Claremont Care Home Limited

Claremont 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 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

Claremont Care Home was last inspected in June 2014 when it was found to be meeting the regulatory requirements which applied to a home of this kind.

The current inspection took place on 18 December 2015 and was unannounced. The inspector returned to complete the inspection on 22 December 2015.

Claremont Care Home is a privately owned residential home for older people. The home accommodates up to 24 residents in 22 single and 1 shared rooms. It is situated on a main road and has small car parks to the front and rear of the premises.

There is a registered manager at the home. 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.

We found that the people who lived in the home and their relatives were pleased with the service provided by the staff. They felt safe and said that there were sufficient staff who knew about them and so provided personal care which met their needs. People were able to exercise choice whilst living at the home and staff had a good idea of people's preferences and how to provide care in a way that met these and took them into account.

The home had a key worker system which meant that each person was allocated to a named member of staff who would look after certain requirements and make sure that personal care needs were addressed. Most people told us that they thought the food was good. Medicines were administered safely for those who wished to have help with this.

Communal areas of the home were clean but we had some concerns about other aspects of infection control. Record-keeping did not always confirm that personal care had been provided or other requirements had been met. Some attention was required to fire precaution arrangements and policies and procedures needed revision. We have included some recommendations in respect of these areas of concern.

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 service was not always safe. Although staff had a good understanding of safeguarding requirements, training and policies were not complete so it was not clear how this would be supported in the home.

Arrangements for effective infection control were not always in place and storage areas were untidy and cluttered. However we saw that communal areas of the home were clean and people told us they were happy with this.

People who lived in the home and their relatives were satisfied with the level of staffing. Medicines were administered safely. Some of the arrangements for fire evacuation and other precautions required review.

Is the service effective?

Requires Improvement

The service was not always effective. Improved stock control was required around the storage and supply of food and better arrangements needed to be investigated for people who required special diets. Better arrangements were needed to reconcile the needs of the home's pet with good food hygiene control.

Most people who lived in the home and their relatives thought the food was good. The registered manager had a good grasp of arrangements required under the Mental Capacity Act 2005 but this needed to be extended to other staff working in the home.

Is the service caring?

Requires Improvement

The service was not always caring because records did not confirm that people had received help with personal care such as bathing or managing nutritional risk. However all the people we spoke with had received personal care and were satisfied with it.

The home had a key worker system which worked well. Staff took care to preserve people's independence whenever possible.

Is the service responsive?

Requires Improvement

The service was responsive. Care plans reflected people's current personal care needs and relevant information was passed between the staff as required. Care responded to people's needs as they changed but was provided with discretion.

Activities were available for people who lived in the home. However people were also able to exercise a great deal of choice about how they spend their time as well as about what they ate at meal times.

Is the service well-led?

Requires Improvement

The service was not always well-led. Quality assurance checks did not always lead to omissions being identified and the required action being taken. Policies and procedures needed updating to take account of current circumstances.

The registered manager took a "hands on" approach. This meant that she was very familiar with all the people who lived in the home and knew their needs.

Claremont 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 was 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.

The home was last inspected in June 2014 when it was found to be meeting the regulatory requirements which applied to a home of this kind.

This inspection was undertaken by an adult social care inspector. It took place on 18 December 2015 and was unannounced. The inspector returned to complete the inspection on 22 December 2015. Prior to the inspection information was requested from the local authority which commissions services and is responsible for safeguarding adults in the area in which the home is located. We reviewed this along with information already held by the Care Quality Commission (CQC) such as previous inspections, registration information and notifications made by the provider to the CQC.

During the inspection we talked with 10 people who used the service as well as four relatives and other visitors to people who lived in the home. We spoke with eight members of staff as well as the registered manager and the owner of the home.

We looked around different areas of the home at various times and, with their consent, the bedrooms of people who lived there. We looked at four care plans and four staff files as well as other records used by staff in connection with the care of people in the home. We also looked at audits and other quality assurance documents as well as the home's policies and procedures.

Requires Improvement

Is the service safe?

Our findings

One relative told us "I never worry about leaving (my relative) in here. I never worry that they are not being looked after. They've lived here for some years and I have never had any concerns about abuse."

Another said "I have absolutely no concerns. My relative is happy, laughing and talking to everybody" and added "Whenever we are here (to visit) there seem to be enough staff in the lounge".

A member of staff told us "If I thought for one minute that anyone in this home was being abused I would whistle blow. I wouldn't allow it for my mother and it is not fair for anyone else".

We saw that there was a safeguarding policy in the home. This identified that training would be available to all staff at basic awareness level 1 and certain more senior staff at safeguarding adults level 2. One member of staff was able to tell us of a safeguarding concern they had had and how they had shared this with the manager and appropriate action had been taken to investigate and resolve it. We looked at the records regarding this incident and saw that the member of staff's concerns had been taken seriously and acted upon.

Staff told us that they had completed safeguarding training through an "ebooklet" during induction. Staff could describe having undertaken this training but when we checked the training matrix SOVA (safeguarding of vulnerable adults) training was not recorded for two out of three of the senior carers identified on the current rotas. However all the staff we spoke with were clear about what they would do if they suspected abuse and that if they were still concerned they would whistle blow or inform an agency such as the Care Quality Commission (CQC).

We compared the staff rotas with what the staff we saw on duty. On weekdays the rotas showed there was a senior carer on duty together with three carers in the morning and two later on up to 8 pm. The registered manager, owners, activities organiser and other staff such as the housekeeper and cooks were also available mainly in the day time. There were two carers on duty each night. At the weekends a senior carer would sometimes be substituted with a member of care staff who was authorised to "act up" in this role".

None of the people we spoke with or their relatives had any complaints about the level of staffing and we did not see delays in providing personal care for people. Staff told us that it could be busy at times but did not feel that staffing levels were inadequate. They told us that at weekends and at night they had good access to support from the management of the home.

We saw senior staff administering medicines to people who did not wish or could not do this for themselves. We saw that this was undertaken in a methodical way. The senior staff were not interrupted whilst they did this which meant the potential for mistakes was reduced.

We tracked the way that medicines were supplied to and administered in the home. We saw that staff made detailed checks including against the medicines administration record (MAR) sheet before reordering stocks

of medicines through repeat prescriptions. A master file was maintained of all changes or variations to medicines so that other staff could double check if a change had been made with the reason for this (for example if a general practitioner had made a change). We were told that people's doctors were always asked to personally record any changes directly on to that person's MAR sheet.

Prescriptions were then raised by the pharmacist from the relevant practitioners and supplied to the home usually though the BioDose system. This is a system that predispenses each dose of medicine (including liquids) into a tray of sealed containers for the period covered by the prescription. People can receive their medicines direct from these containers. However at the time of our inspection the pharmacist's equipment for dispensing in this way was temporarily out of action and so they had reverted to another monitored dosage system.

We were told that on delivery two staff checked the tray to ensure that it corresponded with the medicine ordered. The tray was marked with a photograph as well as the name of the person and the day and time of the dose so ensuring that staff could check that they were delivering the right medicine to the right person at the right time. We saw that there were notes which helped staff to determine how and when PRN ("as required") medicines should be given.

We saw that creams were stored in people's bedrooms and a separate record kept of their administration. We saw that one person administered their own medicines because they remained independent in this respect. Although we found a risk assessment relating to this along with other reviews it had not been updated to ensure that it was still relevant and met current circumstances.

We were told that no one in the home was receiving their medicines covertly that is without their explicit consent. We saw that the home had a medicines policy which had been tailored by the registered manager to suit local circumstances.

We looked around the home on a number of occasions to see if it was clean. We found that the communal areas such as the lounges and dining areas were clean as were the bedrooms we visited. Bathroom areas were clean. One relative told us that they thought that the home was cleaner than it had been before and that when their relative ate in their own room any spillage was always cleared up.

We saw that staff that staff usually wore personal protective equipment (PPE) when undertaking personal care tasks. However we saw two occasions when staff did not wear plastic gloves when disposing of waste. Not all staff observed a "bare below the elbows policy" meaning that rings or other jewellery could compromise effective hand hygiene and increase the risk of cross-infection.

We found stocks of PPE at various points throughout the home although there were two bathrooms where it was not available. We also found some PPE supplied in people's bedrooms. However in the bathrooms and cleaners' stores PPE such as gloves was left in a box on a shelf or a window sill rather than being available from a wall dispenser. In one instance it was obscured by window blinds. Purpose-built wall dispensers make PPE more readily available and can reduce the possibility of cross-infection. We saw that the absence of these dispensers had already been pointed out to the home at previous visits from the local NHS infection control service. In one area where a dispenser had been installed it had not been replenished and so no PPE was available at that location.

In the morning of the first day of our inspection we found that a ground floor toilet next to the main dining area contained foul matter which had not been noted and attended to by the staff. The door was left open and was close to where people were eating. This was unhygienic. Since the day time domestic staff had not

yet come on duty we concluded that it had not been noticed by the night staff. We checked the cleaning schedule and found that the toilets in the home were described as having been cleaned during the previous night. The cleaning routines had not therefore been sufficient to detect the toilet as dirty and needing to be cleaned within a reasonable time.

We brought the matter to the attention of the registered manager who rectified the matter. We were told that there was a fault with the flush in this toilet which would be attended to.

There were a number of areas where there appeared to be inadequate storage facilities in the home. We checked these on both days of the inspection. On the upper floor of the home we found a cleaners' store cupboard which had been converted from a shower. The store was cluttered, and untidy. We found a similar store on the ground floor with a lockable cupboard which could no longer be secured because it was broken and which contained a bottle of toilet cleaner with a warning that it was an irritant hazard. There was a storage container on the floor which was dusty and had not been cleaned. In neither instance were these stores locked meaning that hazardous chemicals were not secured. Only one of the cleaner's stores had a handwashing sink but there was no liquid handwash, towels, disposal bin or hand wash instructions. Access to the sink was cluttered making it difficult to use.

We saw that there were instructions for fire escape kept by each fire extinguisher but these were stored loose and could easily have been displaced and lost. A fire escape route from the dining room was unmarked and we saw garden furniture immediately outside which might have impeded an orderly exit. We found a supply of toilet rolls piled beneath the stairs leading into the basement. Homes should avoid the storage of flammable materials in the voids under stairs because of the potential for a fire to render this means of escape unusable.

We found an emergency evacuation plan in the registered manager's audit file. This listed each person's mobility requirements and allocated them a grade according to the level of assistance they required. However this list would have been of limited use in an emergency evacuation. It did not describe in detail the measures which different people would require such as the use of evacuation sledges which we saw in place around the home. In describing people's requirements it included references to lifts which might be discouraged in the event of a fire. Current guidance suggests that where people have special needs individual "personal emergency evacuation plans" (PEEPS) should be developed and should be discussed with the people to whom they apply.

The fire bells were tested during our inspection but we noted that according to training records no staff had completed fire awareness training and there was no fire drill recorded for some time. We have asked the Greater Manchester Fire and Rescue Service to advise the provider on fire safety arrangements in the home.

We recommend that the provider reviews arrangements for infection control (including the most recent recommendations of the NHS infection control service visit to the home) and overall cleanliness to ensure that these arrangements conform to the most recent guidance.

We recommend that the provider urgently reviews fire precautions and procedures in the home.

Requires Improvement

Is the service effective?

Our findings

We asked people who lived in the home what they thought about the food and they told us "The food here is good". Another person who lived in the home said "I can't fault the food but I think they could give you a bit more. You are only occasionally offered a second helping of sweet." We saw this person ask for a second helping after a meal and this was supplied.

One relative said "(My relative) eats really well here – They're having egg and chips today and that's their favourite" and another commented "They have the sorts of meals here that older people like."

We looked at the arrangements for eating and drinking in the home. There was a main dining room which could accommodate 18 of the people who lived in the home although on the first day of our inspection about 12 people ate their lunch in here. Other people were served their lunch in other parts of the home including in the lounges and other communal areas as well as their bedrooms.

We saw that here was a menu written up on the main noticeboard. The menu choice for the first day of the inspection was fish or egg with chips and vegetables followed by apple crumble for pudding. Tea was a choice of sandwiches, cocktail sausages or chicken nuggets followed by arctic roll or banana. Portions appeared adequate and there was little waste. All of the people we spoke with and their relatives or visitors were positive in their comments on the quality of food in the home.

We noted that a pureed meal was served where required. Pureed meals are usually provided where a person has a particular need for food to be presented in this way perhaps because they have difficulty in swallowing food otherwise. We saw that a member of staff was taking time to patiently support the person with their meal. However on both days of our inspection we saw that the different components of the meal were mixed and served together as a single mush. This did not appear appetising. We pointed this out to the registered manager and discussed it with the cook. It is possible for pureed meals to be presented in such a way as to preserve both the appearance and flavour of the individual components of the meal.

Staff engaged people in conversation about their meals and provided assistance where required. We saw that where people did not eat or seem enthusiastic about the food provided (because they had changed their mind or felt differently since they had chosen or had lost their appetite) that staff made efforts to suggest something different which they then provided.

We spoke with the assistant cook on the first day and the cook on the second day of our inspection. We saw that the menu was constructed around a three-weekly cycle. Arrangements were in hand for the Christmas season.

We saw that the kitchen was well-equipped commensurate with the size of the home. Food was stored in a separate area in the basement. The assistant cook showed us how they checked the temperatures of each of the refrigerators and freezers kept there. Although the cook used a modern infra-red thermometer for this we found that there were a number of old thermometers in these units. Where these were not functioning or

not required they should have been removed to avoid confusion with the correct reading and to reduce the presence of extraneous items along with the food.

We saw logs that recorded that this refrigeration equipment had been checked daily and was all running at the correct temperatures. However we noted a build-up of ice inside both upright freezers suggesting that some maintenance was required. One refrigerator was used only for milk supplies. We noted that the inside of this refrigerator required cleaning and that there was debris on some of the shelves. We brought this to the attention of both the registered manager and the cook.

We also checked some of the contents of the third freezer which was of a chest design. We saw that there were some items in here which had exceeded their "best before" date. The owner explained that they had placed one of these items in the freezer before the "best before" date had been reached. However the date these products were placed in the freezer had not been recorded on them and therefore it was impossible to tell how long they had been there. We also looked at the dry foods store and saw that some foods including trifle sponges and flan cases had exceeded their "best before" dates and should have been discarded. There was no evidence of an effective stock rotation system in place.

We saw that there was cat in the home which we were told was the pet of the people who lived there. We saw that the cat liked to perch on the serving hatch from the kitchen. Although staff repeatedly moved the cat away from the serving hatch as they passed it returned there again almost immediately after. We did not always see the service hatch being cleaned and sterilised after the cat was moved. This was impractical for the care staff that were busy attending to the people who lived in the home. We were concerned that this was unhygienic and that the cat could easily gain access to the kitchen which was also unsupervised in the mornings and in which there was dirty crockery as well as open pots of preserves which the staff were using to prepare breakfast. We brought this to the attention of the registered manager and will ask the local food hygiene standards agency to advise on this at their next inspection.

In order to check that the provider made sure that staff were suitable to work in the home we looked at the staff files for the four people who had most recently been recruited to work there. In each instance staff had completed an application form and had supplied two valid references including, where possible, one from a previous employer. The provider had used an interview question schedule to interview them and had obtained disclosure and barring checks. These checks help providers to verify any criminal convictions declared by applicants and to consider whether these would make them unsuitable to work in the care home.

We found some of the files to be incomplete in that there was no record that the provider had made independent checks of identity. These are required by the relevant regulations. It was also not possible to check that staff had undergone an induction programme as these records were blank or incomplete in most instances. However when we spoke with staff they told us that they had undergone induction training which had included topics such as safeguarding, risk assessment, infection control and privacy and dignity. We also saw that there was a record on each file of specific training completed such as moving and handling, dementia awareness, and infection prevention. Staff had also been provided with "easy read" material relating to dementia and Deprivation of Liberties Safeguards.

Claremont Care Home is a residential home and does not provide nursing services. 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 homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

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. We asked staff what they knew about mental capacity. Staff we spoke with showed a good understanding of key concepts and in particular that when providing personal care for a person they should do so with consent wherever possible.

We were told by the registered manager that there were two people currently who were either subject to or for whom applications had been made for them to be subject to DoLS. We were provided with the care file for one and saw that a mental capacity assessment had been completed by a local authority social worker and that there was a valid DoLS authority completed and returned by the supervising authority (the local authority).

In the second instance a mental capacity test had been completed by the registered manager. This showed that people and parties relevant to the person had been consulted in her assessment. We were told that an application had also been made to the supervising authority but the registered manager was not sure whether or not the application had been granted or the paperwork received back for the local authority. It did not appear on the person's care file.

On a third file we saw that a person living in the home had been deemed not to have the capacity to make a particular decision. A few weeks later they were deemed to have the capacity to make a much more significant decision. We saw no formal mental capacity assessment on either occasion. Whilst mental capacity can fluctuate and must be assessed in relation to the specific decision being considered at the time a record should be kept in these circumstances in order to demonstrate that any decision was valid at the time it was made.

We did not see any examples of best interest decisions which are made in respect of specific courses of action proposed for a person who does not have the mental capacity to make such a decision themselves. We were concerned that staff other than the registered manager were not aware of which people were subject to DoLS arrangements because they might have to implement the safeguards in her absence. We saw from the staff training matrix that training in mental capacity was not included and that the home did not have a dedicated mental capacity policy.

We recommend that the provider reviews the options for preparing and serving meals for people who require special (such as pureed or soft) diets so as to ensure that they remain as appetising as possible.

We recommend that the provider ensures that a robust system of stock rotation is introduced with regard to the storage and usage of food.

We recommend that the provider considers arrangements for pets in the home so that they do not pose a hazard particularly to food hygiene.

We recommend that the provider reviews the information use in connection with and retained on staff recruitment files to ensure that it conforms to the requirements of the current regulations regarding the suitability of workers and confirms that staff have completed induction training together with the content of that training.

Requires Improvement

Is the service caring?

Our findings

One person told us "The staff do a good job – they are very patient. I think they have a lot to put up with – but I have never heard them say anything like that (i.e. complain) to me." Another person said "I like all the staff here – they're all right". Three more people told us "The staff are nice here – they are kind" and "The staff here are very good" and "The staff are all fine. They do their best".

Relatives who were visiting on the day of our inspection said "The difference since (my relative) came here has been unbelievable – they are now really chatty" and "It's homely rather than regimental – my relative can mix now …. They're well taken care of. The staff are great. They are genuine and really nice".

We met a visitor to the home who told us "I am visiting a friend. I have never come to a better home. The atmosphere is very relaxed – nothing stressful. The care staff are brilliant. I am always made welcome at any time – it's as much about the little courtesies you don't always see."

We saw that all of the staff in the home enjoyed a warm and friendly relationship with the people who lived there. They talked to people with respect and engaged them in casual conversation. We saw that when people exhibited signs of discomfort or unhappiness that staff asked them what was wrong and how they could help them rather than the person having to attract staff attention.

We saw that the home aspired to involve people in their own care. The most recent service user guide had been published in May 2015 and stated a goal to "produce with each service user and regularly update and thoroughly implement a plan of care based on initial and then continuing assessment". The guide gave a further commitment to people being able to maintain their own time and retain flexibility over routines.

We checked the care plans to see if these aspirations were reflected in them. In each case we found that detailed information had been sought from the person and their family prior to or at admission. This included preferences about how people would like their personal care provided and also included a space for social interests and hobbies. However we could not see any evidence that these had been completed or agreed with the person who used the service and their family. Although we saw that people's care had been reviewed there was no evidence that this had been undertaken with them either or had otherwise involved them.

We asked staff how they maintained people's privacy and treated them with dignity. They told us that they did so by making sure that people were treated appropriately when receiving personal care for example by making sure they were covered up. We saw staff knocking at people's bedroom doors and waiting to be invited to enter.

All the people we met during our inspection were well groomed and wearing clean, suitable clothing. One visitor told us "The personal cleanliness here is beyond reproach" and told us that they thought that staff were particularly supportive in assisting people with toileting. Most people came into one of the communal areas during the day so did not require the use of the call system. Where people stayed in their room we saw

that staff called in on them to check on their welfare.

We looked at how the home recorded nutrition, weights and bathing. We saw that a record was kept of people's eating and drinking where there was any concern about this. We saw that most of the records were made promptly after the meal concerned. On the other hand the records of bathing suggested that some people had not had assistance with bathing for more than a fortnight.

When we questioned this one member of staff told us frankly that they forgot to record bathing sometimes but were able to reassure us that the person they were key worker for had had a bath more recently. This was consistent with what we saw and the people we met. We also saw that there were occasional gaps in the recording of people's weights. We were told that this was because in these instances people had refused to be weighed and this appeared consistent with other information we were provided with. Accurate records of routine but important care tasks such as these together with any refusal of assistance help to ensure that they are not overlooked.

One relative told us about the key worker system in the home. They told us that they had been involved in devising care plans for their relative and that the registered manager and the key worker (who they named) had involved them in this. They told us that in their experience staff took a close interest in what people wanted but also took notice of the ways in which relatives could inform and might wish to influence care.

We saw that people who lived in the home were each allocated to a key worker which was usually one of the senior or other carers. We asked staff what they understood by the role of key worker and they told us that it included being responsible for keeping a named person's bedroom tidy and making sure they had toiletries as well as liaising with that person's family.

We saw from records that it also included making sure that areas of personal hygiene were attended to, attending reviews and taking a wider interest in an individual person's wellbeing and happiness. Conversations with staff suggested that the key worker system was well understood by them since they were able to give us detailed information of this kind about people when we asked about them.

People told us that they thought the staff were kept busy. One person told us how their abilities and circumstances had improved overall since they came to the home. However they felt that the staff were not able to help them with practising walking more independently because "they are so busy". On the other hand other relatives told us that the staff were encouraging their family member not to become too dependent upon a wheelchair. Another person told us how important they felt it was to keep walking with a frame and we saw staff encouraging them to practice this by walking up and down the corridors in the home.

We met some people who wished to remain as independent as possible. We saw that staff respected this and that this was reflected appropriately in the personal care records of those people.

We recommend that the provider introduces measures to ensure that the completion of personal care tasks or any refusal of these by the person concerned is recorded accurately and comprehensively

Requires Improvement

Is the service responsive?

Our findings

One person told us "In the day we play bingo and we have a special set of dominoes for people who cannot see too well" but added "You can't go to bed when you want – you have to go when they say". Another person told us "I'm well looked after here".

We asked if people went out of the home and one person told us "(The staff) haven't taken me out. But in the Summer the garden is beautiful and we can sit out there so there is no need to go out."

Another person told us "I think if you have to live in a home (Claremont Care Home) is as good as it can be". A relative commented "If (my relative) is in need of anything they give it to them. We can visit when we want. If there is something we didn't like we would say."

We met with relatives who told us their family member been admitted to the home recently. They told us that their relative had been in hospital and when they were ready for discharge two of the staff had visited the hospital and found out about their relative's likes and dislikes. We looked at this person's care documents, and saw this initial assessment and found that whilst an initial care plan had not yet been formulated the home was recording information which the registered manager assured us would be used to construct one shortly.

We looked at three care plans for people who lived in the home. We saw that the plans were divided into twenty different sections detailing areas such as personal care, nutrition, skin care and medicines. We saw that these plans had been drawn up when the person had first arrived in the home and had then been reviewed on a monthly basis. The care plans we looked at were up to date in this respect and where appropriate also included a purple "Do Not Attempt Cardiopulmonary Resuscitation" (DNACPR) notice from the person's general practitioner. These were filed within the care plan. A note was made of how they applied to each person on the front page of the care plan which would direct an emergency ambulance crew to the relevant form.

We saw staff updating care plans during the day of our inspection. They did so whilst sitting with people who used the service so that they could continue to chat with them. We saw that the care plans also included risk assessments around such areas as nutrition, falls, manual handling and skin integrity and that these had been reviewed on a regular basis. The home used recognised tools to assist with these assessments including the Waterlow scale for skin integrity and the Malnutrition Universal Screening Tool (MUST). We saw that the care plans were stored in the registered manager's office meaning that they were secure and people could be assured that their information was kept in confidence.

Each of the plans we looked at had a photograph to aid identification of the person to whom they referred. There was also space to write the name and preferred style of address of the person. This had not been completed on all the care plans we saw and so it was not clear how staff would find out and record this information where it was missing and why it had not been identified as required at a care plan audit.

Some of the documents in the care plans were person-centred meaning that they were written from the point of view of the person who lived in the home. This makes it easier to identify a person's individual preferences and organise the care around their needs rather than the requirements of the service. However on the care files we looked at we could not find evidence that the person who used the service had consented to the care plan or been involved in any review of it. Consent to photographs was not in the appropriate section of the care plan although we saw that the standard initial admission documentation contained the person's consent to the home administering their medicines if they wished this.

Staff used a variety of other systems to record care developments. Daily progress notes for each person were complete at the end of each shift with a summary of what had happened during that shift. We saw that these were short but sufficient to inform the next shift of relevant information so that there could be continuity of care. At night a record was kept for each person showing their pattern of sleeping or wakefulness based on two hourly checks. Messages were passed between the night and day shifts in this way.

We saw that one person's circumstances had given recent cause for concern and because of the risk to this person staff were making sure they checked on them so that they would know where they were. This was recorded hourly on a separate chart. Staff were unobtrusive in checking on this person's whereabouts and because of this other people in the home and their visitors would not have been aware of it.

We saw that care plans contained information from other appropriate professionals involved in people's health care including speech and language therapists. During our inspection the district nurse visited the home to see people who were also assisted with keeping hospital appointments.

We saw that schedules with details of the activities organised for people who lived in the home were available on noticeboards in different places throughout the home. The schedule included hairdressing, nail treatments, bingo and quizzes, armchair exercises and one-to-one chats with staff. No activities were scheduled for the first day of our inspection but throughout the day we saw a steady stream of visitors to people who lived in the home. In the smaller lounge a group of ladies were chatting to each other and one was knitting. Relatives told us that a choir had visited the home the day before our inspection and we were told that there were visiting clergy to provide for the spiritual needs of those who wished this. A Christmas party had been scheduled and on the second day of our inspection and we saw people enjoying this with their visitors and the staff.

We asked staff how they promoted choice particularly if people could not easily express this for themselves. They told us that they used their knowledge of the people who used the service to take into account their personal preferences and interpret any cues they might give such as expression, tone of voice and so on. Where someone clearly refused a course of action such as bathing for example, they might leave the person for a while and see if they were agreeable later. Staff were very clear that they could not force people to accept care against their will. They told us that one of the ways they ensured privacy and dignity was by promoting people making their own choices, respecting what these were and avoiding imposing solutions.

We asked staff how people made choices such as from the menu and were told that staff would ask for preferences sometime each morning and then confirm this closer to the actual serving time. One person confirmed this although they pointed out that they sometimes forgot what they had chosen by the time the meal was served. We saw staff approaching each of the people in the home in the course of the morning carefully describing the menu choices and making a note of these so they could be passed to the kitchen.

We looked at the record of complaints in the home and saw that these had been responded to by the registered manager promptly and resolved appropriately.

We recommend that the provider reviews arrangements for obtaining and recording the consent to care from people who are living in the home.

Requires Improvement

Is the service well-led?

Our findings

One person told us "you get to see the manager – but she is very busy".

The current manager of Claremont Care Home has been registered since 1 December 2014. We saw that the owner was present in the home throughout our inspection. We saw that like the registered manager they knew the people who lived in the home well and related to them on a personal and friendly basis.

We asked the registered manager to provide us with information about how she assured the quality of service provided in the home. We saw that this included a weekly and daily checklist which she completed on the basis of a walk around the home and a check on certain records. The daily checks included on bedrooms, bathrooms, lounges and communal areas as well as observing mealtimes in the home. Other daily checks included on the kitchen and night staff. Throughout our inspection we saw that the registered manager was present throughout the home, helped with practical care tasks such as serving breakfast and engaged with the people who lived there and their relatives.

The weekly checklist included making sure that people had been offered a bath or shower, their weights had been recorded, a review of any complaints and an audit of controlled drugs. We saw records that showed that these checks had been completed recently. We noted however that the audits had not identified the shortfalls we had found in recording, particularly of bathing. The registered manager also undertook a monthly audit of areas including medicines and falls and accidents as well as care plans and a full medicines audit.

We looked at the policies and procedures which the home used to provide guidance to staff on the practice and standards expected of them. We noted that some of these policies were out of date and had not been reviewed in the light of best practice and changes of legislation. For example the policy related to whistleblowing was undated but predated current arrangements making no mention of the role played by the Care Quality Commission (CQC) in these arrangements. The policy on privacy and dignity predated the most recent developments in this area of practice.

Most policies we saw were rooted in legislation which had been superseded in 2008. In terms of what we found at this inspection we found no policy relating to mental capacity. We saw that policies relating to confidentiality, nutrition and dignity, end of life care and control of infection had been produced more recently and within the current year. However the policy on control of infection made no reference to the Department of Health's "Code of Practice on the prevention and control of infections and related guidance" which has recently been reissued.

We saw that the policy relating to safeguarding had been produced in September 2015. This had been adapted from the local authority's guidance but was difficult to use because it was not presented in a format that would make it easy for staff to read and follow.

There were signature lists intended to confirm that staff had read the policies but these were either dated

some time ago (August 2013) or were undated. These policies and procedures did not promote contemporary best practice and overall were not fit for current purposes. We saw that the home had been directed towards the need to address this area during a local authority monitoring visit earlier in the year.

We saw that there was a supervision policy which provided for staff to receive six sessions per year of which half were to be private sessions between the supervisor and the supervisee. The purpose of these sessions was defined in the policy as to "discuss, review and analyse people's work practices" and "individual needs for support, development and learning".

We saw that the staff files contained records of supervision. These recorded meetings held with the manager at roughly three or four monthly intervals. We saw that the registered manager had held meetings with staff about every four months. We also saw records of meetings with people who used the service. As many as 11 people had attended these meetings which discussed topics such as the meals in the home, how routines might be carried out and people's preferences.

We saw a number of internal and external audits relating to infection control in the home. Before our inspection we were provided with a copy of an audit which had been undertaken by the local NHS infection control service a year ago. A further audit had been undertaken by them at a visit in September 2015. Although this showed some overall improvement in the home we saw that some items identified in both the first and second reports for immediate action by the care home had not been actioned more than twelve months later on the day of our inspection. This included, for example, the lack of wall dispensers for personal protective equipment, the storage conditions and the absence of a modern bed and commode pan/washer/disinfector.

We saw that the registered manager undertook her own infection control audit in September 2015. However this had not addressed the areas identified for improvement as soon as possible or urgently. Since the recommendations of these audits had not been acted upon this area of quality assurance was not effective.

Registered providers such as Claremont Residential Care Home are required to notify the Care Quality Commission (CQC) about certain events which may affect people who live in the home and the service provided to them. This helps the CQC to discharge its statutory responsibilities to protect and promote the health, safety and welfare of people who use health and social care services.

We reviewed the notifications which had been made to the CQC by the provider in the last year and found that appropriate action had been taken to inform us in respect of three incidents. However we noted that the provider had not informed the CQC of a safeguarding matter which had been reported to us by another agency. We pointed out this omission to the registered manager who told us she had intended to report it and therefore this was an oversight. The provider had taken other appropriate action in reporting the matter for investigation by the local authority.

We recommend that the registered manager reviews her quality assurance arrangements to ensure that the items identified in this report as well as from other agencies such as the NHS infection control service are routinely identified and acted upon on.

We recommend that the provider reviews practices in the home regarding supervision and appraisal to ensure that they support the current requirements of the home.

We recommend that the provider undertakes a comprehensive and systematic review of policies and procedures in the home so as to ensure that they take account of current circumstances, guidance and

regulations as well as best practice.