved in decisions about their care and treatment. Staff told us there was a key worker system in place and care staff were assigned to ensure specific people had enough personal supplies and liaised with their relatives. We saw that special efforts had been made to ensure people kept in contact with their families abroad and that local relatives were encouraged to be involved in people's' care and consulted about any changes.

We saw DNAR forms that were completed appropriately for people who would not benefit from resuscitation. The registered manager told us the service was working toward Gold Standard Framework accreditation. Under the Framework if someone expressed a wish to die at 'home' every effort was made to keep them in familiar surroundings in the home rather than going into hospital or a hospice. Where the needs of a person increased due to worsening of their condition or needing more one to one care a case would be put forward for additional hours of support around peak times. Both the deputy and registered manager had attended training in The Preferred Priorities for Care (which aims at helping people prepare for the future and gives an opportunity to think about, talk about and write down preferences and priorities for care at the end of your life and were in the process of ensuring these plans were in place for residents who might benefit from this planning.

Good

Is the service responsive?

Our findings

Staff we spoke with demonstrated they were aware of the needs and preferences of the people they were supporting. They told us how they supported people to make choices in their everyday lives taking into account their views and preferences which demonstrated they were providing person centred care. One member of staff described to us in their view personalised care and said " It'sabout people having their own clothes, combs, shampoo towels and flannels and you care for the residents how they want to be cared for. If they wanted a male carer, we would try to accommodate." Although they said at the present time there was only one male carer at the home, so this could not always be accommodated.

People's support plans included clear and detailed information about people's health and social care needs. We looked at six care files and found they contained a general description of the person, how they preferred to be called and a two page profile which was titled care plan which provided staff with clear guidance on how to meet the person's needs. This contained information about all aspects of the persons care needs. For example, their mental capacity and ability to make choices. In one person's care file this section advised the reader that they did not have capacity to make certain decisions and choices without support and then advised what decisions they could make such as what to wear in a morning and what they liked to eat. The plan recorded how to tell if the person was happy and enjoying an activity. One care plan detailed "I am a very sociable person and I like to chat to staff and other people. I like to help around the home particularly the washing up. I really enjoy getting out and about. I love to walk in the garden at Claremont House but I really appreciate a walk into town with a staff member whenever this is possible."

Care plans recorded people's preferences from what they liked to eat and what time they liked to get up and go to bed. For example, in one person's care file the following was recorded "Please offer me a choice of soft cereal or porridge for breakfast." "I like small portions and lots of encouragement" "I usually wake between 8-9am". In the section on oral care the following was recorded "I do not wear dentures, but I will require you to check my mouth and gums are healthy."

Records showed people were involved in planning and reviewing their care and support needs. In one of the care files we reviewed we saw evidence that staff had recorded how the person had contributed to their review. We spoke with three people who used the service who told us they had been involved in their reviews and staff had sought their views and preferences and they were involved in decisions about their care provision. They told us they could choose what time they got up. One said "We can get up when we want, but we get up early." Relatives we spoke with told us they were involved in the care planning and reviews for their relatives and one person who could not attend told us they were sent review information by post.

Daily records completed at each shift showed how support was given in accordance with the care plans and the registered manager told us how they were working with staff to ensure this information was recorded in a person centred rather than task centred way to demonstrate the quality of the experience for the people supported. They recognised this was an ongoing issue, but they had observed improvements.

At times during our inspection we observed people engaged in meaningful occupation. On the first day of our inspection we saw staff sitting with a group of people who used the service engaging them in a game. We also saw staff sitting and chatting with people. However, at other times people were just sitting listening to music and it was difficult to determine whether they were finding this meaningful. One person who used the service showed us a screen in the conservatory "where they show us films." And another person told us it had been a special birthday for them recently and the service made a special tea for them. They told us "They take you out sometimes." Another person we spoke to said "You can't be bored here. We've done music and dancing and we had old songs upstairs."

The service has secured funding for an activity coordinator for 30 hours a week and were waiting for the details to be finalised before commencing the recruitment process. At the current time the service was using an external contractor to provide activities. A harpist had come to the service to do a session in August 2015, Melodies and Memories had attended in February 2016 to sing, and a guitarists and At Home with Art regularly undertook art sessions. The home also had two volunteers who provided activities at the home. One volunteer came on a Tuesday and Thursday to run coffee mornings, sing alongs and manicures and massages. The second volunteer assists with the church service and plays the organ.The registered manager told us they had spoken with the volunteer coordinator to try to encourage more volunteers to support at the service.

People we spoke with knew how to make a complaint and who to go to if they had any concerns. Relatives told us they knew who to go to if they made a complaint and they felt these would be acted upon. The service had a complaints procedure and we reviewed a recent complaint and how the service had resolved this to the satisfaction of the complainant. This showed there was an effective complaints procedure in place for dealing with formal complaints. On discussion with staff and review of records we found that informal complaints were not recorded and staff resolved these at unit level, to the satisfaction of peopleraising concerns. However, it would be useful to record both formal and informal complaints to analyse for trends and use the information to improve the service.

Good

Is the service well-led?

Our findings

The registered manager described the culture at the service as open and honest where staff were not frightened to speak out and a service which was not looking to blame when there had been discrepancies. They said they operated an open door policy to enable staff to come and discuss any issues. They told us they involved staff in developments in the service and this ensured staff were motivated to improve the service provided. The registered manager in conjunction with the staff produced a team annual business and improvement plan for 2015-2016. This looked at the team's purpose, their core activities and the outcomes and reviewed what had gone well, and not so well in the previous 12 months. This demonstrated staff had been involved in the assessing how the service was operating and meeting the needs of the people using the service and were involved in determining the actions required over the next 12 months to improve the service.

The registered manager shared their vision for the service with us. This was "For people to have the freedom to choose how they want to live their lives and be happy and positive." Staff told us the management of the service was very open and approachable. One member of staff told us they enjoyed working at the service and felt able to raise suggestions for improving the service knowing they would be listened to. They gave the example of a seating area staff had suggested so people using the service could have a relaxing area where they could listen to music. The staff we spoke with told us they were happy at the service and enjoyed their jobs. One staff member told us "I enjoy working with this client group. I find it very rewarding. It can be stressful when the home is full."

The service completed quality audits around different areas and the responsibility for completion was allocated between the registered manager, the deputies and the team leaders. For example, the registered manager undertook each month one hand washing audit, one medication observation audit, one medication and file audit and a staff discussion audit. . They showed us completed audits and explained to us how these audits improvedquality. For example, on their staff discussion they would choose a member of staff and ask them randomly chosen but specific questions which assessed their knowledge, experience, attitude and behaviours. Any concerns identified were actioned which included further training and development or exploration of the issues of concern at the person's supervision sessions.

The home observation audit checked staff were politely seeking verbal consent from people using the service prior to undertaking any form of care and staff were delivering care in a caring and respectful way such as knocking on people's doors and waiting for a response before entering. As we observed this practice during our inspection, this aspect of care delivery had been embedded into the culture of the organisation which respected people's rights to be treated with dignity and respect.

Deputy managers undertook weekly audits around the home, such as file audits , nutrition and hydration observation audits, and a financial audit. Activities and social wellbeing observation audit and health and safety and infection control audit were undertaken once a month. We did note the file audit although detailed focused on whether the correct documentation was in the file, rather than focused on the quality of

the completion of the documentation. The registered manager checked to ensure the deputy managers' audits had been completed and ensured actions were completed once identified. Team leaders were responsible for ensuring one file was audited each day. The outcome of these audits in addition to managerial information and measurement against the CQC Key Lines of Enquiry was inputted by the registered manager into an overall Quality Assurance Framework (QAF) which enabled to registered provider to monitor the quality of the service provided at the home and ensures actions required are completed. This demonstrated the registered provider was effectively assessing and monitoring the quality of the service provided to the people living at Claremont House.

The registered manager told us they felt supported by their service manager but also by the registered managers from the provider's other homes in the area. They met regularly with the service manager and had documented one to one sessions. We reviewed the minutes of the latest monthly meeting in January 2016 between the registered manager and the area manager. These discussions focussed on the management at the service such as managing change, whether appraisal objectives had been met, issues around budget management, staffing issues & recruitment & team performance, service user's audits, quality assessment framework, contracts, and other audits within the service.

The registered manager told us they held meetings on a weekly basis with the deputy managers and they had recently set up a weekly meeting with the team leaders to support change management and the development of the team leader role in regard to improving the quality of the service provided to people using the service. We reviewed the minutes of the latest meeting held on 12 February 2016 with the deputy managers which showed the actions from the previous meetings were discussed to ensure staff were aware of the outcomes of these actions. In addition, these meetings demonstrated the service wasassessing how they were currently performing and where they needed to improve. We also reviewed the two latest team meetings. The meeting in November 2015 focussed on dignity and staff watched a DVD to promote Dignity in Care. The objective of this session was for staff to learn through reflecting on present practice how to improve this, and this should be a continuous process which the registered manager would revisit at future meetings. Staff meetings are an important part of the registered provider's responsibility in monitoring the service and coming to an informed view as to the standard of care and support for people using the service.

In July 2015 the service had sought the views of the relatives of the people using the service. They asked the question "Are We Good enough for Mum and Dad?" 100% of people responded that the physical environment and premises were appropriate to keep people safe. In relation to safe staffing numbers, 20 % of people did not think there were enough staff. Comments included: "On some occasions there are not enough staff". "At times short staffed. I feel staff should be with residents at all times but when two staff take a resident for personal care of hoisting that leaves residents alone." The service received positive responses regarding the deliver of high quality care, respect for peoples preference and choices , staff treating people with kindness and compassion, involving people in the planning of the care for their relative and the service listened and learnt from experiences, concerns and complaints. 100% of people thought the service demonstrated good management and leadership that was visible and available

The registered manager told us how they were using nationally recognised guidance to improve practice and they were working towards Gold Standard Accreditation status for end of life care and one deputy manager was leading in this area. Another deputy manager was leading on infection control as a champion and the service was looking at developing the role of dignity in care champion.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We 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 Medicines were not always stored, managed and administered safely.