Mr & Mrs V M Patel

Cloyda Care Home

Inspection report

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Ratings

Overall rating for this service	**Good**
Is the service safe?	**Good**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires improvement**

Overall summary

The inspection took place on the 17 November 2015 and was unannounced. The last inspection of this service was on the 9 December 2013. At that inspection we found the service was meeting all the regulations we assessed.

Cloyda Care Home provides personal care for older people many of whom are living with dementia. It can provide accommodation for up to 35 people over two floors. At the time of our inspection 29 people were living at the home.

The service had a registered manager 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 a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The service had a number of measures in place to monitor the quality of the service. However, these measures were ineffective in some areas. This included the storage of medicines, infection control and the continued suitability of people employed by the service.

Summary of findings

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of this report.

People and their relatives were positive about the care and support they received at Cloyda. We saw staff were knowledgeable about people and knew how to meet their diverse needs. We saw genuine warmth from staff towards people who used the service. Levels of staffing were sufficient to ensure people's needs were met.

We observed people were routinely asked for their consent before care was provided. If people were unable to give informed consent, the provider worked within the framework of the Mental Capacity Act 2005. The Act aims to protect people who may not be able to make some decisions for themselves and to make sure their rights are protected.

There were a range of social activities people could chose to participate in if they wished to. Relatives were encouraged to visit the home and to maintain contact with their family members.

People's care needs were well documented. They reflected individual needs and preferences, and were reviewed regularly so they were up to date in order to meet people's current needs. People had access to professionals that would enable them to stay as healthy as possible.

Staff were knowledgeable about people they cared for. Care plans outlined clearly how care should be provided and these plans were regularly updated. Staff received regular training and support to ensure the care they provided remained in line with current good practice.

The registered manager was open and inclusive. They encouraged people to share their views of the service, and they had put a number of mechanisms in place so people could respond in a different ways. People felt their views and concerns would be listened to and acted upon.

People were encouraged to maintain good health. They had access to healthcare professionals. People's nutritional needs were assessed and monitored and people received a variety of meals according to their needs and choice. People received their medicines as they were prescribed by their GP.

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?

Good

The service was safe. People told us they felt safe and staff knew what action to take if they considered anyone was at risk of harm.

There were sufficient numbers of staff on duty to meet people's needs.

Risk assessments had been undertaken so people were supported to be as independent as possible whilst ensuring their safety. Accidents and incidents were recorded and analysed so the provider could minimise possible re-occurrences.

Is the service effective?

Good

The service was effective. Staff received regular training and support to ensure they had the knowledge and skills to care for people who used the service.

The provider met their requirements of the Mental Capacity Act 2005 to help ensure people's rights were protected. People's consent was sought prior to care being provided.

Staff supported people to stay healthy and well by encouraging them to eat and drink sufficient amounts. People received prompt access to healthcare professionals when they needed this.

Is the service caring?

Good

The service was caring. People were treated with dignity and respect.

Staff were knowledge about the people they cared for. This information was also well documented in care records.

Visitors to the home were made to feel welcome and there were no restrictions on them visiting their family members or friends.

Is the service responsive?

Good

The service was responsive. People were supported to take part in social activities arranged in the home.

People's needs were assessed and care plans were developed which set out how these should be met by staff. Plans reflected people's individual choices and preferences.

People felt able to raise any issues or concerns with the registered manager. They felt these issues would be taken seriously and dealt with appropriately.

Summary of findings

Is the service well-led?

The service was not always well-led. Whilst there were some checks and audits to assess the quality of the care people received. These audits were ineffective to monitor and improve the quality and safety of the service provided to people using the service.

The registered manager was approachable. They used a variety of ways to seek people's views about the service in order to improve the experiences of people.

The service worked well with other professionals to achieve the best outcomes for people. Staff were aware of their roles and responsibilities.

Requires improvement

Cloyda 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 17 November 2015 and was unannounced. It was carried out by an inspector. Prior to the inspection we reviewed information of significant events over the last 12 months.

During our inspection we spoke with four people who lived at the home and a relative visiting on the day. Not everyone at the home was able to speak with us about their views of the service; we therefore used a Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who cannot talk with us. We also spoke with two care workers, the activities coordinator, deputy manager and registered manager. We looked at records which included four people's care records, four staff files and other records relating to the management of the service.

After the inspection we spoke on the telephone with another relative and three professionals who had direct knowledge of the service to obtain further information from them.

Good

Is the service safe?

Our findings

People told us they were well looked after and secure at Cloyda. One person told us, “Everyone seems to be well looked after.” Another person said, “The nurses look after everyone really well.”

Records showed staff received regular training in safeguarding adults at risk of abuse. Staff we spoke knew what they would do if they thought someone was at risk of abuse or harm and the immediate actions they would take to protect them. We assured the registered manager was knowledgeable and experienced regarding the processes of safeguarding adults at risk. For example, we saw they had reported concerns regarding people’s safety to the local authority to make sure people were kept safe.

We looked at recruitment checks for staff to ensure only suitable people were employed. We saw there was a range of checks for each staff employed at the service including application forms, employment references and proof of identity and police checks.

Records we looked at showed assessments had been undertaken to identify risks to people’s health and welfare whilst they were cared for within the service. These risk assessments were updated monthly so they reflected people’s current needs and covered areas such as the risks of falls and manual handling. People also had a general risk assessment. By identifying possible risks to people and establishing strategies for managing them, the provider was minimising the risks of harm to people and staff caring for them. For example, one person needed assistance with their mobility. The risk assessment identified what help was required and how it should be provided by staff to ensure everyone’s safety.

We saw the service kept a record of incidents and accidents. These were monitored regularly by the registered manager to identify any possible trends and patterns so action could be taken to minimise the risks of reoccurrence. For example, where people have had falls and were therefore at risks of further falls the provider used pressure mats to alert staff when someone got out of bed at night.

They were sufficient numbers of staff to meet peoples care needs. We saw staff were present throughout the day of the inspection and were able to respond promptly to people’s request for assistance. We checked the staff rota and saw the number of staff on duty had been planned to take account of the care and support each person required. The deputy manager told us that when the numbers of people within the home increased, the provider ensured staffing levels were also increased. We saw the home employed a number of support staff to assist with the smooth running of the home. This included kitchen staff, laundry and domestics, and a maintenance person.

People received their medicines as they had been prescribed by their GP. Each person had an individual record with their photograph and allergies listed. In this way the risks of errors were minimised. Medicines were stored appropriately in a locked clinical room. People’s individual medicines administration record (MAR) had been completed accurately with no errors or omissions.

Good

Is the service effective?

Our findings

Staff received regular training to undertake their roles. One member of staff told us, "There's a lot of good training and I enjoy most of it." The provider had a training programme in place which included seven mandatory courses which included dementia awareness, end of life care and equality and diversity. These courses were refreshed annually. Staff attended training sessions and if they were unable to attend a session, they were expected to complete a workbook on the specific topic and complete questions. In this way the provider was ensuring staff had an understanding of their roles and how to undertake them effectively.

Staff training was monitored by the registered manager by the use of a training matrix. This identified when training was completed and when staff were required to attend refresher courses. Staff were also able to attend specialist training courses on a one off basis if they were considered important to undertake their role. In this way the provider was ensuring the staff team maintained their skills and were up to date with current practice. New staff to the home completed an induction period before they were able to care for people unsupervised. The registered manager told us new staff spent time with the registered manager going through the operation of the home and reading policies. They then spent time shadowing more experienced care workers until they were assessed as competent to undertake their role without supervision.

Staff told us they attended regular team meetings which were held three monthly and, on occasions emergency meetings if an important issue had arisen. Care staff confirmed they had opportunities to meet with their line manager on a one to one basis in order to discuss their work performance. We saw records of these meetings which showed that the line manager used these sessions to ensure staff were up to date and knowledgeable about certain policy areas such as fire safety.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principals of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

We saw staff had received recent training and were able to explain the impact of MCA and DoLS on people living at the home. The registered manager had made a number of applications to the local authority to deprive some people of their liberty and these had been granted. We saw there were systems in place to ensure timely applications were made to renew the safeguards within a year of them being granted in line with legal requirements.

Appropriate arrangements were in place to ensure people gave consent to their care and support before this was provided. We saw a number of examples throughout the day, where staff asked people their permission to provide care. If people were not able to give consent, then this had been recorded and staff had involved other people such as relatives and healthcare professionals to make decisions that were in people's best interests.

People were supported to eat and drink sufficient amounts to meet their needs. We saw people's nutritional needs were assessed and monitored, and their weight checked monthly to identify any issues quickly. For some people the service had completed a Malnutrition Universal Screening Tool (MUST). This is an assessment to determine if people were at risk of malnutrition. Where risks were identified staff monitored people's food and fluid consumption to ensure they did not become malnutrition or dehydrated . The home catered appropriately for people who required soft or pureed food to make sure they had enough to eat and drink.

People's health needs were met by the service. They were recorded in their care plans and there were daily records which identified any concerns. Where concerns were noted appropriate action had been taken to access healthcare professionals. A GP told us, "Staff are diligent in contacting us when they think it's necessary."

Good

Is the service caring?

Our findings

We observed interactions between people and staff was kind and caring. We saw examples where staff took time to sit with people and listen to what they had to say. In another situation we saw a person became anxious and staff were quick to give them reassurance and to ease their distress.

Staff we spoke with were able to give us examples of how they ensured people's privacy and dignity when they provided personal care. We saw staff routinely knocked on people's bedroom doors and sought permission before entering. However, we did note that some of the bedroom doors had frosted glass inserts, some of which had curtains across and others did not. For the bedrooms that did not have curtains across, there was a possibility that people's privacy might be compromised when in their bedrooms. We discussed this with the registered manager who agreed to rectify as soon as possible.

Staff treated people with kindness and compassion. We completed our SOFI observation over lunchtime and saw a member of staff sit with a person and patiently assisting them, offering gentle encouragement. In addition, the member of staff made the experience sociable and relaxed as they chatted through the interaction. We did observe however, another member of staff standing over the person they were assisting. The registered manager also observed this interaction and had raised it with the member of staff.

People's views about how they wanted care to be provided was documented. Where people were unable to express their views due to their complex communication needs, people's relatives and other people close to them had been involved in these discussions to provide information and advice about what people's preferences may be.

Staff were knowledgeable about the people they cared for. In knowing this information, they ensured meaningful care to people. For example, being able to talk to people about their past lives and interests. It also meant staff could respond appropriately and quickly to changes in people's patterns and behaviours. This was particularly an issue if people were unable to verbally communicate their needs. For instance, when a person's behaviour started to challenge staff realised the person might have been in pain.

We saw people's care plans detailed their cultural and religious needs. Staff had completed equality and diversity training and were aware of individual needs in this respect. Representatives from the local churches visited the home on a regular basis to support people with their spiritual needs. Where people had dietary requirements in relation to their culture and backgrounds the provider ensured appropriate meals were offered to them.

There were no restrictions placed on relatives or friends visiting with people at the home. Visitors told us they were made to feel welcome. Visiting relatives and friends appeared comfortable and at ease in the home.

Good

Is the service responsive?

Our findings

People were encouraged to take part in social activities that took place in the home. One person said, “There’s enough for me to do.” Whilst another person told us, “There’s always someone to play dominos with and I like my beer.” There was a range of activities available during the week, some led by the activities co-ordinator who worked four hours a day, Monday to Thursday, and alternate weekends. The co-ordinator also arranged for other people to come into the service such as musicians, the local school and two volunteers.

We saw there were various games, adult puzzles and photographs used for reminiscence work available for people. The activities co-ordinator told us cake-baking and making bracelets was currently popular in the home. On occasions, there was also an opportunity for people to go out for a coffee or lunch. The provider was offering a range of social, recreational and leisure opportunities so people could lead a fulfilling and meaningful life as far as they were able.

A detailed care plan outlined for each person how their care needs would be met by staff. The service had recently moved to a new format for care plans which outlined each area the person needed support with, for example, mobility and dressing. There were clear guidelines about how support was to be offered and the goals and expected outcomes. In one example we saw staff were advised to ensure a person had a walking frame with two wheels and that two members of staff were always required to assist the person with their mobility.

People’s care and support needs were regularly reviewed to ensure their current needs were identified and planned for. Records showed people and sometimes their relatives were involved in an annual review of their care and support needs. The registered manager carried out a monthly review to check for any changes to people's needs. Where any changes were identified following these reviews, people’s individual care plans were amended to reflect this. In this way, the care people received reflected their current needs.

People within the service had a named key worker. The role of the key worker was to have responsibility for overseeing and coordinating the care and support received by the individual. Staff we spoke with who were assigned these roles could tell us detailed information about the individual they were responsible for. This meant care was tailored to the individual, taking account of their preferences and goals.

The home encouraged people to raise any concerns or complaints about the service. People told us they were comfortable raising any issues with the registered manager, who they considered to be approachable. A relative said, “If I had a problem, I’d talk to [name of registered manager], she’s a lovely lady.” We saw a process was in place for the registered manager to log and investigate any complaints received which included recording all actions taken. People were confident the registered manager would take any complaints they had seriously and deal with them appropriately.

Requires improvement

Is the service well-led?

Our findings

The provider carried out some checks and audits within the home to monitor the quality of the service people experienced. However, we noted there were some areas that were not monitored effectively. People received their medicines as prescribed by their GP. However, there was no mechanism to check the temperature of the refrigerator which could result in medicines becoming ineffective because of incorrect storage. In addition, there were out of date medical items in the first aid boxes we checked. We raised this with the registered manager who agreed to rectify this immediately.

We found that whilst the home was clean throughout and free from any offensive odours and staff were able to confirm had all completed infection control courses. We noted the home had not been completing infection control audits in line with the 'Code of Practice on the Prevention and Control of Infections' from the Health and Social Care Act 2008. We discussed this with the registered manager who agreed to put audits into place.

We noted that some of Cloyda's policies and procedures for areas of work were out of date or inaccurate. For example the policy for safeguarding adults at risk did not mention of the local authority and the services responsibility to refer any concern to them. In addition, the complaints policy incorrectly stated that complaints should be made to the CQC only, with no reference to other bodies that may have a responsibility. This may mean that people may be incorrectly directed to the wrong agency causing unnecessary delay.

Whilst we saw evidence the provider recruited people who were suitable to be employed by ensuring all appropriate checks were completed prior to employment, we noted that criminal records checks were completed initially and then not renewed. In some cases we saw this had not been for 25, 15 and 11 years. The provider therefore did not have effective processes in place to manage the renewal of criminal records checks to the continued suitability of staff to remain employed.

The areas identified above represent insufficient governance. The provider has a responsibility to ensure measures are taken to mitigating the risks to people who use the service. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In other areas of auditing we saw there was a three monthly audit of health and safety and care plans were checked and updated regularly. We noted the deputy manager conducted visits to the service during out of hours and at weekends. This was to monitor the quality of service throughout a 24 hour period.

The registered manager encouraged an open and inclusive environment in which people, their relatives and staff were able to speak openly. People and their relatives told us the manager was approachable and willing to listen. A member of staff said, "We're like a family. We can talk to the manager anytime."

People and their relatives were consulted about their views of the service. They were able to share their experiences in various ways about how the service could be improved. For example, every year the provider sent people a questionnaire survey and asked them to rate their satisfaction with the quality of care they experienced. The registered manager also told us about questionnaires that were sent out about specific issues. In recent months there had been a questionnaire about a specific entertainer and also about people's key workers. In addition, the home held meetings which they called 'Get together' for people who use the service once every two/three months. In this way the provider was enabling people to express their views frequently and in a variety of ways.

The registered manager had a clear understanding and vision about what people could expect in terms of the quality of care they received within the home. They took action to reinforce the understanding and vision of staff through team meetings and individual one to one sessions. During the sessions they ensured staff understood various policies and procedures they were expected to adhere to. The registered manager also observed specific tasks to make sure staff maintained a high level of competency, for example, when using equipment for hoisting.

Staff were aware of their roles and responsibilities within the home, although staff we spoke with were willing to assist with other tasks if required or appropriate and worked as a team. For example, we were told a member of

Requires improvement

Is the service well-led?

the kitchen staff had not been at work for some time, and other kitchen staff had covered the absence. A member of the domestic staff had also undertaken food and hygiene training so they could also cover.

The service had a registered manager in post. They had notified the Care Quality Commission (CQC) of significant events in the home in line with legal requirements. The registered manager worked alongside other professionals to promote best practice within the service. Professionals we spoke with were positive about the service. They told us staff knew about people they were caring for and any requests or issues were dealt with quickly and professionally. We noted a paramedic who was called to an emergency at the home, subsequently took time to contact the CQC to let us know how knowledgeable and caring the staff had been.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The provider did not have effective systems to assess, monitor, and improve the quality and safety of services provided to service users.**

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.