Claremont Care Services Limited

Offington Park Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Good**

Summary of findings

Overall summary

About the service
Offington Park Care Home is situated in Offington, Worthing, West Sussex. It is a residential 'care home' for up to 24 older people, some of whom are living with dementia. At the time of the inspection there were 19 people living at the home.

People's experience of using this service and what we found
Staff had worked to ensure people were safe from the COVID-19 pandemic. They had received guidance and support informing them of how to keep themselves and others safe. We found three members of staff did not always use personal protective equipment (PPE) in accordance with the provider's or government's guidance. Medicines had not always been provided according to prescribing instructions for one person. Medicines were sometimes out of stock and two people had not received their medicines. Once these findings were fed back to the provider, they acted immediately to ensure improvements were made.

People told us they were happy, secure and safe at the home. Staff ensured people were provided with care that met their assessed needs and minimised risks. Lessons had been learned from previous incidents to help ensure people received safe care following falls. People were protected from the risk of abuse. Staff worked together to help ensure there was sufficient staff to meet people's needs during the COVID-19 pandemic.

The manager and provider had acted to help improve the care people received. Systems and processes had been introduced to help provide greater oversight of people's care. This provided assurances people were receiving safe and appropriate care to meet their assessed needs. Similar themes, to those that were found as part of our inspection, had been identified by the manager, provider and an external consultant. This provided confidence that they had identified where further improvements were needed and were acting to ensure these were made. The provider had made improvements and was no longer in breach of any regulations. Staff, people and relatives were involved in decisions that affected people's care and the running of the home. Staff told us they felt well-supported, listened to and value. People told us they felt well-cared for and that staff were kind and compassionate. One person told us, "This care home is lovely and the staff are all so nice."

Rating at last inspection and update
The last overall rating for the home was requires improvement (Supplementary report published 7 April 2020). The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection, we found improvements had been made and the provider was no longer in breach of the regulations.

Why we inspected
We carried out an announced focused inspection on 25 September 2020. We contacted relatives on 29 September 2020. We gave the manager and provider 48 hours' notice of the inspection to enable CQC and

the manager to consider any infection prevention and control protocols due to the COVID-19 pandemic.

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 that the service can respond to coronavirus and other infection outbreaks effectively.

We undertook this focused inspection to check they had followed their action plan and to confirm they now meet legal requirements. This report only covers our findings in relation to the Key Questions of Safe and Well-led.

The ratings from the previous comprehensive inspection for those Key Questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the home remains rated as Requires Improvement. This is based on the findings at this inspection.

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

In February 2020, the provider notified us of an unexpected death of a person who had sustained a head injury. This incident is subject to ongoing investigation. As a result, this inspection did not examine the circumstances of the incident. However, we looked at how the provider had learned lessons from the incident to help ensure people's safety.

Follow-up
We will continue to monitor the intelligence we receive about the home until we 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?

Requires Improvement

The home was not always safe.

Details are in our safe findings below.

Is the service well-led?

Good

The home was not always well-led.

Details are in our well-led findings below.

Offington Park 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
The inspection was undertaken by two Inspectors.

Service and service type
Offington Park 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 home had a manager who was in the process of applying to be registered with the Care Quality Commission. This meant the provider was legally responsible for how the home was run and for the quality and safety of the care provided.

Notice of inspection
The inspection was announced. We gave the manager and provider 48 hours' notice of the inspection to enable CQC and the manager to consider any infection prevention and control protocols due to the COVID-19 pandemic. We also established if people had COVID-19 or associated symptoms.

What we did before the inspection
We reviewed information we had received about the home since the last inspection. We had not asked the provider to submit a provider information return (PIR). A PIR is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. We took this into account, alongside the evidence gathered, when making our judgements in this report . Prior to the

site visit, we requested care plans, risk assessments and medicine administration records for four people. We also requested staff rotas and documents relating to quality assurance and oversight.

During the inspection
At the site visit, we observed the care and support people received. 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 spoke with six people, five staff and the manager. We looked at two staff files and viewed the systems the manager and provider used to provide oversight of the care people had received.

After the inspection
We spoke with the provider and manager to seek further assurances about people's care. We spoke with five relatives and one person's representative to seek their feedback on the care people had received.

Requires Improvement

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 Requires Improvement. Risks in relation to people's health had not always been appropriately managed to ensure their safety. Medicines had not always been administered according to prescribing guidance. The provider was in continued breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to complete an action plan to show what they would do and by when to improve.

At this inspection, we found improvements had been made and the provider was no longer in breach of Regulation 12. The improvements made needed to be further embedded in practice and sustained over time to ensure all risks were identified and mitigated. This key question remains rated Requires Improvement. This meant some aspects of the service were not consistently safe.

Using medicines safely

● Staff had not always taken timely action to ensure there was enough stock of some medicines. Two people were prescribed medicines to help manage their anxiety. Records showed and staff confirmed, both people had not always received their medicines due to them being out of stock. One person had been without their medicines for nine days and records showed they had experienced periods of anxiety during this time. The manager had identified this and had changed staff's practice to help ensure this did not reoccur. For example, staff were required to complete a stock check of remaining medicines each time one was administered. They had been reminded of the importance of reordering medicines when there were seven days remaining to ensure there was enough time for these to be obtained. This would help ensure there were enough medicines to meet people's needs.

● One person was prescribed medicines to help manage pain. Prescribing guidance advised to allow between four to six hours in-between doses. Records showed and staff confirmed that on one occasion staff had not ensured there was enough time in-between each dose and the person had been provided with the next dose of medicine 30 minutes before the next dose could be safely given.

When this was fed back to the manager, they took immediate action. Staff were reminded of the importance of ensuring there was enough time in-between doses of medicines, so people did not receive too much.

● Since the last inspection, there had been enhanced oversight of medicines. Regular audits were completed to help ensure people received their medicines according to prescribing guidance. Errors found as part of this inspection, had occurred after the last audit and there was confidence the provider's systems to monitor the safe administration of medicines would have identified the concerns found.

●Improvements had been made to the way medicines were stored, dispensed and administered. At the last inspection, people's medicines were stored in pre-sealed packs in a communal medicine cabinet. The provider had recognised this had created an 'institutional' feel and staff had not always been vigilant when dispensing medicines for each person. The provider had changed the pharmacy that provided people's medicines, so people were provided with individual boxes of medicines. With people's consent, the provider

had placed individual medicine cabinets in people's own rooms. These measures meant staff were more person-centred when dispensing and administering people's medicines as this could be done in the privacy of the person's own room.
● People's independence and abilities were respected, and they were able to administer their own medicines if they preferred. Appropriate and safe practices were in place to help ensure people were receiving their medicines as prescribed.

Preventing and controlling infection
● As part of CQC's response to the COVID-19 pandemic we are conducting thematic reviews of infection control and prevention measures in care homes. Some of our observations raised concerns about some staff's practice. For example, three members of staff did not always ensure they used the PPE provided in accordance with the provider's policy or government guidance. This placed people and staff at risk of infection.

This was immediately fed back to the provider and manager. The provider reinforced the importance of following Public Health England guidance to staff.

● The provider, manager and staff had worked to ensure systems and processes were in place to help keep people safe. Staff had received additional support and coaching to remind them of what personal protective equipment (PPE) they should wear and how they should support people to reduce the risk and spread of infection. No people or staff had contracted COVID-19.
● People had been supported to socially distance from one another. Most people had chosen to stay in their own rooms to reduce the risk of infection. Some people who had moved into the home from hospital during the pandemic, were appropriately supported to isolate for the required timeframe to minimise the risk and spread of potential infection. Staff ensured people received appropriate support to meet both their physical and emotional needs to help reduce the risk of social isolation.
● Some people were living with dementia and did not always understand the reasons why they needed to distance from others. Staff had supported them to be in the communal lounge whilst maintaining sufficient distance from one another to ensure their safety.
● Once lockdown measures were eased, people had been supported to see their loved ones in the home's garden. When physical visits were unable to take place, people had been supported to remain in contact through phone and video calls. A relative told us, "Staff have been fabulous, they have people's interests at heart. They set up a WhatsApp video and I can tell how my relative is from the video. I have every faith in the staff, I don't know how they do it. I can't praise them enough."

Learning lessons when things go wrong
● Lessons had been learned following a serious incident that had occurred. Changes had been made to policies and processes so staff were provided with clearer guidance should people experience falls or injuries to their heads. Staff demonstrated a good awareness of the actions they needed to take. Staff confirmed that when people had experienced falls, appropriate action had been taken to help ensure people's safety. Work was in progress to further improve the documentation relating to staff's actions to help provide assurances of the care people received.

Staffing and recruitment
● People had access to enough staff to meet their needs. Before regular COVID-19 testing, if staff were unwell and had to isolate, existing staff worked together to help ensure there were enough staff to meet people's needs. They told us they wanted to minimise the amount of staff going into the home and instead of using agency staff had made the decision to increase their hours to provide a consistent staff team.

People told us staff were busy but were on hand should they need their support. One person told us, "When I want staff they come quickly, I haven't had to wait."

● People were supported by staff who the provider had assessed as being suitable for the role. Safe recruitment processes enabled the provider to be assured that staff were of suitable character and had appropriate experience to meet people's needs. Staff's experience and skills were considered when allocating tasks and responsibilities. This ensured people received support from staff who were competent.

Assessing risk, safety monitoring and management;

● People told us they felt safe. One person told us, "I feel safe here. I had a fall a few weeks ago in my room, I used the call bell and they all came running straight away."

● Risks to people's health had been identified and managed to help ensure they received care according to their needs. For example, when people were at risk of dehydration, staff encouraged fluids and documented the amount they had consumed. These were monitored each day to help ensure people had enough fluids to maintain their health.

● People's care had improved due to an increased oversight of their health needs. People's nutrition and healthcare needs were closely monitored to help identify any changes. Appropriate actions had been taken to ensure people received timely support to help maintain their health. For example, when people had lost weight, they were monitored more closely and provided with food that was fortified with high-calorie products to help maintain and increase their weight. People's weight had increased as a result of these actions.

Systems and processes to safeguard people from the risk of abuse

● Risks in relation to people's health and well-being were identified and considered and people's care had improved. Staff had increased awareness of people's needs and how to provide safe and effective care.

● Staff demonstrated an awareness of the signs and symptoms that could indicate people were at risk of abuse. They knew who to report concerns to and when there were concerns about people's safety and well-being, these had been raised with the local authority for them to consider as part of their safeguarding duties.

Good

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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people.

At the last inspection this key question was rated as Requires Improvement. There were concerns about the management of the home and the oversight of risk related to people's care. We found the provider was in continued breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We served a Warning Notice to the provider and they were required to become compliant by 30 April 2020.

At the last inspection, the home did not have a manager who was registered with the Care Quality Commission and had failed to formally notify us of this. The provider was in breach of Regulations 5 (Registered manager condition) and 14 (Notice of absence) of the Care Quality Commission (Registration) Regulations 2009. We asked the provider to complete an action plan to show what they would do and by when to improve.

At this inspection, we found significant improvements had been made and the provider was no longer in breach of any regulations.

● Since the last inspection, the health and social care sector has faced unprecedented challenges caused by the COVID-19 pandemic. The provider, manager and staff had worked to ensure people were protected from the risk of COVID-19 whilst acting to continually improve the quality and standard of care people received.
● Since the last inspection the day-to-day management of the home had changed. The manager who had previously been registered with the Commission, and who had worked at the home for a number of years prior to them leaving, had returned. The manager was in the process of applying to become the registered manager.
● People, relatives and some staff told us this had a positive impact on people's care and staff's morale. When talking to us about the manager, two people told us, "She's back now and she livens the place up ," and "She's very sweet, sometimes she does a special evening, we had an Irish night, it was absolutely lovely. We had wine, hors d'oeuvres, Irish stew and apple pie." Relatives were equally as positive. A relative told us, "It was a nightmare when she left, people coming in to try and change things when it wasn't needed, now she is back things have changed for the better." Another relative told us, "Yes positive changes she's on the ball trying to bring in more activities. When I speak with her, I feel things happen."
● The manager and provider had improved the oversight and monitoring of the service through several measures. Regular audits conducted by the manager, provider and an external consultant had helped provide better oversight and management of systems and processes. When shortfalls were identified, these were acted upon and improved to ensure people were provided with the care and support that met their

assessed needs. This had a positive impact on outcomes for people as well as their experiences.
● The provider had asked staff what additional support and development they would benefit from. Specific training related to people's needs had been provided, this included Parkinson's disease and Dementia . These had increased staff's knowledge and awareness and had in turn improved the quality of care provided to people.
● Staff told us having an improved structure gave them clearer direction. Staff had dedicated roles and allocated tasks. They told us they had a better understanding of their roles and what was expected of them. Staff were accountable for their actions and this helped improve people's experiences. When speaking about the leadership and management of the home, one member of staff told us, "The home is alive again. I feel more supported now. She has made a lot of changes and it is better, we work as a team now and that's important." Another member of staff told us, "There is more structure now and we know where we stand."
● The provider had acknowledged staff's hard work as well as the emotional impact working during the pandemic had on them. Staff told us they had received letters and presents thanking them for the work they were doing to keep people safe. They told us this made them feel valued and appreciated.
● The provider's values were based on providing a caring, welcoming and family-run home. People told us they were happy, and they felt well-cared for by a team of staff who knew them and their needs well. Staff created a warm, friendly atmosphere with people's experiences central to their work.

Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Consideration and adaptations had been made due to COVID-19 so that people could continue to have an input into their care. Residents meetings had taken place whilst observing social distancing and for those people who chose to stay in their rooms, efforts had been made to involve them in independent discussions. People had been given the opportunity to discuss their care as well as the running of the home.
● People told us they felt comfortable speaking to staff and when they had suggested changes these had been listened to and changes made. For example, one person told us it had worried them that their bed was made late in the morning as this was something they had always preferred doing early when they had lived in their own home. They told us staff had listened to their concerns, and ever since had ensured the person's bed was made earlier in the day.
● Staff liaised with external healthcare professionals and worked alongside them to ensure people received appropriate and coordinated care to meet their needs.

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
● Relatives told us they felt reassured that their loved ones were well-cared for and they were always informed if there were any changes or concerns in relation to people's needs.
● The manager and provider demonstrated a candid, open and transparent approach. They had informed CQC and other external health and social care professionals, when care had not gone according to plan. They had notified us of incidents that had occurred to enable us to have oversight to ensure appropriate actions were taken.