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Cloneen Care Home

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**
Is the service effective?	**Inspected but not rated**

Summary of findings

Overall summary

We inspected Cloneen Care Home 29 June and 7 July 2016. The first day of the inspection was unannounced which meant that the staff and registered provider did not know that we would be visiting. We informed the registered provider of the second day of our inspection. The service was last inspected on 5 June 2015 and was awarded an overall rating with requires improvement but with no regulatory breaches.

In May and June 2016 we received some information of concern. This included concerns regarding low staffing levels, equipment was out dated, there was a lack of money in the registered providers budget to purchase equipment such as pressure relieving mattresses and some concerns re care practices. As a result of the concerns we made the decision to undertake a focussed inspection of the service.

Cloneen Care Home provides care and accommodation for up to 15 older people and / or older people living with a dementia. Cloneen is a converted Victorian house in a residential area of Saltburn. There is a communal lounge and dining room on the ground floor of the home. The service is close to shops, pubs and public transport. On the first day of our inspection there were 13 people who used the service and this had increased to 14 people by the second day.

The home did not have a registered manager. 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. A manager had been appointed in June 2015 and had submitted their application to be registered, however, at the time of the inspection the registered provider was making changes to their registration which had delayed this process. Until a registered manager is in place the registered provider is breaching their registration conditions.

We looked at the arrangements in place to ensure safe staffing levels and found there were two staff on duty both day and night. In addition the manager of the service worked during the day usually Monday to Friday and the registered provider worked at the service three days a week. We raised concern that at teatime two care staff were responsible for numerous duties in addition to providing care and support to people. In addition to this one of the care staff was responsible for the administration of medicines. We observed that the design of the building could mean that people were left unattended for some time.

We spent some time in the lounge and dining area observing people who used the service and staff and saw that on occasions communal areas were unattended for periods of 15 to 20 minutes before there was a staff presence. We noted that staff were extremely busy and readily interrupted when administering medicines to people. This meant the staff member could become distracted and make a medicine error.

After our inspection we raised our concerns with the manager and registered provider who carried out a review of staffing levels and increase staffing numbers at busier times.

There were systems and processes in place to protect people from the risk of harm. Staff were able to tell us about different types of abuse and were aware of action they should take if abuse was suspected. Staff were able to describe how they ensured the welfare of vulnerable people was protected through the organisation's whistle blowing and safeguarding procedures.

Appropriate checks of the building and maintenance systems were undertaken to ensure health and safety. The manager assured us there was money within the registered provider's budget to purchase any equipment that people needed. We saw that a new pressure relieving mattress had been purchased for a person who was to be discharged from hospital.

Risks to people's safety had been assessed by staff and records of these assessments had been reviewed. However, some risk assessments required further development to ensure they identified the actual risk to the person. This enabled staff to have the guidance they needed to help people to remain safe.

We saw that staff had received supervision on a regular basis and an annual appraisal.

Staff had been trained and had the skills and knowledge to provide support to the people they cared for. The manager had a chart for all staff and was aware of any gaps in training and had arranged this.

Staff understood the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards which meant they were working within the law to support people who may lack capacity to make their own decisions. However further work was needed in the development of care plans to ensure MCA assessments were decision specific.

We found that safe recruitment and selection procedures were in place and appropriate checks had been completed on staff. This included obtaining references from previous employers to show staff employed were safe to work with vulnerable people.

Appropriate systems were in place for the management of medicines so that people received their medicines safely.

There were positive interactions between people and staff. We saw that staff treated people with dignity and respect. Observation of the staff showed that they knew the people very well and could anticipate their needs. People told us that they were happy and felt very well cared for.

We saw that people were provided with a choice of food and drinks, which helped to ensure that their nutritional needs were met. Staff had undertaken nutritional screening to identify specific risks to people's nutrition. However, there were some errors in the calculation of risks, but this had not prevented staff from contacting the doctor or dietician when people had lost weight.

People were supported to maintain good health and had access to healthcare professionals and services. People were supported and encouraged to have regular health checks and were accompanied by family or staff to hospital appointments.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inspected but not rated

The service was not always safe.

At times there were insufficient staff on duty to meet the needs of people who used the service and ensure their safety.

Staff we spoke with could explain indicators of abuse and the action they would take to ensure people's safety was maintained. This meant there were systems in place to protect people from the risk of harm and abuse.

There were arrangements in place to ensure people received medicines in a safe way.

In general good recruitment procedures were in place to help ensure suitable staff were recruited and people were safe.

Is the service effective?

Inspected but not rated

The service was effective.

Staff received training and development, supervision and support. This helped to ensure people were cared for by knowledgeable and competent staff.

People were supported to make choices in relation to their food and drink.

The registered manager and staff had an understanding of MCA 2005 and DoLS. However, work was needed to ensure all people who had been assessed as lacking capacity had decision specific MCA assessments and that best interest decisions were recorded within care plans.

Cloneen 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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

We inspected Cloneen Care Home 29 June and 7 July 2016. The first day of the inspection was unannounced which meant that the staff and registered provider did not know that we would be visiting. We informed the registered provider of the second day of our inspection. The inspection team consisted of one adult social care inspector.

Before the inspection we reviewed all the information we held about the service. We did not ask the registered provider to complete a provider information return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time with people in the communal areas and observed how staff interacted with people. We spoke with six people who used the service and one relative. We looked at all communal areas of the home and some bedrooms.

During the visit we spoke with six staff, this included the registered provider, the manager, a senior care assistant, two care assistants and the cook. We also contacted commissioners to seek their views on the service.

We reviewed a range of records. This included two people's care records, including care planning documentation and medicine records. We also looked at staff files, including staff recruitment and training records and records relating to the management of the home.

Inspected but not rated

Is the service safe?

Our findings

At the time of the inspection there were 13 people who used the service. On the second day of the inspection this had increased to 14 people.

We looked at the arrangements in place to ensure safe staffing levels. The manager told us that during the week from 8am until 8pm there were two care staff on duty and two care staff overnight. In addition the manager of the service worked during the day usually Monday to Friday and the registered provider worked at the service three days a week. The service employed two cooks to work from 8am until 1pm each day.

We raised concern that at teatime two care staff were responsible for numerous duties in addition to providing care and support to people. The cook who was on duty during the day would prepare tea for staff to cook and plate up, however, at tea time this took staff away from their caring duties. Care staff were also responsible for clearing up after tea. In addition to this one of the care staff was responsible for the administration of medicines. We observed that the design of the building could mean that people were left unattended for some time. We were told that staff were also responsible for emptying bin and keeping the laundry flowing.

During the inspection we spoke with one relative who said, "There doesn't seem to be sufficient staff on the floor. Previously when I have visited there has been no staff on the ground floor. [Name of person who used the service] has not come to any harm but on occasions there doesn't seem to be anyone about." A person who used the service said, "I'm happy here but the staff are so busy. The dinners running late today because they are attending to people."

We spent some time in the lounge and dining area observing people who used the service and staff. We noted that on occasions communal areas were unattended for periods of 15 to 20 minutes before there was a staff presence. We noted that the staff member administering medicines was routinely interrupted by people and others. This meant the staff member could become distracted and make a medicine error.

After the inspection we spoke with the manager and registered provider about our concerns. They carried out a dependency of people who used the service to determine how many staff should be on duty. The registered provider told us they had identified their busiest times and were to put an extra care staff member on duty from 8am until 9am, from 1pm until 2pm and from 4pm until 5pm seven days a week.

After this we were in further contact with the registered provider who told us that since the inspection their occupancy had dropped to 11 people. The registered provider told us occupancy levels were to drop further as another two people had been reassessed as needing specialist care that couldn't be provided by staff at Cloneen. They told us they had carried out a further review on dependency and staffing levels were to change slightly. Staffing on a morning would be a minimum number of two care staff and the manager working the floor to provide care and support to people. They told us on an evening there would be two care staff and an additional care staff member who would work for two hours at tea time to help out when staff were busy administering medicines and serving tea. On a weekend the registered provider told us they

were not as busy and staffing levels would be a minimum number of two care staff with an additional staff member to cover the busier times. The registered provider told us they were to monitor and staffing levels on a daily basis to ensure people's needs were met.

We asked people who used the service if they felt safe. People told us they felt safe. One person said, "I've lived here a good while now and have always felt safe." Another person said, "Yes I do."

Staff we spoke with during the inspection were aware of the different types of abuse and what would constitute poor practice. Staff told us they had completed training in safeguarding and were able to describe how they would recognise any signs of abuse or issues which would give them concerns. They were able to state what they would do and who they would report any concerns to. The service had safeguarding policies and procedures in place for recognising and dealing with abuse. Staff said that they would feel confident to whistle-blow (telling someone) if they saw something they were concerned about. Staff were able to speak about the registered provider's whistleblowing policy.

The two care plans we looked at incorporated a series of risk assessments. They included areas such as the risks around moving and handling, falls, skin integrity and nutrition and hydration. The quality and content with care records and risk assessments varied. We saw that one person's ability to eat independently could fluctuate and care records were detailed informing staff to encourage independence. However, at times the person just left food in front of them and care staff needed to be mindful and support the person to eat. We saw that when this person needed help during the inspection staff respectfully supported the person. Some of the risk assessments we looked at needed further development as they did not identify the actual risk to the person. For example, one person had a risk assessment for the hoist and the risk assessment identified the hoist needed to be serviced but didn't actually identify the risk to the person (if there were any at all). Those people identified at risk of falls had been referred to the falls team for advice on prevention or reducing the risk.

We looked at the arrangements in place for managing accidents and incidents and preventing the risk of reoccurrence. We saw that a monthly analysis was undertaken on all accidents and incidents and that these were analysed to identify any patterns or trends and measures put in place to avoid re-occurrence.

The manager told us that the water temperature of baths, showers and hand wash basins were taken and recorded on a regular basis to make sure they were within safe limits. We saw records that showed water temperatures were taken regularly.

We saw certificates to confirm that portable appliance testing (PAT) was up to date. PAT is the term used to describe the examination of electrical appliances and equipment to ensure they are safe to use.

We looked at records which confirmed that checks of the building and equipment were carried out to ensure health and safety. We saw documentation and certificates to show that relevant checks had been carried out on the fire alarm, hoists, fire extinguishers and emergency lighting. The registered provider told us they were to change the hoist and were in the process of obtaining quotes. The registered provider had recently purchased a new bath hoist. This showed that the registered provider had developed appropriate maintenance systems to protect people who used the service against the risks of unsafe or unsuitable premises and equipment.

We received information of concern that there was not any money in the registered provider's budget to purchase equipment such as pressure relieving mattresses. During the inspection we walked around the

service with the manager. We saw that the manager had taken delivery that day of a mattress they had purchased in preparation for a person who was to be discharged from hospital. The manager assured us there was money in the budget and if a person needed a mattress this could be ordered and delivered within 24 to 48 hours.

We saw that people had emergency evacuation plans. These provided staff with information about how they can ensure an individual's safe evacuation from the premises in the event of an emergency. Records showed that regular checks were made on the fire alarm to make sure it was in working order and that staff had taken part in fire drills.

We looked at the files of three staff who had been recently recruited. In general the registered provider operated a safe and effective recruitment system. The staff recruitment process included completion of an application form, a formal interview and previous employer reference. We saw that all files contained a Disclosure and Barring Service check (DBS). The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also minimises the risk of unsuitable people working with children and vulnerable adults. We saw that two of the DBS checks had been undertaken before staff started work; however, one was dated after the person had started work. The manager told us when they started work at the service in June 2015 they completed an audit of all staff files and saw that this check had not been completed by the previous registered manager and because of this they immediately applied for a new DBS check.

We saw that appropriate arrangements were in place for the management, storage, recording and administration of medicines.

At the time of our inspection people who used the service were unable to look after or administer their own medicines due to their dementia or medical condition. However, the manager told us if people were able they would encourage and support the person to remain independent with the administering and ordering of their medicines. Staff had taken responsibility for the storage and administration of medicines on people's behalf. We checked peoples' Medication Administration Records (MARs). We found these were fully completed, contained the required entries and were signed.

We saw staff recorded when people refused or did not take their medicines for any reason. We checked records of medicines against the stocks held and found these balanced. The manager and staff were able to describe the arrangements in place for the ordering and disposal of medicines. We were told that medicines were delivered to the home by the pharmacy each month and were checked in by nursing staff to make sure they were correct. Records of ordering and disposal of medicines were kept in an appropriate manner with copies of prescriptions kept for each person's medicines. Staff told us they checked these against the medication received from the pharmacist. They said the medicine administration records were checked each month to ensure they corresponded with the information from the previous month's records and with the medicines prescribed. These systems helped to ensure people received their medicines safely.

People were prescribed medicines on an 'as required' basis and we found 'as required' guidelines had been written for these medicines.

We saw that one person had been prescribed a medicine for the thinning of their blood and because of this they needed to avoid certain foods as if eaten this could decrease the effects of the medicine. Staff had carefully written a list of all the foods they must not eat and all staff were aware of this including the cook.

The service had a business contingency plan for the service. A contingency plan is a course of action designed to help an organisation to respond effectively to a significant event or situation.

Inspected but not rated

Is the service effective?

Our findings

We spoke with people who used the service who told us that staff provided a good quality of care. One person said, "Sometimes I get a bit fed up, but that's more about me not being independent anymore, but I give myself a talking to and I'm fine. You can talk to anyone of them [staff] and they will help you." A relative we spoke with said, "The home is very good. I've been very pleased with the staff over the last year. This is a homely place and they [people and staff] all seem to get on."

We asked staff to tell us about the training and development opportunities they had completed at the service. Staff told us that there was a plentiful supply of training. They told us they had received training in moving and handling, mental capacity, fire safety, infection control, deprivation of liberty safeguards and health and safety amongst others. Staff told us the quality of their training was good. One staff member said, "I had a good induction and have done lots of other training which has helped me to do my job." The manager had a record of all the training staff had completed and where there were gaps in training this training had been planned.

Staff told us they felt well supported and that they had received supervision. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. We saw records to confirm that supervision had taken place. One staff member said, "[Name of manager] is so supportive and approachable, which is very important. I have had quite a few supervisions now."

We asked the manager if staff received an annual appraisal. An annual appraisal is a review of performance and progress within a 12 month period. This process also identifies any strengths or weaknesses or areas for growth. The manager told us they had completed appraisals with staff, we saw records to confirm this.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The manager told us that staff had attended training within the last 12 months on the MCA. The manager and staff told us that people and their families were involved in discussions about their care.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager showed us documentation which detailed people who used the service were subject to Deprivation of Liberty Safeguards (DoLS), and who had no conditions attached to the authorisations.

On the first day of the inspection we looked at the care records of one person who had been assessed as lacking capacity. We saw that mental capacity assessments were available, however they were confusing as there were lots of assessments for different areas such as health, care, administering medicines and finance on one assessment. However, by the second day of the inspection the manager had developed decision specific assessments for this person. Relatives, staff and professionals had been involved in making best interest decision for people and these had been recorded in the plan of care. Discussion took place with the manger about the need to complete MCA assessments for other areas such as the flu vaccination, bed rails and lap straps.

We looked at the menu plan and chatted with the cook. They told us they had worked at the service for 11 years and enjoyed their job very much. They told us they spoke to people on a daily basis and provided them with a choice of food for that day. They told us all food and cakes were cooked from scratch and people who used the service appreciated that. People we spoke with confirmed there was choice and told us they liked the food provided. One person said, "You can have anything you want to eat and it's always good." Another person said, "The food is very good." A relative we spoke with said, "I think the food is very good and everyone seems to enjoy it. Before [name of person] came in here all they had was a sandwich but in here there is plenty of variety. The menus provided a varied selection of meals. People told us there were two choices available at each meal time.

The cook and staff were able to tell us about particular individuals and how they catered for them and how they fortified food for people who needed extra nourishment. Fortified food is when meals and snacks are made more nourishing and have more calories by adding ingredients such as butter, double cream, cheese and sugar. This meant that people were supported to maintain their nutrition.

We observed the lunchtime of people who used the service. First meals were served to those people who had chosen to eat in the lounge area. Food was then served to others. Food was well presented and where needed, people received help and support to cut up their food and eat.

People told us they were provided with lots of drinks. One person said, "I sit here and read my paper and they just keep topping up my mug with tea."

People who used the service had undergone nutritional screening to identify if they were malnourished, at risk of malnutrition or obesity. We saw records to confirm this, however on occasions staff had miscalculated this risk but appropriate action had been taken when people had lost weight to contact the doctor and / or dietician. We pointed out the miscalculations of the nutritional screening to the manager who told us they would review the nutritional screening tool for all people who used the service. People were weighed at regular intervals and appropriate action taken to support people who had been assessed as being at risk of malnutrition.

We saw records to confirm that people had visited or had received visits from the dentist, optician, chiropodist, dietician, and their doctor. People were supported and encouraged to have regular health checks and were accompanied by family or staff to hospital appointments. People told us staff contacted the doctor if they were unwell. One person said, "I regularly need to see the doctor with my condition and they always come to see me. In fact they are coming out today." A relative we spoke with told us that staff were quick to spot when people were unwell and call the doctor. They told us that staff communicated with them well when there had been any medical concerns.