Rosemere Care Home Ltd

St Claire's Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 27,28 and 31 October 2016 and was unannounced.

St Claire's Care Home provides care and support for up to 39 older people. There were 35 people living at the service at the time of our inspection. People cared for were all older people; most of whom were living with dementia and some who could show behaviours which may challenge others. People were living with a range of care needs. Some people needed support with all of their personal care and some with eating, drinking and their mobility needs. Other people were more independent and needed less support from staff.

St Claire's Care Home is a large house, previously arranged as three attached houses, now converted to a single property. People's bedrooms were provided over four floors, with a passenger lift providing stair free access. There were communal sitting rooms and a communal dining area. There was an enclosed area of garden at the front of the property.

A registered manager was in post. 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.

St Claire's Care Home was last inspected on 2 September 2014 and no concerns were identified. At this inspection we identified shortfalls where some regulations were not being met.

Medicines were not administered or stored safely; some people did not receive the medicine they were prescribed when needed.

There were insufficient staff at key times of the day; the registered manager often supplemented staff to provide support at busy times, this impacted upon the completion of management tasks.

No system was in place providing an oversight of incidents and accidents; reviews following an incident did not take place or link back to risk assessments and care planning.

The safety certificate for the electrical wiring of the service had expired, urgent remedial work had not been completed and checks of portable electrical appliances had lapsed.

Maintenance of the service was not adequate, some pipes were leaking, some furniture was no longer serviceable, a magnetic gate lock didn't work and some areas required redecoration.

Records of staff recruitment and training were muddled and not readily accessible, induction training for new staff was not completed. Supervision of staff had lapsed and did not meet the requirement of the

service's policy.

Deprivation of Liberty Safeguarding authorisations had not been applied for where people were unable to consent to restrictions in place.

Elements of some care plans were not tailored to individual preferences and clear links were not always made between some conditions and other associated care needs. This did not provide the service with the best and earliest opportunity to be responsive to changes in people's needs.

Auditing carried out for the purpose of identifying shortfalls in the quality and safety of the service provided had not been effective; deficiencies brought to the attention of the provider were not acted upon when needed.

People were supported by enthusiastic staff who received regular training and appropriate supervision. There were enough staff to meet people's needs.

Staff were caring, compassionate and responsive to people's needs and interactions between staff and people were warm, friendly and respectful.

Referrals to outside healthcare professionals were made in a timely way.

People enjoyed their meals, they were supported to eat when needed and risks of choking, malnutrition and dehydration had been adequately addressed.

People commented positively about the openness of the management structure and were complimentary of the staff.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not always suitably managed to ensure they were administered when needed.

Risk assessments were in place; however, the measures needed to keep people safe were not always effective or fully developed. Incidents and accidents were not suitably investigated.

There were not always enough staff to safely support people.

Maintenance did not keep pace with the rate of wear, checks intended to ensure the safety of electrical wiring and appliances had lapsed.

Is the service effective?

Requires Improvement

The service was not always effective.

The service was not meeting the requirement of the Deprivation of Liberty safeguards and Mental Capacity Act 2005.

Staff did not receive appropriate induction training when they first started work and were not provided with opportunities for formal supervision and appraisal.

People had access to health care professionals to ensure health care needs were met.

People were supported to eat and drink when needed and they enjoyed the variety of food provided.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff deployment resulted in a functional, task orientated approach to care delivery.

Staff were kind to people. They respected people's privacy and dignity, and maintained their independence.

Staff communicated well with people and their family members, giving them information about any changes.

People's families and friends were able to visit at any time and were made welcome.

Care records and information about people was treated confidentially.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Individual support preferences had not always been established and some information was not detailed enough to guide staff how to support people consistently.

A complaints procedure was in place, people and visitors told us they had not needed to complain.

Views from people and their relatives were taken into account and acted on.

People were supported to stay in touch with friends and family.

Is the service well-led?

Requires Improvement

The service was not well-led.

Audits were not effective in ensuring safe practice; some concerns identified had not been acted upon.

Training and staff employment records were muddled and difficult to locate.

Policies and procedures were available, however, most referred to old legislation.

People and staff were positive about the leadership at the service. Staff told us that they felt supported by the registered manager.

St Claire's Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 27, 28 and 31October 2016 and was unannounced. The inspection was carried out by one inspector.

Before our inspection we reviewed the information we held about the service including previous inspection reports. We considered the information which had been shared with us by the local authority and other people, looked at safeguarding alerts and notifications which had been submitted. A notification is information about important events which the provider is required to tell us about by law. The provider had also sent us regular action plans following the last inspection.

We met and spoke with 11 people who lived at St Claire's Care Home and observed their care, including the lunchtime meal, medicines administration and activities. To help us capture the experiences of people who may not be able to express this for themselves, we used short observational framework for inspection (SOFI). SOFI is a tool developed with the University of Bradford's School of Dementia Studies and focusses on people's levels of engagement and mood as well as the quality and purpose of interaction between people and staff. We spoke with six people's relatives, a visiting health care professional and a visiting social care professional. We inspected the environment, including the laundry, bathrooms and some people's bedrooms. We spoke with three care workers, kitchen staff, housekeeping and maintenance staff as well as the registered manager.

We 'pathway tracked' three of the people living at the service. This is when we looked at people's care documentation in depth, obtained their views on how they found living at the home where possible and made observations of the support they were given. It is an important part of our inspection, as it allowed us to capture information about a sample of people receiving care. We also looked at care records for three other people.

During the inspection we reviewed other records. These included staff training and supervision records, staff recruitment records, medicines records, risk assessments, accidents and incident records, quality audits and policies and procedures.

Inadequate

Is the service safe?

Our findings

People we spoke with told us they were happy living at St Claire's Care Home, they felt safe and secure. Comments included, "I think myself lucky to live here", "The staff look after me well" and "I am very happy to be here". Visitors felt they were kept up to date with the care and support their relatives received. Discussion with health and social care professionals found no concerns about the people living there, the service and staff. However, we identified a number of areas of concern which meant the service was not safe.

We assessed the procedures for ordering, receipt, storage, administration, recording and disposal of medicines. People were at risk of unsafe care and treatment because management of medicines was not safe; processes did not ensure people always received medicine they were prescribed. For example, a medicine to be given to two people once a week had not been administered when due in the current week; it remained in its packaging. The Medicine Administration Record (MAR) had not been signed or annotated with a code to explain why it had not been given; staff were unable to provide a reason why. Although identified during the inspection, established staff checking procedures also independently identified that this medicine was not given. Staff followed reporting protocols, this ensured senior staff were aware of this incident and any advice needed was sought.

Where people were prescribed pain relief patches, although staff were able to tell us where they applied them, this information was not recorded. Therefore, should a patch be removed before its replacement, there would be no record of where it previously was to ensure rotating of application positions to avoid skin irritation. Similarly, records to indicate if topical creams had been applied were not always completed. This made is difficult to establish if they were administered as required. Most liquid medicines need to be used or disposed of within a given timescale to ensure they do not become desensitised; it is therefore good practice to record on the medication its date of opening. This was not always done.

A central medication stock room contained newly received medicines and also acted as a storage area for any medicines due to be returned to the pharmacy. Non refrigerated medicines are required to be stored at temperatures not exceeding 25 degrees Centigrade; this helps to ensure active properties do not deteriorate. Although cooling equipment was provided within the central stock room, occasionally excessive temperatures in a secondary medication storage area had not been similarly addressed. This introduced a risk that these medicines may be affected by storage temperatures outside of the maximum levels

People were at risk of unsafe care and treatment because risk assessments did not always record sufficient measures required to keep people safe. For example, falls risk assessments noted several people should have a member of staff to support them when they moved around such as going from a seated to a standing position, getting out of bed and when walking around. Risk assessments were reliant on people asking for help, or remembering to use walking aids, however, most people lacked capacity to structure tasks to anticipate this need. Accident records showed people had fallen while unsupervised and were reliant on calling out or on staff checks for help. There was little use of assistive technology such as bed, chair or floor pressure monitors which may have alerted staff to the unsupported movement of people and increased possibility of them falling. Incidents and accidents were not routinely investigated or linked to reviews of risk

assessments. Following a fall sufficient consideration was not given to alternative strategies; the risk of falling was not suitably mitigated. People were at risk of continuing injury and poor care because management of accidents and incidents did not reflect learning to minimise the risks of incidents happening again.

Providers are required to ensure the premises and any equipment used there are safe. Thermostatic water mixer valves, intended to deliver water at a safe temperature, were fitted throughout the service. With the exception of one reading, water temperature checks established maximum safe temperatures were not exceeded. However, this was achieved through the adjustment of boilers because a number of thermostatic water mixer valves had failed. This presented two risks; firstly some thermostatic water mixer valves, known to be defective, would not operate correctly in the event this function was needed; this presented a risk of scalding. Secondly, hot water was not produced or distributed at sufficiently high temperatures to comply with the service's Legionella prevention policy. In addition to this, other than an annual Legionella test, none of the other preventative measures set out within the service's Legionella prevention policy took place. These should include regular temperature checks of hot and cold water, flushing of pipework and cleaning of shower heads. This presented a risk of infection.

Safety testing of portable electrical appliances (PAT) had lapsed in July 2016 and, although brought to the attention of the provider by the registered manager, no action had been taken to address this. The electrical instillation certificate, intended to ensure the safety of the wiring within the service had lapsed in April 2015. When last inspected, engineers noted two pages of observations and recommendations for improvement and remedial work to the safety of the wiring; seven of the items noted required urgent attention. The provider was aware this work had not been completed; this showed complacency for the safety of people, visitors and staff at the service.

The provider had failed to ensure that medicines were properly managed; assess the risks to the health and safety of service users or do all that was reasonably possible to mitigate risks. The provider had not ensured the service was safe; water temperatures were not safely regulated; arrangements were not in place to safeguard against the risks of Legionella. This was a breach of Regulation 12 (1)(2)(a)(b)(d)(e)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us staff experience and skills were used to inform staff deployment; there was no staffing tool used to link people's dependency levels to staff requirement. At the time of our inspection there were 35 people using the service, accommodated over four floors. 11 people needed support of staff while mobilising or receiving personal care, while a further three people needed the support of two members of staff to be turned in bed to reduce the possibility of developing skin pressure areas. Staffing comprised of five care staff including a senior carer between 8am and 8pm, support at night was provided by three wake night staff. In addition, the registered manager regularly worked alongside staff supporting people. There was no post for a deputy manager or administration support, although historically there had been. The service employed a maintenance person who was shared between three sites owned by the provider. Kitchen staff were not present at weekends beyond 3pm; cleaning staff were present Monday to Friday but only for four hours on a Saturday and not at all on a Sunday; in their absence all of their duties were undertaken by care staff. Although no one was receiving end of life care during our inspection, the registered manager always ensured a member of staff was available to sit with people in their final hours. There was no contingency for this within staff deployment which meant, when required, this additional staffing need was met at the expense of staff supporting other people.

Discussion with staff and the registered manager identified busy times of the day where additional staffing was required. For example, some people received medicines at 7am, this was because they needed to be

taken a certain time before food. This meant one member of staff was engaged in giving out medicine. Since only three staff were on duty until 8am, where other people needed support from two members of staff at the same time, this effectively meant there were no staff to supervise or support the remaining 33 people at the service. On the second day of our inspection, some medication that should have been given at 7am had not been. Although through prioritisation, staff felt people received the support they needed, some staff felt the support provided was delayed because they were busy and, during these times, the support provided could feel task orientated. Other busy times included meal times and periods during the evening when people wanted to go to bed. Since many people required support to eat, staff reported some people's food was no longer hot when they were supported to eat.

The provider had not ensured there were sufficient numbers of staff deployed. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked around most areas of the service, although the basement dining area had recently been decorated with new flooring and furniture ordered, other areas were poorly maintained and in need of decoration and repair. For example, one toilet cistern lid was broken leaving sharp edges and another toilet cistern was not securely attached to the wall. Half gates placed at stairs prevented unaccompanied access to people to reduce the risk of falls, however, one magnetic gate lock was broken and the gate secured with a lifting belt. Although this secured the gate, it would not release automatically as intended if required in the event of fire. Pipe joints in the central medication room had been leaking and were tied with rags in an attempt to absorb dripping water. Some chests of drawers and bedside tables were in poor repair with collapsed drawer frames and drawer fronts, water damage to the surface of a bedside table meant it was permeable, it would absorb and retain liquids and be difficult to clean. Some lap tables were in poor repair with pieces missing or exposed wooden carcase enabling absorption of fluids and presenting surfaces which were difficult to clean.

Decoration throughout most communal areas of the service required attention; wallpaper in a stair well was no longer stuck firmly to the wall, areas of ceilings and walls on the top floor of the property were water stained or bare plaster where water leaks had once occurred. Corridors, in particular on the ground floor required decoration; most painted woodwork was heavily chipped exposing bare wood which is absorbent and therefore difficult to effectively clean. A plastic edge protector on the corner of a wall inside the main reception area was broken and jagged, presenting a skin tear risk. Discussion with the registered manager found they were not aware of any maintenance plan for the service and although new dining furniture was ordered, it was unclear when it would be in place. Checks undertaken by the registered manager showed they had recorded the deficiencies above as needing repair; with the exception of decorating and the magnetic gate lock, all other work was rectified during the inspection.

Maintenance had not kept pace with the rate of wear. When carried out, maintenance was completed reactively with little evidence of forward planning. The provider had not ensured the premises were properly maintained. This was a breach of Regulation 15 (1)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We read six staff recruitment files to make sure proper pre-employment enquiries had been made. All appropriate documentation had been completed and references, identity and Disclosure Barring Checks (DBS) checks had been recorded. DBS checks establish if any cautions or convictions mean that an applicant is not suitable to work at a service. Interview notes had been kept and these showed the service had made efforts to take on the best staff for the job. However, although the registered manager had completed the required checks and reference requests for two new staff, recruitment files were yet to be completed. This made it difficult for the service to effectively audit recruitment processes and introduced a

risk that key recruitment checks may be overlooked. This is an area we have identified as requiring improvement.

Discussion with staff showed they understood about keeping people safe from harm and protecting them from abuse. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. There was a policy and procedure that informed them what to do. The service were familiar with locally agreed safeguarding protocols. Staff said in the first instance they would alert any concerns they might have to the registered managers, but understood about and could name the relevant agencies that could be contacted if their concerns were not acted upon.

Records showed fire alarm and fire fighting equipment was checked regularly to help keep people safe. Tests and checks of the alarm and emergency lighting were carried out on a weekly and monthly basis, to ensure equipment was in working order. Fire drills had been completed in line with the service's policy. Personal emergency evacuation plans ensured staff knew the support people needed to leave the building in the event of an emergency. Service contracts ensured equipment to support people with their mobility such as the service's passenger lifts, standing and lifting aids and bath chairs were safe and fit for purpose. A current gas safety certificate was in place.

Requires Improvement

Is the service effective?

Our findings

People, their relatives and visitors were positive about the quality of care provided. People had confidence in the staff who supported them, they felt staff understood their needs and knew how to meet them. Comments included, "No concerns whatsoever about the staff", "They seem to know what they're doing" and "All of the staff are friendly and approachable". People and their relatives said that staff communicated with them well. A visitor commented, "Staff are always polite and welcoming. Communication is good, they ring if mum is poorly and make a point of telling me how she has been when I visit. I can't fault them". Although people commented positively, we found aspects of the service were not effective.

The Care Certificate is an identified set of competency standards for social care workers to keep to in their daily working life. The Care Certificate is not a mandatory requirement; however, the expectation is staff who are new to services will achieve the competences set out in the Care Certificate, or their equivalent, as part of their induction. Discussion with the registered manager found the service subscribed to the Care Certificate and training records confirmed all new staff were expected to complete the various modules during their induction period. However, the service did not have access to the coursework or training material required to enable staff to undertake this training; there was no equivalent training in place. Although new staff did not work unsupervised, induction training was incomplete. In addition certificates were not available for all training delivered and the staff training matrix was not up to date with the names of each staff member; this made it difficult to establish a complete overview of training delivered and training requirements.

Although the registered manager regularly worked alongside staff, enabling them to complete observation and competency assessments of staff, no formal supervision had taken place in the current year. The service's policy set out that supervision should be completed every eight weeks. This had not happened.

Staff had not received appropriate induction training to enable them to carry out the duties they were employed to perform; the provider had failed to ensure staff received appropriate and effective supervision to meet with the requirement of their policy. This was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most staff had received training about the Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS). DoLS form part of the MCA and aims to make sure that people in care settings are looked after in a way that does not inappropriately restrict their freedom. Where restrictions are needed to help keep people safe, the principles of DoLS ensure that the least restrictive methods are used. Restrictions could include, for example, bed rails, lap belts, stair gates, restrictions about leaving the service and constant supervision inside and outside of the service.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). Some people living at the service were subject to restriction of movement around the service and needed to be supervised if outside of the service. The MCA requires providers to submit DoLS applications to a 'Supervisory Body' for authority to impose restrictions. An application and authorisation had been made and granted for one person; applications for another 10 people had been made but awaited decision from

the supervisory body. Three people at the service did not lack capacity and were either consenting to restrictions in place or had uninhibited movement inside and outside of the service. However, applications were required for the 21 remaining people at the service who were subject to restrictions, such as a locked half gate preventing access to the front door, stair gates preventing free movement around the service and could only leave the service accompanied by staff. Discussion with the registered manager found DoLS applications had not been made for the remaining people as was required.

A person must not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. This is a breach of Regulation 11of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed staff handover during the change of shift. This was structured and informative, giving a detailed and individual summary of people in terms of their wellbeing and any needs as yet unmet. The service used a diary system to keep track of medical appointments, blood tests and follow up of blood test results.

Each person had a health care plan. This set out their initial assessment when they arrived at the home and regular, subsequent reviews charted changes in their health needs and on going support needed. Care staff were knowledgeable about the people they supported, their specific health needs and how the needs should be met. Where needed, the service sought input from social and health care professionals such as the community psychiatric team, speech and language therapists and occupational therapists. This helped to ensure people received the right help to support any emerging needs. People told us they saw their GP when they needed to and felt their health care needs were being met. We spoke with a visiting health care professional, they were complimentary of the staff and the care provided by the service; telling us effective health management and communication ensured people's changing needs were identified and, where needed, professional health care input obtained. This helped to ensure people's health care needs were met.

Relatives were satisfied with the health care people received at the home. Chiropodists, dentists and opticians visited the home when people needed them. The registered manager recognised the importance of seeking expertise from community health and social care professionals so people's health and wellbeing was promoted and protected. Where people needed specialised support, for example, pressure relieving mattresses and cushions to help reduce the risk of skin damage, suitable equipment was in place.

People received a wide variety of homemade meals, fruit and vegetables were available every day. People told us they enjoyed the food and appreciated the efforts of the chef and kitchen staff. A menu planner showed lunch and supper time meals and choices of desserts. There was a selection of breakfast choices, including a cooked breakfast. The food served was well presented, looked appetising and was plentiful. People were encouraged to eat independently and supported to eat when needed. Drinks were provided during meals together with choices of refreshments and snacks at other times of the day. Where people required soften or low sugar meals, these were provided. Staff encouraged people to drink where needed. The chef was familiar with people's different diets, and kitchen staff regularly discussed menus and the food with people. This helped to ensure they were aware of people's preferences and received direct feedback about the food they provided. Kitchen standards had been assessed by the Environmental Health Authority and had achieved a five star rating, this being the highest standard. A relative commented to us, "the kitchen staff do a good job".

Requires Improvement

Is the service caring?

Our findings

People who spoke with us told us they felt respected as individuals and were happy and content in the service. One person said, "Staff are great, kind, gentle and caring, what more could you want?" Another person told us "I have no concerns about the staff or the care I receive". A visitor commented about their relative, saying, "They take great care of her, she is looking so well". In a survey another relative had commented, "Friendly and kind atmosphere with staff respectful of the individual and the adult status of the resident". People told us staff listened to them and acted on what they said; this was evident from our observations during the inspection. Although people and their visitors were positive about the care received, there were areas for improvement which meant the service was not consistently caring.

Although staff interactions were kind, compassionate and well-intended; staffing numbers meant interaction with people tended to be on a functional level as staff attended to people's needs. For example, staff comforted people who were calling out or distressed and provided personal care as needed, however, staff rarely had time to meaningfully engage with people outside of the functions of care delivery. Our observation found some people sat for periods, in one instance of 12 minutes without any social interaction from staff, during this period they were disengaged, withdrawn and passive. Additionally, other people would for example, sit staring into space or at the floor, some with their eyes closed, occasionally opening them, sometimes changing position and sighing. People only received attention by way of a check or if they became unsettled. Activities were limited in scope and two instances of missed medication during our inspection did not promote the wellbeing or a caring ethos of the service. Staff deployment meant the service was limited in overcoming a functional approach to care and were unable to develop the approach of its staff team to drive forward improvement in all aspects of care delivery, such as a focus on meaningful social interaction and a focus on individual wellbeing. This is an area we have identified as requiring improvement.

Staff were clear about how to treat people with dignity, kindness and respect and communicated in a way to maximise understanding and solicit a response. For example, if people were seated staff crouched down, often touching the person's hand or arm and spoke with people at the same level. They made eye contact and listened to what people were saying and responded according to people's wishes and choices. This approach helped people not to feel intimidated, gave people the sense that staff were sincere and helped people to focus on the responses staff gave. Staff were courteous and polite when speaking to people behind closed doors. For example, we heard a staff member supporting a person in their room. They gave the person time to respond and spoke in a way that was friendly and encouraged conversation.

A number of visitors commented staff had always helped their relative to look their best. Telling us their relative's finger nails were clean and trimmed and their hair was always nicely brushed. Visitors felt staff took that extra bit of care and they appreciated it.

Staff knew people well and demonstrated a high regard for each person as an individual. Staff spoke with affection about the people they cared for. They were able to tell us about specific individual needs and provide a good background about people's lives prior to living at the service; including what was important

to people. We saw people were addressed by their preferred name and staff took the time to recognise how people were feeling when they spoke with them. For example, when one person became agitated staff spoke calmly and slowly with the person and supported them to back to their bedroom. They chatted with the person while doing this which helped to calm them down.

Where possible, people told us they were involved in their care planning and that, in particular, the registered manager found time to chat about their care, ensuring it met people's requirements and was delivered in a way that they wanted. Visiting relatives were given the opportunity to discuss care requirements where some people were unable to communicate their needs or preferences directly. Some people had previously owned pets, they found much enjoyment and spoke of the therapeutic quality in seeing a pet cat belonging to a person at the service.

People's privacy and dignity was protected. Staff knocked on people's doors and tended to people who required support with personal care in a discreet and dignified manner. Care records were stored securely and information was kept confidentially. Staff had a good understanding of privacy and confidentiality and there were policies in place to support this.

Requires Improvement

Is the service responsive?

Our findings

People told us they felt staff supported them and responded to their needs, they said they were asked about their interests and preferences and were offered choice in all parts of their care. One person told us, "It is my choice to stay in my bedroom that is what I prefer to do, I don't like mixing as part of a group. Staff look in on me, they check I'm alright". Another person commented, "I've never needed to raise a concern everything has always been fine here". People were relaxed in the company of each other and staff. Staff had developed positive relationships with people and their families. Staff kept visitors up to date with any changes in their relative's health. Visitors gave positive feedback telling us "The staff are wonderful, everything is done with endless patience". Throughout our inspection people were cared for and supported in line with their individual wishes. However, the service was not always responsive because some elements of care planning were not tailored to individual care needs.

Pre-admission assessments were completed from the outset and intended to ensure the service could meet people's individual needs. These included all aspects of their care, and formed the basis for care planning after people moved to the service. Each person had a care plan. Their physical health, mental health and social care needs were assessed and care plans developed to meet those needs. Care plans included information such as people's next of kin, medication, dietary needs and health care needs. However, we found guidance and Information about care requirements was not always fully explained, making it difficult to know how staff would manage some health care needs consistently. For example, there was no guidance provided to staff about how and when people's catheter bags should be emptied, what to do if blood was present in urine, the increased risk of urinary tract infections (UTIs), how to recognise a UTI, how this may affect people's mobility and cognitive abilities or how the catheter tube should be positioned to prevent risk of skin damage or compression of the tube, which may prevent adequate drainage. Discussion with staff and the registered manager found varied understanding of catheter care and, in the absence of clear instruction; care provided was subject to staff knowledge rather clear processes and individual requirements. People could not be assured of consistency of care; this introduced a risk that these needs would not be met.

Where people had limited or no communication, pain assessments were not in place or any guidance for staff about how people may express pain. Communication may, for example, may be changes in behaviour, a person becoming withdrawn, different facial expressions, crying, pointing to areas of discomfort or changes in eating or drinking habits. Without guidance about how individuals may express pain, it made it difficult for staff to pick up on cues to ensure pain relief was provided or medical advice was sought when needed. This placed people at risk of experiencing unnecessary pain and discomfort and therefore these needs not being met.

Activities were delivered by care staff in addition to their other duties. Some activities took place such as quizzes, puzzles, armchair exercise, outings, and visits from a choir. People also celebrated events such as key Royal family anniversaries, harvest festivals and Christmas as well as people's birthdays. Some people received a daily newspaper and spent time reading or listening to music. Some people shared experiences with each other as they chatted, reflecting on past times. Staff actively encouraged people to remain independent by supporting them to keep in contact with friends and encouraging visitors to the service, one

person occasionally visited the pub and another went shopping. Although people enjoyed the activities provided, they were limited in variety and delivery. In dementia settings activities can include, for example, emphasis on olfactory sensory activities. These evoke memories from smells such as herbs and spices, fruit, cooking and baking. Other activities may include map therapy, using maps of people's past home towns and other familiar places. Similarly, objects of reference, such as rummage boxes and various tactile items enable people to explore which may prompt memories. This helps reminiscence, invoking memories, leading to feelings and emotions being expressed. This can help staff learn more about people's personality and character, which in turn acts as an aid to enhance day to day communication with people through familiarity of areas of interest. The range of activities and interaction with people reflected staff availability rather than being planned to meet people's needs.

Individual needs and preferences had not been fully established. The provider had not ensured care and treatment was person centred to meet with people's needs and reflect their preferences. This was in breach of Regulation 9 (1)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Short term care plans were in place for people with acute conditions for example chest infections. Some care plans were drafted with the support of mental health services where people's behaviour had changed. Where weight loss was noted, relevant external bodies had been consulted such as GPs and a dietician, where needed fortified drinks and enriched diets were provided. This helped to ensure people's nutritional needs were met. Where advice and instruction was received from health care professionals, such as District Nurses, these directions were put into practice. This demonstrated responsiveness to evident changing needs, such as turning programmes in addition to pressure reduction mattresses and cushions to help reduce the risks of pressure areas and breakdown of skin condition.

People and their relatives told us that they knew how to make a complaint; but those we spoke with said they had not had cause to do so. There was a complaints protocol on display which gave directions for how the process worked. People and their relatives told us they could raise any concerns with staff or the registered manager. One relative told us, "They are all very approachable, we can raise any little thing and it gets done". There was an 'open door' policy and the registered manager made themselves available to people and their relatives, this was evident during our inspection and commented upon positively by visitors we spoke with. There was a system for people to write down any concerns and staff told us how they would support people doing this. People were confident they could raise any concerns with the staff or the registered manager and said they would not hesitate to complain if they needed to. At the time of the inspection, the service was not dealing with any complaints; on the contrary, they had received cards feedback expressing thanks for the care and support they had provided.

Requires Improvement

Is the service well-led?

Our findings

The service had an established registered manager in post. People, staff and visitors spoke positively about the manager describing them as "Hard working, approachable and dedicated". Although once in place, the service did not employ a deputy manager or any administrative support, all of these tasks fell to the registered manager together with regularly supporting care staff during busy times of the day and covering care work shifts when other staff could not. One person told us "I think the manager does a good job, they all work very hard." However, we found significant shortfalls in how the home was led.

During our inspection, the registered manager was responsive to our concerns about the breaches of regulations identified and, where possible, put in place immediate measures to reduce some of the risks. However, the quality assurance framework was not effective; there were widespread and significant shortfalls where regulations were not met; it was evident competing priorities, in particular supplementing staffing during busy times, impacted directly upon their time to perform some management functions. Checks undertaken by the registered manager included audits of the kitchen, care plans, staff files, medication, infection control and maintenance. These identified some concerns to the provider; however, not all had been acted upon. Although staff and people told us the provider regularly visited the home, there was little evidence of formal assessments or their review of the quality of the service provided. This meant, because of inadequate evaluation, the need for support and resources to run the service was not always recognised and provided.

Provider systems had not ensured continuity of some key safety requirements. For example, the test certificate intended to ensure the safety of electrical wiring in the service was safe had lapsed. Records showed this had also happened previously, certificates did not run consecutively. This demonstrated a lack of planning and illustrated the service had not learned from previous incidents. Testing of portable electrical appliances had been pointed out to the provider as falling due in July 2016 and had not been addressed.

Other concerns identified during this inspection illustrated the quality assurance framework was not effective. This was because checks had not recognised or put measures in place to address apparent shortfalls. These included systems to ensure care needs were set against staff deployment to ensure at all times an adequate staff resource, appropriate planning of maintenance of the premises and evaluation of the condition of some furniture, effective storage of all medicines, a system to ensure reviews of incidents and accidents and associated risk assessments, effective planning and delivery of training, adequate water management checks and DoLS processes. Systems were incomplete or not suitably robust, they had not ensured continuous oversight of all aspects of the service.

Some records were inconsistent and in some cases incomplete. For example, although adequate recruitment processes and checks were undertaken, some staff files were not fully developed to provide a single reference point for all required information. The training matrix for the service was not up to date with all training delivered and did not contain the names or training records of all staff employed. This did not promote good practice or meet with the requirements of regulations. A review of the policies found most had not been reviewed since 2009, policies were therefore not reflective of the Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

This inspection highlighted a failure to act on feedback received about deficiencies within the service; some shortfalls had not been identified by monitoring systems in place, additionally some records were incomplete. The failure to provide appropriate systems or processes to assess, monitor and improve the quality and safety of services was a breach of Regulation 17(1)(2)(a)(b)(d)i(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager demonstrated a good knowledge of people's needs. During the inspection we observed that people engaged well with the registered manager who was open and approachable. Staff were clear about their role and responsibilities and were confident throughout the inspection.

There was a positive and open culture between people, staff and management. Through our observations it was clear that there was a good team work ethic and that staff felt committed to providing a good quality of life to people. All staff we spoke to told us they felt they all worked well as a team and enjoyed working at St Claire's Care Home.

Systems were in place for quality monitoring checks. Recent quality assurance surveys from relatives gave positive feedback and suggestions had been either responded to or implemented. One visiting professional had commented, "It's always a pleasure to visit, the staff are welcoming and work well as a team."

Services that provide health and social care to people are required to inform the Care Quality Commission, (CQC), of important events that happen in the service. This enables us to check that appropriate action had been taken. The registered manager was aware that they had to inform CQC of significant events in a timely way and had done so.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured care and treatment was person centred to meet with people's needs and reflect their preferences. Regulation 9 (1)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure people were not be deprived of their liberty for the purpose of receiving care or treatment without lawful authority. Regulation 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure medicines were properly managed and assess the risks to the health and safety of service users or do all that was reasonably possible to mitigate risks. The provider had not ensured the service was safe; water temperatures were not safely regulated; arrangements were not in place to safeguard against the risks of Legionella. Regulation 12 (1)(2)(a)(b)(d)(e)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment

The provider had not ensured the premises were properly maintained. Regulation 15 (1)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to act on feedback received about deficiencies within the service; some shortfalls had not been identified by monitoring systems in place, some records were incomplete. Regulation 17(1)(2)(a)(b)(d)i(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were sufficient numbers of staff deployed. The provider had failed to ensure staff received appropriate induction training; staff did not receive appropriate and effective supervision to meet with the requirement of their policy. Regulation 18(1)(2)(a)