Abreu Limited

# Claremont House

## Inspection report

Lovent Drive
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Tel: 01525852628

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

| | |
|---|---|
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Requires Improvement |

# Summary of findings

## Overall summary

This inspection took place on 6 January 2017 and was unannounced. We last inspected this service on 14 and 15 July 2016 and found that improvements were required to ensure people were safe and that their care was effective and caring. Improvements were also required in the way the service was managed.

Claremont House is a residential home in Leighton Buzzard, providing care and accommodation for up to sixteen older people who require personal care. There were fourteen people living at the home at the time of our inspection, some of whom lived with dementia.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People who lived at the home were safe because improvements had been made in the management of their medicines and in the way infection control was managed. Improvements had also been made in the staffing levels and there were now enough staff to meet people's needs. Staff were trained in safeguarding and they knew how to keep people safe from avoidable harm. There were risk assessments in place to manage risk posed to people and the provider had robust policies and procedures for the safe recruitment of staff.

There were also improvements in the support that staff received in that there were now regular supervision meetings and appraisals of staff's performance. Improvements had also been made in the management and understanding of the Mental Capacity Act 2005 and the associated Deprivation of Liberty. We found that staff were trained, skilled and understood their roles. They received an induction into the service at the start of their employment and supported people to eat a healthy and balanced diet.

People's care needs had been identified prior to them living at the home, and appropriate care plans were in place to ensure that their needs were met in a consistent way. People's care plans were reviewed as appropriate and they were supported in a personalised way by staff that were caring and friendly. Staff respected people's privacy and dignity.

We found that improvements had been made in the way the service was managed, and in the quality of the service. There was a new registered manager in post, and they and the staff team were knowledgeable in their roles and responsibilities. There was also an improved quality assurance system in place to monitor and manage the quality of the service provided and in addition, the provider had an effective system in place for handling complaints. However, improvements were still required around the management of records particularly risk assessments. People's personal risk assessments did not conform to current health and safety guidance on risk assessments. The environmental risk assessments were also not robust because they did not contain sufficient detail to guide staff on managing risk.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

There were enough staff to meet people's needs.

Staff were trained in safeguarding and they knew how to keep people safe from avoidable harm.

The provider had robust policies and procedures for the safe recruitment of staff.

There were risk assessments to manage risks posed to people.

People's medicines were managed appropriately.

### Is the service effective?

Good

The service was effective.

Staff were trained and they were knowledgeable about people's care needs. They had received an induction when they stared working at the service, and were supported by way of regular supervision and appraisals of their performance.

The requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were being met.

People were supported to access other health and social care services when required.

### Is the service caring?

Good

The service was caring.

Staff were kind and caring in their interactions with people who lived at the home.

Staff were respectful of people's dignity and privacy.

### Is the service responsive?

Good

The service was responsive.

People were supported in a personalised way.

People's care needs had been identified before they started using the service.

Appropriate care plans were put in place to manage people's care needs .

There was an effective system in place for handling complaints.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

People's personalised risk assessments did not conform to current health and safety guidance on risk assessments, and the environmental risk assessments needed to be more robust.

There was a new registered manager in post.

Improvements had been made in the quality of the service in comparison to our last inspection.

Both the staff team and the new registered manager were knowledgeable in their roles and responsibilities.

There was a new and improved quality assurance system in place to monitor and manage the quality of the service provided.

# 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 6 January 2017 and was unannounced. It was carried out by one inspector 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. The expert had experience of caring for older people who use regulated services such as this one.

Before the inspection, we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law. We reviewed the report of our previous inspection and spoke with the local authority's contracts monitoring team who carry out regular audits of services to gather feedback.

During the inspection, we spoke with six people who used the service and a relative of a person to gain their feedback about the quality of care provided to them. We also spoke with two members of the care staff, the deputy manager, the cook, the administrator and the registered manager.

We observed how care was provided and reviewed the care records and risk assessments for three people who lived at the home. We looked at three people's medicines and medicines administration records, and three staff recruitment, training and supervision records. We also reviewed the action plan from our previous inspection and looked at information on how the quality of the service was monitored and managed.

Good

# Is the service safe?

## Our findings

During our last inspection we found that the service did not have adequate measures to ensure the safety of people who lived there. Improvements were required in the staffing levels as there was not always sufficient staff to meet people's needs, people's medicines were not managed safely and the environment was unclean and not adequately maintained. We found during this inspection that improvements had been made and there was ongoing work to fully address the concerns we raised at the time of our last inspection.

One of the improvements made was around the staffing levels and the way that staff were deployed. There were four members of staff supporting people every morning and three members of staff in the afternoons. In addition, there was a member of staff responsible for cleaning the home and another responsible for laundry, and a cook. This staff ratio was what we found on the day of our inspection and was confirmed when we reviewed the roster. People told us that the staffing levels adequately met their care needs, and that staff responded quickly when they called for help. One person said, "Yes there is enough staff. I very rarely ring my bell but they have responded very quickly to me when I have." Another person told us, "There is enough staff, I have a bell but I have never used it. They're very kind girls [staff]." Members of the staff team's views were similar to that of the people we spoke with. One member of staff told us, "We have four [members of staff] in morning and three in the afternoon and that is plenty. It is working well, there is no pressure. We would like more permanent staff instead of agency. We are recruiting and want to get the right people. Some people have been interviewed but they were not taken on because they wouldn't fit in here."

The provider had an effective recruitment policy in place to support the recruitment of new staff. We reviewed the recruitment records for three members of staff and found that the required pre-employment checks had been carried out. These checks included identity checks for new staff, employment history checks and verification of their previous experience, and health checks to ensure new staff were fit for the role they were considered for. The provider also obtained references from previous employers and completed Disclosure and Barring Service (DBS) checks. DBS helps employers make safer recruitment decisions and prevents unsuitable people from being employed.

People told us that they were safe living at the home. One person said, "Yes I do feel safe, there is nothing to be frightened of here." Another told us, "I feel safe here because there's everyone around me. Some staff are nicer than others, but on the whole I can't complain." The relative we spoke with told us, "I know [Relative] is safe here, she can't wander off." One member of staff said, "[People] are definitely safe. Since the last inspection a lot of improvements have been made to make sure they [people] are kept safe."

The provider had an up to date safeguarding policy that gave guidance to the staff on identifying and reporting concerns relating to people's safety. Staff had received training on safeguarding people. They understood the different types of abuse and the signs that could indicate that someone was at risk of possible harm. A member of staff we spoke with told us, "Yes, I have done the safeguarding training. We did it in May [2016] and we [refresh] all our training every year." When asked how they would go about reporting concerns relating to safeguarding and to whom, a member of staff told us, "If I witnessed it [abuse] I will note

it all down and report it to [registered manager] and see what she recommends. We will report to safeguarding [local authority] and the CQC [Care Quality Commission]. We raised a safeguarding alert after [recently]. [They] are in our care at the end of the day and we don't like to see that."

The provider also had a whistleblowing policy that provided staff with a way in which they could report misconduct or concerns within their workplace without fear of doing so. Staff were aware of this and understood their responsibilities within it. We saw flowcharts relating to this policy displayed in the office and in the staff room. A member of staff we spoke with about this told us, "I will definitely whistle blow to protect service users."

People who used the service had personalised risk assessments in place. These identified risks relating to their care, health or wellbeing, and detailed the measures in place to safeguard them from potential harm. People's risk assessments covered areas such as the use of medicines and safe movement around the home. Staff were aware of the identified risks to people and the measures that were in place to manage risks. A member of staff we spoke with told us, "Risk assessments are in their [people's] care plans. Risk assessments are done when risks are identified. Like [Person] has a risk assessment for [their] behaviour when upset so staff know what to do."

People also had personal emergency evacuation plans (PEEP) in place. These gave guidance to staff on how people were to be evacuated from the building in the event of emergencies. Information and guidance was also displayed in the entrance hallway and around the home to provide guidance to people, visitors and staff on how they could evacuate the home in the event of a fire. The service also had plans in case of an emergency, which included information of the arrangements that had been made for other major incidents such as a flood or utility failure. There were risk assessments in place also to manage risks associated with the environment. These included health and safety, fire and infection control.

Another area of improvement was in the way people's medicines were managed. During our previous inspection we found that people's medicines were not stored securely with some people's medicines stored in cabinets with broken locks. During this inspection however, we found that new medicines cabinets with functioning locking systems had been put in place to store people's medicated creams. People's other medicines such as tablets were stored correctly in the designated medicines storage room within the home. A routine had also been established to ensure medicines storage facilities were checked regularly during the day to make sure they were secure. Staff were trained to support people with the safe use of their medicines and we saw that people's medicines were administered as prescribed. We checked the stock of medicines held for three people against their medicine administration records (MAR) and found that records had been completed properly with no unexplained gaps. We also saw that regular audits of people's medicines were carried out to ensure all medicines were accounted for. This had significantly reduced the risk posed to people by unsafe management of medicines.

Good

# Is the service effective?

## Our findings

People who lived at the home and members of the staff team told us that the care provided to people was effective because staff were trained and understood people's needs. One person said, "I'm not a nurse, but staff seem intelligent enough to know how to care for me." Another person said, "Staff know what they are doing." One member of staff told us, "The fact that we know our residents and their needs makes [the care effective]."

Staff had received training in areas required for them to effectively carry out their roles. A member of staff we spoke with regarding the arrangements for training said, "We have training every Tuesday and Thursday. The training could be food first, first aid or MCA [Mental Capacity Act 2005]. [Registered Manager] does our training, we watch DVDs and she goes through it all, and we will ask her questions afterwards."

Staff training was conducted in house and delivered by the registered manager. A review of the registered manager's training indicated that they had received training to train staff in subjects that included health and safety, dementia care, infection control and safeguarding. We saw that staff training was recorded on a form which was used to keep track of when training needed to be refreshed. We reviewed this information and saw that staff training was mainly up to date with some training needing to be refreshed, which the registered manager confirmed was going to be addressed with the ongoing training program they had in place.

New members of staff received an induction which involved receiving the training needed for their new role and an assessment to ensure they had the skills to effectively carry out their roles. This was completed before they passed their probationary period and were confirmed in post. This was confirmed in the records we looked at and the staff we spoke with.

During our last inspection, we found a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, because the provider failed to take action to address the lack of appraisals of staffs' performance. During this inspection, we found that improvements had been made in this area. We saw that the registered manager had developed an annual calendar detailing the planned dates of staff's supervisions to ensure they were completed and their frequency monitored. This meant that staff knew when their supervision meetings were going to take place and could make the necessary preparations for them. Staff supervisions were carried out in a one to one meeting format with a member of the management team. A member of staff we spoke with told us they found supervisions useful and that they felt supported. They said, "We have supervisions every couple of months, I find them useful. [Registered manager] will give us the supervision form to prepare for what you want to talk about. I always find [registered manager] has valid points and is always accommodating. We have appraisals now every year."

Another area of improvement we found related to the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty (DoLS). 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.

The requirements of the MCA were not met during the last inspection because people's consent had not been sought around the use of CCTV cameras. There were also restrictions or deprivations of people's liberty in order to safely care for them that had not been authorised. 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). Based on discussions we had with staff, we were satisfied that they had been improvements in their understanding of the MCA and DoLS. We saw that applications to deprive two people of their liberty in order to safely care for them had been made to the relevant authorising body. More work was required however to ensure the individual needs of all the people who lived at the home had been considered.

People's consent was sought before care or support was provided. A person we spoke with told us, "Yes, they do [ask permission] before they see to me." A review of people's care records showed that people signed forms, giving consent to their care and support. With regard to the use of CCTV cameras in the communal areas of the home, we saw that people who had mental capacity to consent to this had signed forms giving the provider permission for their continued use. However, people that were deemed to lack capacity were yet to be consulted because the provider was working to produce a robust mental capacity assessment framework to assess their capacity in this area. We saw evidence that they had sought support from the local authority around this.

People told us that there was a good variety of food for them to eat throughout the day. One person said, "The food is excellent, if I didn't want today's menu I can choose something else." Another person told us, "I love the food, look at my plate, (they laughed), it's empty." A third person said, "Yes the food is very nice and you can have more if you're hungry still." We spoke with the cook and they told us that all food was freshly prepared at the home, and people were given two choices at mealtimes. They said that they went around before mealtimes and asked what people wanted to eat. If people didn't like the two choices on offer, then a member of staff went quickly to the local shops and bought the ingredients to what they wanted, which was then made for them. People had been asked for their likes and dislikes in regards to food and drinks prior to moving to the home and the kitchen staff were notified. Records in the kitchen detailed people's preferences and specific dietary needs, such as diabetic diet and allergies.

People were supported to access a range of health and care services in order to maintain their health and well-being. A review of people's records showed that people had obtained support from professionals such as, GPs, district nurses, and chiropodist as appropriate to their needs. We saw that people's health conditions were recorded in their care plans together with the support they required from staff or healthcare professionals and the outcome of treatments.

Good

# Is the service caring?

## Our findings

People and the relative we spoke with spoke positively about the service and the staff. They told us that the staff were kind, caring and that they were happy with the care they received. One person said, "I wouldn't live anywhere else." Another person told us, "I can honestly say the girls [Staff] are very good, very pleasant towards me." A third person said, "The girls are very kind to me, I have a very bad back problem they are very gentle." The relative we spoke with told us, "My [Relative] is very happy here, I see the expression on her face when certain carer's approach her, her face and eyes light up."

Based on our observations, we were satisfied that staff had developed excellent relationships with people who lived at the home. They interacted with people in a caring and friendly way. We found that the staff were very protective about the people who lived at the home, and they were patient and supportive when they interacted with people. They displayed a genuine interest in the people they supported and had a 'happy to help' attitude. A member of staff we spoke with told us, "We've got a good and caring team. We know the residents and their needs well and we all try to meet their needs. Everybody [Staff] here is caring." People were well presented and appeared well looked after, apart from one person who did not appear to have had a shave on the day of our inspection. When we asked them if they were growing a beard they said, "No", and said they would like the staff to assist them with a shave. We brought this to the staff's attention and they supported the person accordingly.

An area of improvement we found during this inspection was that there was ongoing work to refurbish people's bedrooms that needed it. We saw that the rooms we raised concerns about during our last inspection had been decorated and well presented. People were able to bring with them their own furniture, paintings and ornaments when they came to live at the home. Staff were knowledgeable about people's care needs. People's care records contained information about their life history, preferences and choices which helped staff to understand people and their backgrounds.

Staff respected people's privacy and dignity. This was confirmed by our observations and people we spoke with. One person told us, "They always knock on my door and tell me they are going to do this and that, you know letting me know what's going on." We observed during our inspection, one particular person who lived with dementia repeatedly asked to go to the toilet or clean their teeth. Members of staff demonstrated a very caring attitude towards this person and assisted them to the toilet each time they asked. Staff also understood how to maintain confidentiality by not discussing people's care needs outside of the work place or with agencies that were not directly involved in people's care. We also saw that people's care records were kept securely in the staff room.

There were a number of information posters displayed within the entrance hallway which included information about the home and the provider's vision statement, safeguarding, the complaints procedure and a suggestion box, a fire safety notice and activities available. We also saw information from other services and local charitable organisations that offered support to older people. This ensured that people had information they required to make informed choices about their care.

Good

# Is the service responsive?

## Our findings

People's care needs had been assessed before they started using the service. People's pre – admission assessment records which were called their 'Suggested Care Agreement' covered areas such as their history, religious beliefs and any advance decisions or care plans. These assessments identified the level of care people needed, and formed the basis by which their care plans were developed. A member of staff we spoke with showed us a copy of one person's needs assessment and told us, "[Registered Manager] goes and does the assessment and then the care plan is done on the first day. These are done for everyone yes."

People who lived at the home had care plans that took account of their needs and preferences. Care plans were personalised and included information on their background, choices, hobbies and interests. They contained clear instructions for staff on how best to meet people's needs. We spoke with a member of staff about people's care plans and they told us, "We develop care plans mainly through observations and conversation, also by reading [People's] medical history. This works for example [Person's], a lot of her problems are from her anxieties because she had lots of falls in the past, so that is now in her care plan. We review care plans every month and do our best to involve the families. We are now thinking about emailing care plans to families so that they can read them and be involved because they might not always have time for that when they visit." We reviewed three people's care plans and found that they were up to date with any changes recorded as they occurred.

People and members of the staff team told us that the care provided to people was person centred. One person said, "I can go to bed when I want, the night staff might say would you like us to turn your TV off now, and I say no and that's fine by them." Another person told us, "I can have my door open or closed it's up to me." A member of staff said, "The care is individualised, for example, [Person] likes her back rubbed during personal care and if you don't that's a big problem, this is written in her care so that staff know when she requests it." We reviewed the person's care plan and found that this was detailed.

People's hobbies and interests were identified and there was a range of activities offered to them. We found that the provider had developed a monthly calendar detailing the activities on offer to people on a daily basis. Activities on offer to people included pamper days, arm chair exercises and sing along days. The activity calendar was displayed in the entrance hall so people and their relatives knew what activities were on offer. There was also a photo album by the entrance showing the activities that people had taken part in. The feedback we received from people about the provision of activities was mixed. One person told us that they were happy with the level of activities provided but others felt the scope needed to be broadened. This was similar to what we found during our last inspection. We raised this with the registered manager after the inspection as an area for further development.

There was an up to date complaints policy in place and a notice about the complaints procedure displayed in the entrance hallway. People and their relatives told us they were aware of the complaints procedure and knew who they could raise concerns with. A person we spoke with told us, "I know who to make a complaint to, [registered manager]. She's very approachable they all are." Another person said, "If I saw something bad I would tell the manager, I don't really complain, I don't need to I'm very happy here." We saw that records of

complaints were separated into three sections. There was one section for people who lived at the home, another section for their relatives and a third for staff. We reviewed the records of complaints that had been received and found that they were resolved in a timely manner and to the complainants' satisfaction. There was also a suggestion box placed in the hallway which was checked regularly.

Requires Improvement

# Is the service well-led?

## Our findings

Improvements had been made in the management of the service however, further development was required around records in particular, risk assessments. We looked at three people's personalised risk assessments and found that they did not conform to current health and safety guidance on risk assessments. This was because the risk management plans did not clearly detail the hazards that could pose a risk to people, the levels of risk and the people responsible for mitigating risks. We raised this with the registered manager and they took immediate action to identify a more appropriate risk assessment document, and added the implementation of this to the service's on-going action plan.

We also found that environmental risk assessments did not contain detailed information for staff to be able to minimise risk. For example, the measure noted in the risk assessment for minimising the risks relating to infection control simply stated, "Food hygiene, infection control policy and laundry." This failed to include what they staff were supposed to do on a day to day basis to support the minimisation of risk of infections or the actions they were supposed to take if there was an outbreak of infection. We again raised this with the registered manager after the inspection. They told us that the completion of these risk assessments was outsourced to another company but, they were going to personally review these and ensure they were appropriate.

The home had a registered manager, who was the deputy manager during our last inspection. They were supported by a newly appointed deputy manager, senior support workers, an administrator and the provider in managing the service. People, a professional we spoke with and staff spoke positively about the registered manager and the service. One person told us, "I can't always remember her name, she is in the office." The professional said, "There has been noticeable improvement within the service. There has been a lot of improvements with audits and there is a very supportive staff structure in place. There is now a head of care who is doing their NVQ in leadership and management and an administration assistant who they delegate tasks to. Decorations and refurbishments continue. DoLS applications are being made and there is a better understanding of the MCA. They are also very good at asking for support." A member of staff told us, "[Provider] is a really, really good owner and whatever we need he will get it. I couldn't wish for better with [Registered manager]."

We found the registered manager to be knowledgeable in their role and was aware of their responsibilities. They had a good working relationship with the people who lived at the home and staff. There was a general atmosphere of comradeship amongst them and the staff which supported teamwork. A member of staff told us that the registered manager was professional, approachable and provided stable leadership for the service. They also said, "[Registered manager] has an open door policy, I will instantly refer to her with any issues."

The atmosphere within the home was relaxed and friendly, and people were at ease in the presence of staff. There was open communication between the management team and the staff team. We found that staff were knowledgeable in their roles and responsibilities, and they were involved in the development of the service by way of regular team meetings where they could collectively discuss issues that affected the

service. They told us that there was a culture of openness and transparency, and they knew about the provider's values which were displayed in the entrance hallway to the home.

The provider carried out a regular satisfaction survey to gain feedback about the quality of the service. We reviewed questionnaires that had been sent to people who lived at the home, their relatives, visiting professionals and staff. All of the responses received were positive in nature. The survey had asked for respondents to identify any areas for improvement in the service and none were suggested.

The provider had a quality assurance system in place to measure the quality of the service. During our last inspection we found that the provider's quality assurance system was not fit for purpose because audits failed to identify and effectively address shortfalls within the service. We found during this inspection that improvements had been made in this area. Quality audits focussed on areas such as people's medicines, health and safety and care plans. Additional audits had been introduced to cover staff records, infection control and the premises. Audits were carried out by the registered manager and the administrator on a monthly basis. An action plan was introduced on following our last inspection and the provider continued work on this to ensure further development of the service.

During our last inspection, we saw disused equipment such as a chair and an old refrigerator that had been disposed of at the back of the home. There was also some rubble and rubbish located at the front where people would access the home. On entry to the home we saw that the ceiling in the reception area was badly damaged in some areas. We found a broken call bell socket in one of the bedrooms which was being used and posed a direct risk of electrocuting people when used. Other areas of concern we found related to a bit of metal that was found to be sticking out as well in one of the corners of the upstairs hallway and part of a skirting board missing with nails sticking out. We found during this inspection that the management team had taken action to address some of these health and safety concerns. On a tour of the premises, we saw a trailing wires at the back of one person's electrical arm chair in the lounge, that was close to the dining table. People were getting up from having their meals and walking past the exposed cable lead placing them at risk of falling. We notified the provider and they spoke with an electrician who was visiting at the time and a plan was put in place to address this. We also found that the gardens needed some attention to make it look welcoming. The registered manager told us that a gardener had been instructed to come once the cold weather had cleared to address this.