Crabwall Claremont Limited

Claremont Parkway

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

Overall summary

This unannounced inspection took place over two days on the 6 and 7 November 2014. Claremont Parkway provides accommodation for persons who require nursing or personal care for up to 66 older people. There were 60 people in residence during this inspection, some of whom had dementia care needs.

A registered manager was not in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social care Act 2008 and associated regulations about how the service is run.

Staff safely met people's essential care needs but improvements were needed to ensure people received consistently good quality care. There were systems in place to regularly assess and monitor the delivery of the service although they were not always effectively monitored.

Suitable arrangements were in place for the safe storage, management and disposal of medicines. The arrangements for ensuring medicine stocks were replenished in a timely way had not always been effective. Some people had experienced delays in receiving their medication.

Summary of findings

People were cared for by staff that had been trained to provide the care they needed. People's rights were protected. The registered manager and staff were aware of their responsibilities as defined by the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS).

Staff were able to demonstrate that they understood what was required of them to provide people with the care they needed. People's views about the quality of their service were sought and acted upon. People were treated with dignity and their right to make choices was upheld. Staff were caring, friendly, and attentive. There were activities to keep people entertained and constructively occupied if they chose to participate in them.

People's healthcare needs were met and they had enough to eat and drink. People enjoyed their food and there was variety of meals to suit people's tastes and nutritional needs. People's care plans reflected their needs and choices about how they preferred their care and support to be provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

People had experienced delays in receiving medicines.

People were cared for by suitable staff that had been appropriately recruited.

Risks had been assessed to prevent unsafe care.

Requires Improvement

Is the service effective?
The service was not always effective.

Staff knew their responsibilities as defined by the Mental Capacity Act 2005 (MCA 2005) and in relation to Deprivation of Liberty Safeguards (DoLS) Some staff, however, had not had the training in the legislation that underpins their responsibilities.

People enjoyed their food and had enough to eat and drink.

People received care and support from staff that were appropriately supervised.

Requires Improvement

Is the service caring?
The service was caring.

The staff were kind, considerate and treated people in a dignified manner.

People were involved in making decisions about their care and the way it was provided.

People's privacy was respected. Staff respected people's individuality, and acted upon their likes and dislikes with regard to the way they preferred their care to be provided.

Good

Is the service responsive?
The service was responsive.

People's needs were assessed and regularly reviewed.

People's care was individualised and their preferences were catered for as far as was practicable.

People knew how to complain and were assured that they would be listened to.

We found that appropriate action was taken to resolve people's complaints.

Good

Is the service well-led?
The service was not always well-led.

Requires Improvement

Summary of findings

A registered manager needs to be in post.

The manager was aware of their responsibilities under the Mental Capacity Act 2005 (MCA 2005) and in relation to Deprivation of Liberty Safeguards (DoLS) and applied that knowledge appropriately.

Staff had the managerial support they needed to do their job.

There were systems in place to audit the quality of people's care although record keeping was not always consistently monitored.

Claremont Parkway

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 unannounced inspection took place over two days on the 6 and 10 November 2014.

Our team consisted of two inspectors and an 'expert-by-experience'. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection, we reviewed information we held about the provider including, for example, statutory notifications that they had sent us. A statutory notification is information about incidents in the home that the provider is legally required to inform us about, such as abuse or an allegation of abuse.

During this inspection we spoke with 18 persons who used the service and 10 visitors to the home. We also spoke with 12 staff in addition to the manager, including two nurses, an activity organiser, and nine care staff. We reviewed the care records of six people who used the service and six staff recruitments files. We also reviewed the records relating to the management of the home and the quality assurance of the service provided.

We undertook other general observations in the communal areas of the home, such as the lounges and dining areas. We viewed six bedrooms with people's agreement. We looked at the overall appearance of the physical environment and took into account people's experience of using the facilities such as whether they felt physically comfortable in the home and liked their surroundings.

Requires Improvement

Is the service safe?

Our findings

We found that two people had experienced a delay in receiving their prescribed medicines. One person's record showed that they had not received their dietary supplement for four days because the nurse on duty mistakenly thought it was unavailable and the stock needed replenishing. Staff had requested a repeat prescription for another person's medicine but this had run out before the supplying pharmacy delivered it to the home. The manager said there had been communication difficulties with their supplying pharmacy which meant that people's repeat prescriptions had not always been provided in a timely way. They said were aiming to resolve through meeting with the GP practice and pharmacist. They also told us that they would seek advice and support from the Community Pharmacist.

We saw that medicines were stored and administered safely. Prescribed medicines had been safely supplied in a sealed monitored dose system (MDS). Medicines were safely disposed of when people no longer required them. We saw that a record was kept of all discontinued medicines and their safe disposal.

One visitor said, "[My relative] is safe here and they look after [my relative] very well." We saw that staff were deployed flexibly across different areas within the home and that people's needs were safely met. We saw there were sufficient numbers of staff on duty to provide safe care. However, staff said they often felt 'under pressure' to get things done without compromising people's safety, particularly on the first floor where people had high dependency nursing care needs. Additional staff were being recruited to reduce the workload on staff.

Staff were appropriately recruited so that people were safeguarded against the risk of being cared for by persons unsuited to, or previously barred from, working in a care home. New staff did not start work until all necessary checks had been satisfactorily completed.

People said they were confident that the staff would keep them safe. Staff knew how to recognise and respond to abuse or allegations of abuse.

We saw that a range of risks were assessed to minimise the likelihood of people receiving unsafe care. Where people had accidents in the home, such as a fall, appropriate safety measures were implemented to minimise the risk of such an incident happening again. At the beginning of each shift staff that had arrived for duty were briefed on people's changing needs so that they were able to safely manage each person's care.

There were suitable arrangements in place to respond to and manage emergencies safely such as fire, or power failures. Staff were familiar with these arrangements and knew what to do if, for example, the fire alarm sounded. There was always a designated senior member of staff available 'on call' throughout the day and night to support staff if they needed guidance.

Requires Improvement

Is the service effective?

Our findings

All new staff had received an induction that equipped them with the information and basic skills that enabled them to work competently in the home. Staff said they had received the induction training they needed when they were employed. We saw that staff had received regular refresher training to ensure they had the practical skills they needed to do their job effectively. However three staff said they had not received training relating to the MCA 2005 and DoLS. They understood that people had a right to make potentially unsafe choices as long as they had the mental capacity to understand and weigh up the possible consequences of their actions. In this respect, therefore, they acted upon and understood their responsibilities. The manager was aware of their responsibilities under the Mental Capacity Act 2005 (MCA 2005) and in relation to Deprivation of Liberty Safeguards (DoLS) and applied that knowledge appropriately.

We saw that, where possible and appropriate, people were encouraged to make decisions about their day-to-day lives and their independence was promoted. People had given their consent for professionals to access their care records. We saw clear records of review and how the people who lived in the home were involved in decisions about their care. We also saw that where family members wished to be involved in their relative's care planning regular meetings were held to discuss and review the care and support required.

People had access to healthcare professionals, such as GPs, physiotherapists and chiropodists. However, recorded information about people's healthcare needs was in some cases kept separately from the person's care file. For example, one person had been treated by the Chiropodist, but their treatment record had not been transferred to their care file and had remained as a separate record. This made it more difficult for staff to effectively monitor people's care because pertinent records were not always kept together to provide staff with a readily available overview of treatment the person had received. Other care plans we looked at were routinely reviewed and updated monthly to enable staff to provide people with the appropriate care and timely support they needed.

Staff acted upon the advice of healthcare professionals that were qualified to advise them on people's nutritional needs. However, we saw that one person with swallowing difficulties had been provided with a drink that had been ineffectually thickened to the consistency recommended by the healthcare professional that had assessed their needs. The manager rectified this but conceded that, in this instance, the professional's advice had not been effectively acted upon.

People said they always had enough to eat. They said they were not rushed when they ate their meal and they had time to enjoy their food. People's comments included, "The food is excellent and you get plenty. " People who needed assistance to eat their meals received the support they needed. We saw that staff sat at the same level of the person they were assisting, however we saw one member of staff standing over someone and feeding them while they were in bed. We were told that this was a new member of staff on their first day that should have been effectively supervised by a more experienced member of staff.

Performance appraisals for each member of staff were scheduled to take place at intervals throughout the year. Staff received supervision meetings with the manager to review how effectively they were doing their job. Staff described the manager as supportive and felt they were encouraged to do a good job.

Good

Is the service caring?

Our findings

People said that staff treated them with kindness and consideration. One person said, “When I was in hospital I saw no one but it is very different here. I am well looked after.” Another person said, “I like it here, I love it here.” A relative said, “My [relative] is definitely treated with dignity and respect.” People’s privacy was respected. Staff were mindful that a person’s bedroom was their private space. We saw staff knock on doors and, for example, pause to listen for an invitation to ‘come in’ before going into people’s bedrooms. We saw that bedroom and toilet doors were kept closed when staff attended to people’s personal care needs.

All rooms were single occupancy and people were able to spend time in their room in private if they wished to. People said they were encouraged to personalise their room with items they valued so they felt ‘at home’, such as photographs and small pieces of furniture. People invited their visitors into their rooms or met with them in the communal lounges or quieter areas where there was seating. Visitors said they were always greeted and made welcome.

People used their electronic ‘call bell’ to summon assistance from staff. One person said, “When I ring the bell they are sometimes slow to respond.” Other people had similar experiences but said the staff always came to help them.

Staff interacted positively with people even when they were busy and their manner of approach was patient and good humoured. We saw staff had conscientiously attended to people when they needed assistance or were observed to be in discomfort. Staff encouraged people to do things for themselves. People were not 'rushed' to do things. Care plans included people’s preferred name and people said the staff used this when they spoke with them.

The activities organiser visited people in their rooms on the morning of the inspection to deliver papers and post. People were approached in a caring, respectful and friendly manner and all were asked how they were. We saw that curtains were adjusted in one person’s room as the sun was shining directly in their eyes; another person’s pillows were adjusted to make them more comfortable. We saw a nurse guide a relative to a private area to discuss their relation who was very unwell. The nurse dealt with this in a professional, kind and caring manner.

People and their relatives said they were encouraged to be involved in care planning. A relative said, “My [relative] struggles a bit to put things into words so the staff involve me as much as they can. I like that and it helps my [relative] feel happy.”

Staff were mindful of people’s diversity and understood each person’s right to make choices and preferences had to be respected when caring for them. A staff member said, “What is the right approach for one person might not be the case for someone else even though the basic need might be the same.” They recognised that the people they cared for came from diverse backgrounds and that each person had their own fears and worries about having to be supported to do things they had previously managed themselves. One person said, “They care about me. That is it in a nutshell. It gets me through the day.”

Good

Is the service responsive?

Our findings

People's needs were assessed prior to admission and their care plans were reviewed so that they continued to receive the care they needed. Care and treatment was planned and delivered in line with person centred care. One relative said, “The staff did a full assessment prior to my [relative’s] admission to the home.” They said this reassured them that their relative’s care would be tailored to what they personally needed support with and not just because they were unable to manage to care for themselves. Another relative said, “They see my [relative] as the person they are; not just a number on a bedroom door.”

People were supported to follow their interests and take part in social activities. Two activity coordinators were employed to work with people and facilitate activities they enjoy. They were organised so there was always one on duty seven days a week. They were involved in delivering people’s post to them personally and went around with the menus to help people choose their meals. On the day of our inspection we saw that a variety of communal and individual activities were underway. People were listening to music in the lounge, others were watching television and others reading. A variety of activities were provided such as massage and reminiscing events, including singing sessions, ‘make-overs’ and craft sessions. Where people were unable or chose not to take part in group activities alternative one-to-one activities were provided, which included hand massage, pet therapy, being read to, and listening to music. One group of people regularly enjoyed a crossword solving session. One person said, “It keeps the brain active. We all thoroughly enjoy it.”

People who required to be cared for in bed, or who chose to spend much of their time in the privacy or their room, were included in the activity coordinators workload. This was to minimise the risk of people becoming socially isolated. Activities were tailored to people’s choices and their circumstances. One person said, “I like someone to read to me. I enjoy that because I cannot do much in the way of joining in and my eyesight is not so good anymore.”

People’s personal history and preferences were also included in their care plans so that staff had an insight into what was important to the person, ranging from where they liked to sit in the lounge or at the dining table, to their choice of clothes and when they usually wanted to go to bed.

When we spoke with staff they also had a good knowledge of people’s past history, such as their family background, their previous occupation and where they had lived before they were admitted to the home. This insight enabled staff to personalise the care they provided to each individual, particularly for those people who were less able to say how they preferred to receive the care they needed.

People knew how to share their experiences or raise a concern or complaint. The home had a formal written complaints policy, with a clear procedure to be followed through the required stages. The policy encouraged any concerns to be raised as quickly as possible with a member of staff. If any concerns or questions could not be resolved immediately and informally, the matter would be referred to the manager. The policy identified that the manager of the home dealt with any immediate concerns, with an appropriate escalation procedure available as required. Meetings were also held with the people and their relatives at regular intervals when issues could be raised and discussed. A record of complaints received was kept and included details of what had been done to resolve the concerns. Those acting on behalf of people unable to complain or raise concerns on their own behalf were provided with written information about how and who to complain to. We found that people's negative comments were investigated and resolved, where possible, to their satisfaction.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was not in post when we inspected. The manager registered with us had been promoted within the same organisation in 2014 and although a new manager was promptly appointed their application to register with the Care Quality Commission (CQC) had not been submitted.

The manager had not always ensured that quality assurance systems identified instances where people's care records had been inconsistently kept up-to-date by staff. For example, a healthcare professional recommended that one person who was ill required mouth care every hour to keep them comfortable. The record of care for the two days we looked at did not match the recommended hourly interval. There was, for example, a gap of approximately six hours between two entries on one day and another of four hours on the following day. This record, therefore, had not been effectively monitored and it was not possible to verify if the staff who had been on duty had simply forgotten to complete the record. There was no evidence that the gaps in the record had been challenged by senior staff or a reason given to explain them. The person was too unwell to ask if they had received the mouth care they needed to keep them comfortable. There was evidence, however, that their GP had been consulted about their condition and was involved in their ongoing treatment.

People, including relatives and other visitors, said the new manager was approachable and encouraged them to speak up if they were unhappy with the service provided. Staff said the manager had an 'open door' to them whenever they needed to raise an issue or ask for guidance. Comments from staff included, "If I need to talk with the manager that is not a problem; the manager prefers that I ask if I am not sure about something and I know I will get the constructive advice I need."

Staff said that when they participated in appraisals of their work performance they were asked to reflect upon the way they did their job. They said this made them think about the way people's care had been provided and if they could have done things better.

People were assured that improvements to their living environment, such as repairs, or routine maintenance, were carried out in a timely way. There were systems in place to audit the quality of care provided and to monitor risks. These included audits of medicines, people's care plans, and risk assessments. Other audits included checking that the equipment used in the home had been maintained according to service schedules, such as hoists, electrical appliances and fire detection systems.

The provider had arrangements in place for a senior staff member of the company to visit the home regularly to meet with the manager and review the progress on implementing previously agreed action plans for improvements.