Park Homes UK Limited

Claremont Care Home

Inspection report

New Street
Farsley
West Yorkshire
LS28 5BF
Tel: 0113 236 0200
Website: www.parkhomesuk.co.uk

Date of inspection visit: 24 April 2015
Date of publication: 26/06/2015

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

Overall summary

This was an unannounced inspection carried out on the 24 April 2015.

Claremont Care Home is situated in Farsley, Leeds and is easily accessible by car and public transport. The home sits within extensive grounds consisting of lawned areas and a car park to the front. The home can accommodation up to 63 people. Some people were living with dementia.

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.

The care plans we looked at did not contain appropriate and decision specific mental capacity assessments. The applications for the Deprivation of Liberty Safeguards had been carried out; however, people had their liberty deprived illegally.

There were enough staff to keep people safe and staff training and support provided equipped staff with the

Summary of findings

knowledge and skills to support people safely. Robust recruitment and selection procedures were in place to make sure suitable staff worked with people who used the service and staff completed an induction when they started work.

People were happy living at the home and felt well cared for. People's care plans contained sufficient and relevant information to provide consistent, person centred care and support. People enjoyed a range of social activities and had good experiences at mealtimes. People received good support that ensured their health care needs were met. Staff were aware and knew how to respect people's privacy and dignity.

People told us they felt safe. Staff had a good understanding of safeguarding vulnerable adults and knew what to do to keep people safe. People were generally protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines safely. People's physical health was monitored and appropriate referrals to health professionals were made.

The service had good management and leadership. People got opportunity to comment on the quality of service and influence service delivery. Effective systems were in place that ensured people received safe quality care. Complaints were investigated and responded to appropriately.

You can see what action we told the provider to take at the back of the full version of the 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?
The service was not always safe.

We found that medicines were generally managed well; however, we found some areas of concern regarding the management of medicines prescribed for people who had recently been admitted to the home.

There were enough staff to meet people's needs and the recruitment process was robust this helped make sure staff were safe to work with vulnerable people.

People told us they felt safe. The staff we spoke with knew what to do if abuse or harm happened or if they witnessed it. Individual risks had been assessed and identified as part of the support and care planning process.

Requires Improvement

Is the service effective?
The service was not always effective in meeting people's needs.

People were asked to give consent to their care, treatment and support. However, the care plans we looked at did not contain appropriate and decision specific mental capacity assessments. The applications for the Deprivation of Liberty Safeguards had been carried out; however, people had their liberty deprived illegally.

Staff training and support provided equipped staff with the knowledge and skills to support people safely. Staff completed an induction when they started work.

People enjoyed their meals and were supported to have enough to eat and drink. People received appropriate support with their healthcare.

Requires Improvement

Is the service caring?
The service was caring.

People valued their relationships with the staff team and felt that they were well cared for.

Staff understood how to treat people with dignity and respect and were confident people received good care.

Good

Is the service responsive?
The service was responsive to people's needs.

People's care plans contained sufficient and relevant information to provide consistent, person centred care and support.

There was opportunity for people to be involved in a range of activities within the home and the local community.

Good

Summary of findings

Complaints were responded to appropriately and people were given information on how to make a complaint.

Is the service well-led?

Good

The service was well led.

The registered manager and operations manager were supportive and well respected.

The provider had systems in place to monitor the quality of the service.

People who used the service, relatives and staff members were asked to comment on the quality of care and support through surveys and meetings.

Claremont 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.

This inspection took place on 24 April 2015 and was unannounced. The inspection team consisted of two adult social care inspectors, a pharmacy inspector, a specialist advisor in Dementia and nursing and an expert by experience in people living with Dementia and older people. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

At the time of our inspection there were 51 people living at the home. During our visit we spoke with 10 people who lived at Claremont Care Home, eight relatives, 13 members of staff, the registered manger and the operations manager. We observed how care and support was provided to people throughout the inspection and we observed lunch in both dining rooms of the home. We looked at documents and records that related to people's care, and the management of the home such as staff recruitment and training records and quality audits. We looked at six people's care plans and 15 medication records.

Before our inspection, we reviewed all the information we held about the home. We contacted the local authority and Healthwatch. We were not aware of any concerns by the local authority. Healthwatch feedback stated they had no comments or concerns. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe in the home and did not have any concerns.

We spoke with members of staff about their understanding of protecting vulnerable adults. They had a good understanding of safeguarding adults, could identify types of abuse and knew what to do if they witnessed any incidents. They said they would report any concerns to the manager and were confident it would be acted upon. Staff told us if they were not satisfied with the outcome they would escalate their concerns. They said there was a whistleblowing policy and although none of the staff had any experience of using it, they knew the procedure.

Staff we spoke with told us they had received safeguarding training. They said the training had provided them with enough information to understand the safeguarding processes that were relevant to them. The staff training records we saw confirmed staff had received training in 2013 and 2014.

We saw written evidence the manager had notified the local authority and CQC of safeguarding incidents. The manager had taken immediate action when incidents occurred in order to protect people and minimise the risk of further incidents.

Care plans we looked at showed people had their risks assessed appropriately and these were updated regularly and where necessary revised. For example, there were detailed assessments for medication management, moving and handling, falls, skin integrity and nutrition. Of particular note in relation to good practice was the assessment of oral hygiene for a person who was unable to eat or drink. We spoke with this person and what we saw and were told confirmed the person's oral hygiene had been completed. This helped ensure people were supported to take responsible risks as part of their daily lifestyle with the minimum necessary restrictions.

We observed people being moved using a mechanical hoist safely throughout the day. People had individual slings in the home and a staff member who had completed a moving and handling 'train the trainer' programme. We noted in two care plans there was a 'Do Not Resuscitate' order. We spoke with staff who knew which people these were for and what it meant.

We saw people had personal emergency evacuation plans so staff were aware of the level of support people living at the home required should the building need to be evacuated in an emergency. We spoke with the handyman who confirmed there were systems in place to ensure the home was maintained in good order and tests for fire, electrical and water safety and temperatures were undertaken and recorded. We saw the home's fire risk assessment and records, which showed fire safety equipment was tested and fire evacuation procedures were practiced. We saw that emergency lights and small electrical item checks had been completed. Staff knew the fire assembly area and told us the fire alarms were tested weekly and there had been a recent fire evacuation test.

There were several health and safety checks carried out, for example, room safety, window restrictors, trip hazards and water temperatures. The operations manager told us safety checks were carried out around the home and any safety issues were reported and dealt with promptly. However, whilst walking around the home we noticed several fire doors on the corridors were left open even though they had signs saying 'keep closed at all times'.

We found staffing levels were sufficient to meet the needs of people using the service on the day of our visit. We found that team leaders did not always direct staff which meant that sometimes the service delivery was a little chaotic, especially during meal times and tea rounds. Staff did not always seem to have clear direction about who was doing what tasks. Staff told us they felt they needed a good bank staff team to cover for sickness and holiday as it was often hard to find staff to cover shifts. The registered manager told us they would look at how staff were deployed and their activities.

On the day of our visit the home's occupancy was 51. The registered manager told us the staffing levels agreed within the home were being complied with, and this included the skill mix of staff. The people who lived at the home and their relatives all felt there were sufficient staff to provide the care services that were required.

We found recruitment practices were safe and relevant checks had been completed before staff had worked unsupervised at the home. This helped to ensure people who lived at the home were protected from individuals

Requires Improvement

Is the service safe?

who had been identified as unsuitable to work with vulnerable people. Disciplinary procedures were in place and this helped to ensure standards were maintained and people kept safe.

We found that medicines were generally managed well; however, we found some areas of concern regarding the management of medicines prescribed for two people who had recently been admitted to the home.

We spoke with the registered manager and two nurses about the safe management of medicines in the home. We also spoke with two care staff about how creams and nutritional supplements were used. We observed medicines being prepared and administered at different times of the day and spoke with two people who lived in the home about their medicines. We reviewed records including Medication Administration Records (MARs) and other records for 15 people living in the home.

Medicines were stored safely and were locked away securely to ensure they were not misused. Most medicines could be accounted for easily as printed records were clear and accurate and we saw there were adequate stocks of each person's medicines available. This meant we were able to be sure people had been given their medicines correctly. Having good stock control helps to reduce the amount of medicines stored and potentially wasted.

We saw nurses supporting people to take their medicines safely, whilst respecting and meeting each person's individual needs and preferences. For example, one person did not wish to take some of their medicines at the time they were offered. The nurse respected this person's wishes and returned later when the person was ready and happy to take them. We spoke with one person who told us they were happy with the way they were given their medicines and felt able to ask for any support they needed.

Many people were prescribed creams or medicines, such as painkillers, that were to be taken only 'when required'. There was clear guidance detailing how these products should be used to enable nurses and care workers to support people to take their medicines safely whilst having due regard to people's individual needs and preferences.

We looked at the medicines and records for two people who had recently been admitted to the home. Both people were prescribed controlled drugs, although these had not been stored and recorded correctly on receipt. On pointing this out, the nurse on duty immediately responded making the necessary records and ensuring the medicines were stored correctly. We also saw for one of these people, not all the medicines had been recorded on their MARs. This meant some of the medicines had been administered had not been recorded. Again, nurses took immediate action to rectify this.

Medicines were only handled and administered by nurses, although trained care workers were generally responsible for applying and recording creams. One care worker told us about the system for applying and recording creams and added that nurses often checked whether the care workers had applied creams correctly.

The registered manager used an audit tool to carry out regular checks to determine how well the service managed medicines. We saw evidence where concerns had been identified, action had been planned and carried to further improve medicines management within the home.

Requires Improvement

Is the service effective?

Our findings

Some of the staff we spoke with did not fully understand their responsibilities or the implications for people who lived at the home in regards to the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards applications. For example one staff member told us, "I am not up to date with my training." Two staff told us they had received no training on these subjects and were unsure of how this subject was dealt with at the home. Another staff member told us they had received training in 2013. None of the staff we spoke to knew if anyone living at the home was under a Deprivation of Liberty Safeguards order. The training records we looked at showed staff had completed Mental Capacity Act training in 2013, 2014 and 2015. However, two staff had not completed the training since 2012 and 11 of the 55 staff were still due to complete it.

However, during our visit we observed staff gaining permission from people before they performed any personal care or intervention. We saw evidence in the care plans that people or their relatives had given consent for their photograph to be taken, to the sharing of their information and their involvement in their care and treatment.

We looked at care plans and saw they contained a mental capacity care plan. We found the home was assessing people's capacity very generally and that assessments were not decision specific. This meant that we could not be sure people who used the service were being given appropriate choices. One care plan we looked at stated the person had full capacity to make choices in their lives. However, on a monthly evaluation that was completed, it was documented the person did not have capacity to make more complex decisions. We were not able to see that a decision specific capacity assessment had been completed and staff did not appreciate capacity had to be considered on a decision by decision basis.

One person's care plan stated the person had 'full capacity'. The care plan detailed the person could not understand decisions relating to their care. It was unclear how the home had concluded this as no specific capacity assessments had been completed. The care plan had not been evaluated since February 2015.

In one person's care plan there was some confusion in relation to communication, capacity and cognitive ability. For example, in the Deprivation of Liberty Safeguards tick box assessment they were considered to be able to communicate their need, whilst in the care plan under capacity they 'were unable to make decisions'. In the care plan for communication they could 'make their needs known' and in the plan for cognitive ability it stated 'choices and preferences respected'.

The care plans we looked at did not contain appropriate and decision specific mental capacity assessments which would ensure the rights of people who lacked the mental capacity to make decisions were respected. This is a breach of Regulation 11; Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they were referring Deprivation of Liberty Safeguards applications to the local authority. These were being sent every month slowly at the request of the local authority. We saw evidence of these applications within care plans. However, on the day of our visit we noted that one person was been closely monitored by staff. Staff told us this was because the agency care worker was on a break. We observed the person was agitated and attempting to walk. Staff put the person into a chair and reclined it so the person could not get up. We observed the person was trying to climb out of the chair and was becoming unsafe. Staff kept moving them back up the chair and ignored their behaviours. There was no Deprivation of Liberty Safeguards application in place for this person. The staff had not considered that using the chair in the reclining position was a form of restraint and deprived the person of their liberty as it prevented them from freely moving out of the chair.

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

We looked at a care plan for a person who had behaviours that challenged and spoke with staff about how they managed this at the home. Staff told us they used different distraction techniques and recorded when incidents occurred so they could monitor to see if any particular triggers were evident. We saw records of these observations within the care plan and there was guidance available for staff on how to manage particular issues.

We looked at staff training records which showed staff had completed a range of training sessions. These included fire training, infection control, food hygiene, Dementia awareness and pressure care. Staff told us they had been

Is the service effective?

supported to undertake a variety additional training such as medication management and diabetes, as well as the mandatory updates in relation to moving and handling, food hygiene, health and safety at work and infection control. We saw from the training records some training courses were only scheduled to be completed once by staff members. For example, safeguarding, Mental Capacity Act (2005) and Dementia awareness. However, we saw from the training planners for weeks commencing 27 April 2015, 4 May 2015 and 11 May 2015 that several training course were due to be completed which included safeguarding, pressure care and Dementia awareness. The training records did indicate staff received regular training but it was not clear how often the training was required from the records.

During our inspection we spoke with members of staff and looked at staff files to assess how staff were supported to fulfil their roles and responsibilities. We found they were either group supervisions or topic specific. We saw a supervision schedule was in place for 2015. We had a mixed response from staff when we asked about supervision and appraisal. Whilst most of the staff we spoke with could recall they had supervision and appraisals, some told us they had not received either supervision or an appraisal, whilst others were unsure or uncertain. We looked at the staff supervision records and found the supervisions were not based on the individual staff member's training and development requirements. We saw an appraisal plan for 2014/2015 and saw that the majority of staff had received an appraisal in 2014. However, the registered manager told us that not all staff had a current appraisal. The registered manager and the operations manager told us they would look at the supervision process.

People we spoke with told us the food was nice. One person said, "It's okay, but a bit bland. I liked the gammon the other day, that was lovely, but often it lacks flavour. I asked if I could have curry one day and they brought me one. That was really nice." One relative said, "It's extremely clean, and the food is good. There's never a smell, and some places really smell, don't they."

We observed the breakfast and lunch time meals. Staff were responsive to people's needs and choices were offered. Breakfast went on until after 11am, however, we spoke with people who told us they liked to eat a later breakfast. One person told us "I can have breakfast as late as I want, there is no rush." We saw staff assisting people to eat and they explained what they were doing and they encouraged people to eat and drink in good amounts. We observed a member of staff supporting one person who wished to stay in their room to eat breakfast. We noted staff chatted to the person and this was amiable and respectful and the person appeared to be enjoying their breakfast.

We saw during the lunch time meal in one dining room staff appeared a bit disorganised at first but did split themselves up between the tables and the meal became a little more settled. We did note that some people waited for ten to fifteen minutes before they were asked what they wanted. In another dining room we saw people were being brought in to the area and left with little or no interaction for twenty five minutes before food was served. For example, two people were left for thirty and fifty minutes before they were supported to have their meal. Again the staff initially appeared disorganised. The registered manager told us they would look at this immediately.

We saw one person who was unable to consume their food orally, was sat in the lounge overlooking the dining room where they could smell the food and watch other people eating. When we asked this person how they felt about that they told us, "I have got used to it." We also asked them if they have chosen to sit near the dining room and they said, "No." We looked at their care plan and could see no evidence that this aspect of their care had been considered. The registered manager told us they would look at this immediately.

The tables in the dining room were set with tablecloths, cutlery glasses and paper napkins. We saw some people ate their meal in the dining room, other people choose to eat in their room or the lounge area. We saw a four week menus offering a wide choice of food was displayed on the lounge wall and in the entrance to the home. However, we noted this was in small print and not easily accessible for people. When we asked people what was for lunch they replied, "I haven't got a clue."

People's nutritional needs were assessed during the care and support planning process and we saw people's likes, dislikes and any allergies had been recorded in their care plan.

Requires Improvement

Is the service effective?

Throughout the home, especially the lounges, we saw there were jugs of juice and bowls of fruit and assorted snacks available all the time. There were also tea trolleys circulating throughout the day. One person told us, “We can help ourselves; there is always plenty on offer.”

We saw evidence in the care plans and were told by relatives that their family members had received support and services from a range of external healthcare professionals. These included GP, community nurses, dentists, opticians and dieticians. We saw when professionals visited, this was recorded and care plans were changed accordingly.

We saw when a referral was identified by staff as being needed; this was made swiftly and without delay.

The operations manager told us the home was scheduled to undergo a refurbishment and they said thought was been given to people’s needs and to dementia friendly décor, signage and fittings during this process.

Good

Is the service caring?

Our findings

We observed staff spoke with people in a caring way and supported their needs. We saw staff responded to people swiftly and respectfully when they asked for things such as going to the toilet or wanting a drink. We observed the interactions between staff and people were unhurried, friendly and sensitive. Staff appeared to know people well. We observed a number of movements by hoist, and these were done with two staff, talking to the person throughout. Relatives told us they were fully involved in planning of their family members care and were actively encouraged to be involved in activities.

Relatives were coming and going throughout the day without restriction. One relative told us that on the first day her mum, dad and herself had had a meeting with the manager to discuss the care package and preferences.

People we spoke with told us they liked the staff and felt comfortable with them. They said they were, “Very happy” and the care staff were, “Very good.” One person said, “It's very good. The staff are nice and well qualified. They know what they're doing.” Another person said, “I have made lovely friends here.”

One relative told us their father had been in several places and had visited around twenty homes before finding Claremont. They said, “They have made us all feel very welcome. It's just lovely. They're helping him keep as independent as he can be, and he's come on in leaps and bounds. It's the best he's been in twelve months, and it's all down to them.”

Another relative told us they felt fully included in the life of the home. They said, “It's such a relief. I can't tell you. He gets involved in some of the things that go on. He wanted us all to come to the Easter event. It was a lovely day. In the other place, he was so distressed all the time. Now he never asks to come home any more. He's so settled. I've never come and not been able to talk to someone. They've taken time to get to know him. He's always clean. It never smells here. He couldn't accept to be washed by a woman, so a male staff member washes him every time. They all know him and they treat him like, well, you know, like a person. We're all over the moon with this place.”

During the morning, we heard one person shouting very loudly and swearing at a member of staff who was helping them prepare for the day. The member of staff remained calm and after a couple of minutes another member of staff joined them. The member of staff was also sworn at repeatedly. They also remained calm and the first member of staff came out of the room to fetch a towel. We asked them if this person was often agitated, they said, “Oh yes, but only in the morning. She doesn't like having her personal care done. She'll be fine once she's dressed. It's not a problem.” The member of staff was not perturbed by this behaviour.

The home operated a key worker system for the people who used the service which was in the process of being updated to reflect staff turnover. When asked, the care staff explained although there was no extra time allocated for this role, it involved mainly ensuring a person’s personal effects and supplies were in order and liaising with their relatives.

We saw people were able to express their views and were involved in making decisions about their care and support. They were able to say how they wanted to spend their day and what care and support they needed. The premises were spacious and allowed people to spend time on their own if they wished.

Staff treated people with dignity and respect. They had a good understanding of equality and diversity and we saw support was tailored to meet people’s individual needs. However, we noted within the lounge areas lots of people required a hoist to move them from one seat to another. We saw staff did this safely but due to the large amount of people within these communal areas, the home may need to find a way that would help maintain people’s dignity. The registered manager told us they would look at this immediately.

Good

Is the service responsive?

Our findings

We saw the provider undertook pre admission assessments before people moved into the home. This ensured the service could meet the needs of anyone in their care. We found care plans were detailed and contained information that staff needed to provide effective and kind care. One staff member told us, “We are encouraged to read the plans so we know all the information that’s written in them.” One person who had newly arrived in the home told us, “The manager had come to visit me at home prior to me moving in and my daughters had visited Claremont several times and asked lots of questions before deciding that's where I would move into.”

We saw life history information was collected and recorded within care plans. This contained information about past work, history, likes and dislikes that would enable staff to provide person centred care. We saw additional care plans were put in place for short term needs such as an infection. Care plans were well written, comprehensive and personalised. Regular reviews were undertaken. Care staff told us they contributed to the reviews and maintained daily records of peoples’ care. We saw people personalised their rooms and there was a wall chart they or their relatives could complete which contributed to the specific information about their family members and preferences that helped deliver personalised care.

We saw from the care plans we reviewed that appropriate assessments of care were undertaken, reviewed and adjusted to the changing needs of the people in the home. The evaluations of care were informative and outlined the changes in people’s condition and the consequent changes required to their personal care or medication. Care staff told us they had shift handovers and a communications book they used to keep staff informed of any planned appointments or events that needed to be considered when delivering care for particular days.

During lunch one person complained of having a headache. A member of staff offered to call a nurse. At first the person declined, so the member of staff said “I know you don't like nurses, but I'll call you a really nice one.” The nurse was duly called and the person was given some pain killers. They said they wanted to go outside for some fresh air and they were supported to go outside by another member of staff.

We observed a person who needed assistance with eating and drinking. The person did not appear to like the drink, however, was not able to verbalise this. We noted the staff member picked up on this, reassured the person and sought an alternative drink the person then enjoyed.

The registered manager told us people living at the home were offered a range of social activities. We saw information on a noticeboard for up and coming events at the home in the entrance. These included baking, games, cinema experience, coffee morning, flower arranging and outings. We saw there was a regular outing for a pub lunch and a monthly trip to the local church, plus a visit from the church one Wednesday per month. There had been a number of events such as an Easter party, birthday parties, events around major sports events such as the FA cup and Rugby six nations. Which have included BBQs, strawberry teas, coffee mornings, visiting singers and a regular visit from Music for Health. There were also various quizzes and games afternoons. The activity coordinator told us she tried to encourage relatives to attend also. The activity coordinator was enthusiastic and they said they always visited new people as soon as possible to find out what their likes and dislikes were and encouraged them to become involved in activities.

One person told us they used to play the violin, but they said they didn't play anymore and he did not have the violin with him. We were told by the registered manager they were a lead violinist, but they did not play any longer, and their family wished to keep the violin for sentimental reasons.

Visitors we spoke with told us they had been included in discussions about their relative's care, they were aware of the relatives and residents meetings and they were actively encouraged to join in with activities.

However, on the day we visited we saw limited evidence of any meaningful involvement or activity with some people. We observed a game of dominoes with four people on the patio but people were not able to remain engaged in activity. The operations manager told us they were looking at training for activities for people living with Dementia and involving people in life tasks.

The staff we spoke with told us they would report any concerns or complaints made by people who used the service to either a senior carer or to the manager.

Good

Is the service responsive?

People told us they felt comfortable raising concerns with staff and particularly with the manager and several people told us the manager was extremely approachable. We saw the complaints procedure displayed in the entrance to the home.

Relatives we spoke with had made complaints to the manager regarding the laundry arrangements. One person had made a complaint about their relatives' laundry. For example, when their relative was found dressed in clothes that had not been properly ironed and when their clothes were not properly stored in their room. The manager had apologised about some jumpers that were ruined. They came in with three dozen knickers and they are down to five. They keep losing her hearing aids and her bottom teeth have been missing for some time. They said, "I've brought all these issues up with the manager and at residents and relatives meetings."

Other relatives told us a significant number of the people's clothes had 'disappeared' and could not be accounted for. They had also complained their relative had been dressed in somebody else's clothes and despite continued requests items of undergarments had been omitted when staff dressed their relative. Three relatives we spoke with had not been satisfied these issues had been resolved and indeed they continued to experience problems in relation to their relative's clothing going missing despite the fact they had all been clearly labelled. The registered manager told us they had previously looked at laundry situation but would look at this again.

Relationships with friends and families were actively encouraged through an open visiting policy, and encouragement of friends and families to join in with activities and events at Claremont.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection the manager was registered with the Care Quality Commission. The registered manager worked alongside staff overseeing the care given and providing support and guidance where needed. They engaged with people living at the home and were clearly known to them.

People who used the service and visiting relatives said they felt comfortable and at ease discussing issues and care packages with the registered manager. One person told us, “She's lovely. So helpful.”

The home was very busy with a range of people who were relatively independent to those that were highly dependent either because of their physical impairment or because of the degree of cognitive and social disability. Despite this there was an unhurried, open and welcoming atmosphere in which people lived and relatives visited at their convenience.

Staff spoke highly of the registered manager and said they were very approachable and supportive. They said they were kept informed of all changes that were appropriate to them and their role. One staff member said, “Management is good here.” Another staff member said, “Very helpful and supportive.” Other comments included, “Nice and approachable”, “Really good”, “The manager is very supportive, she makes this home” and “The manager is very approachable.” Staff spoke were happy working at the home. They told us most people work well together and staff were really good. One staff member said, “I love my job.” Another staff member said “It is a great place to work.” One member of staff told us, “I am here for the people.”

The registered manager told us they monitored the quality of the service by monthly quality audits, daily walk rounds, resident and relatives’ meetings and talking with people and relatives. We saw a monitoring visit report for March 2015 which included premises, events, complaints and infection control. We also saw audits in place for catering and medications. We saw evidence which showed that any actions resulting from the audit were acted upon in a timely manner. The service employed a maintenance person who carried out all the health and safety checks. This meant the service identified and managed risks relating to the health, welfare and safety of people who used the service.

The environment was spacious and clean and the operations manager told us the home had a refurbishment plan in place and this would include new signage and reminiscence corridors. They said they were scheduled to complete an audit for Dementia in care homes by the end of May 2015, which would feed into the refurbishment plan.

Staff told us they had regular meetings and we saw a notice on the door leading to the staff room, which displayed the dates of the planned meetings for the year. We saw staff meetings included nurse’s meetings and all staff meetings. We saw the minutes from the March 2015 meetings which included shift patterns, handover, care plan updates, audits and documentation. Staff said they could contribute to the agenda and had no difficulty in raising any concerns they might have with the manager.

Relatives told us they had discussions with the manager and were aware that regular meetings occurred. However, some people told us that as the meetings were always in the evening they found these difficult to attend. They had completed a questionnaire in relation to the quality of the services provided to their relative. We saw resident and relative meetings were scheduled for 2015, outlining meetings every two months. People who used the service said they were aware of meetings. We looked at January and March 2015 meeting minutes which showed areas of discussion included flooring, kitchen, care plan reviews, advanced care planning and activities. We saw resident and relative quality assurance survey analysis for January to March 2015 displayed in the entrance to the home which showed results of good, very good and excellent to arrange of questions asked.

Records showed the registered manager had systems in place to monitor accidents and incidents to minimise the risk of re-occurrence. The registered manager said that a record was kept in people’s care plan and lessons learnt were recorded. We saw the lessons learnt from accidents, incidents and complaints were feedback to staff during handover and a record was kept of the handover discussions. Staff we spoke with said they knew what to do in the event of an accident or an incident and the procedure for reporting and recording any occurrences. We saw safeguarding referrals had been reported and responded to appropriately.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The care plans we looked at did not contain appropriate and person specific mental capacity assessments, which would ensure the rights of people who lacked the mental capacity to make decisions were respected.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The applications for the Deprivation of Liberty Safeguards had been carried out; however, people had their liberty deprived illegally.**