

Park Homes (UK) Limited

Claremont Care Home

Inspection report

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15 April 2021

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

About the service

Claremont Care Home can accommodate up to 63 people who require support with nursing or personal care needs. At the time of our visit, 55 people were living at the service. Claremont Care Home is situated in Farsley, between Leeds and Bradford.

People's experience of using this service and what we found

The registered provider did not have effective governance systems in place to maintain and improve the quality and safety of the service. Analysis of accidents and incidents were brief in detail and did not show clear evidence patterns or trends were being identified. We found quality assurance audits did not cover all areas relating to the quality and safety of service provided and there were no clear lines of accountability for progressing actions arising from audit findings.

Care plans were inconsistent, and we found some care plans were not accurate. People were not being weighed as frequently as directed by their care plan. One relative said, "Well [name of person] is very thin now. I don't know if they weigh her or not because they haven't said." We found records of food and fluid and re positioning charts were inconsistently recorded as well as what pressure relief was required. We fed this back to the registered manager and nominated individual.

The home was clean, however, we found cleaning documentation was not been being completed by staff in full. We spoke to the registered manager about this. They told us they were working with the infection control prevention team in addressing this. We observed staff on the first day of inspection touching their masks or having masks under their chin. We spoke to these staff on inspection as well as the management team. On day two of the inspection we saw improvements in this, and all staff were wearing their PPE appropriately.

We saw maintenance of the building was underway and an action plan was in place to support this. Most actions had been completed.

On the whole people received their medicines as prescribed. We found some areas of improvement were needed which was fed back to the nurse and registered manager on the day of inspection. For example, not all protocols had been updated for prescribed medication. The nurse was in the process of completing these at the time of our inspection. People, relatives and staff felt there was enough staff. Staff told us it was hard when other staff called in sick or were on annual leave. We observed people's needs were met in a timely manner during the inspection.

People we spoke with told us they felt safe and staff had a good understanding of how to safeguard adults from abuse. One staff member said, "I would contact my manager straight away. I know this would be dealt with." Safe systems of recruitment were followed to ensure staff were safe to work with vulnerable people.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection

The last rating for this service was good (published September 2017).

Why we inspected

This inspection was prompted in part due to concerns received about staffing levels, environment, record keeping, and overall management of the service. A decision was made for us to inspect and examine those risks. We found evidence during this inspection that people were at risk of harm from some of these concerns, however, we did not find evidence that harm had occurred.

This report only covers our findings in relation to the key questions of safe and well-led which contain those requirements and concerns. We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance the service can respond to coronavirus and other infection outbreaks effectively.

Prior to the inspection we reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

We found evidence the provider needs to make improvement. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Claremont Care Home on our website at www.cqc.org.uk.

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service.

We have identified breaches in relation to people's safety, infection control and governance at this inspection.

Follow up

We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and the local authority and clinical commissioning group to monitor their progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Requires Improvement ●

Is the service well-led?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Claremont Care Home

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

This inspection was carried out by two inspectors, a specialist advisor specialising in governance and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

Claremont Care home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was unannounced. Inspection activity started on 24 March 2021 and ended on 15 April 2021. We visited the home on 24 March and 1 April 2021.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and health commissioners. The provider was not asked to complete a provider

information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this information to plan our inspection.

During the inspection

We spoke with two people on the phone who used the service about their experience of the care provided. We spoke with 11 relatives on the telephone. We spoke with 10 members of staff including the nominated individual, registered manager, operations director, clinical lead, a nurse, housekeeping and care staff. We reviewed a range of records during and after our visit to the home. This included six people's care records and multiple medication records.

After the inspection

We continued to seek clarification from the provider to validate evidence found. We looked at maintenance, risk assessments and quality assurance records including policies and procedures.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management

- Risks to people's safety were not always assessed and recorded. Some people's risk assessments did not contain clear information to support staff to reduce identified risks safely. For example, moving and handling risk assessments did not always show what type of sling to use and one person who was known to have seizures had no risk assessment in place.
- People were not being weighed as frequently as directed by their care plan. Where people were required to be monitored hourly these checks were not consistently recorded.
- We found food and fluid charts were not always completed in full. We could not always determine how much people should be drinking daily.
- We observed one person who had footwear on which was too big and kept slipping off. The risk management plan stated, '[name of person] is at risk of falling and is unsteady on their feet'. The care plan had conflicting information in regarding the persons mobility.
- We spoke with staff about people's current risks and the recording of these. One staff member said, "We want to support people in the safest way possible. We do not rush things; we do things right. I feel we give 100% if not, I would not work here. We all know people very well."

We found no evidence people had come to harm; however, the provider had failed to ensure people's safe care and treatment and also failed to access the risk of the spread of infections. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We observed good moving and handling techniques by staff in the service. Staff were observed communicating with people while supporting them.
- The building was properly and securely maintained.

Preventing and controlling infection

- We were somewhat assured the provider was using PPE effectively and safely. We found on day one not all staff was wearing masks appropriately. Some staff had their masks under their chin, while others were consistently touching these and not replacing the mask in line with current guidance. We found significant improvements on day two with staff wearing masks appropriately.
- Relatives and people told us staff wore masks when they visited their relative in the home.
- We found the home was clean, however, records in relation to cleaning tasks were inconsistent. The registered manager told us they were working alongside infection control on a pilot document to improve

these.

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

Staffing and recruitment

- Appropriate recruitment checks were carried out such as requesting disclosure barring service (DBS) checks, carrying out interviews and obtaining references from previous employers.
- Through observation and looking through staff rotas there were enough staff to care for people safely and the feedback from staff, relatives and people living at the home were that current staffing levels were mostly ok. We spoke with the registered manager and nominated individual about the deployment of staff. A member of staff said, "It does get busy especially when staff call in sick, but I don't feel anyone is at risk." Another staff member said, "I feel it is bad there are not enough to do the job, however, service users are not neglected." A third staff member said, "I feel there is enough staff yes." A relative said, "Yes, there always seems to be staff around when I call."

Systems and processes to safeguard people from the risk of abuse

- Staff had completed safeguarding training. Staff were aware of what abuse was and how to report this. Staff knew people well in the home.
- People and relatives, we spoke with told us they felt safe at Claremont Care Home. One person said, "Oh yes, I feel safe. A lot of people are here, so I feel better." A relative said, "Yes, because I speak to [name of person] on facetime and [name of person] likes the staff. [Name of person] gets on well with them, they are very kind." Another relative said, "Hard to answer really as I have only had two visits."

Using medicines safely

- Medicines were ordered, stored, recorded and administered safely. During the inspection we looked at five medication charts which were all completed accurately with no missing signatures by staff.
- We found 'as required' (PRN) protocols in place and at the time of inspection the nurse was actively updating these.
- Medicines were stored in secure trollies, within a locked room. which both were locked when not in use. A medicines fridge was also used, some room temperature checks had not been taken place, this was addressed with the nurse who was going to address this.
- People and relatives, we spoke with felt their medications were given on time. One relative said, "The nurses take care of that, they go see [name of person] on a night to make sure he takes his medication."

Learning lessons when things go wrong

We have referred to this in the well led section of the report.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care, Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- Quality assurance systems were not always effective in identifying and resolving issues in a timely way.
- The provider did not always ensure action was taken to mitigate risks. For example, some people had missing risk assessments and out of date care plans. Care planning training for staff had been identified by the registered manager, although, this had not been actioned.
- The registered manager recognised there was work to be done in relation to improving the standard of care records and this would be a priority moving forward.
- Feedback was sought from staff, people and relatives, however, there was no date on the survey as to when this had taken place nor was it clear how many people or staff had responded to the survey. There was no associated action plan to address areas any covered.
- Accident or incidents were recorded, however, there was limited evidence to suggest lessons were learned as the manager's analysis of incidents was brief and didn't refer to identified patterns or trends.

We found no evidence that people had been harmed, however, systems were either not in place or were not robust enough to demonstrate risks were effectively managed and complete and contemporaneous records were in place in respect of each person. This placed people at risk of harm. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed views in relation to communication. One relative said, "We have had no contact with the home, only if I ring and ask how [name of person] is doing then they tell you." Another relative told us, "Yes, I have contact with the home on facetime. Every time I see [name of person] they are always happy."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- People we spoke with were happy with the care. One person said, "The staff are lovely." Relatives we spoke with, overall were happy with the care their relative received. One relative said, "The staff are approachable and so is the manager." Another relative said, "I would recommend the home. They are normal and very friendly. I know quite a few of them now." However, another relative said, "I think they could do better because I know there are better homes."
- Staff told us the registered manager was approachable and supported them in their role. One staff

member said, "My manager is great, she works really hard and supports all the staff in and outside work." We spoke with the registered manager around some concerns raised by staff about the management team. This was been addressed.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider and management team understood their responsibilities and acted on the duty of candour.
- The rating from the last inspection was on display in the home.

Working in partnership with others

- The management team worked in partnership with community professionals and organisations to meet people's needs.

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 will check that this action is taken by the provider.

| Regulated activity | Regulation |
|--|---|
| Accommodation for persons who require nursing or personal care | <p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>We found no evidence people had come to harm; however, the provider had failed to ensure people's safe care and treatment and the risk of the spread of infections in relation to regulation 12.</p> |
| Regulated activity | Regulation |
| Accommodation for persons who require nursing or personal care | <p>Regulation 17 HSCA RA Regulations 2014 Good governance</p> <p>We found systems were either not in place or were not robust enough to demonstrate risks were effectively managed, maintained securely and accurately, complete and contemporaneous records in respect of each person. This placed people at risk of harm.</p> |