Claremont Lodge Care Limited

Claremont Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

In response to concerns about a specific incident, we carried out an unannounced focused inspection of Claremont Lodge on 19 April 2016. Focused inspections do not look at all five key questions of safe, responsive, caring, effective and well-led, they focus on the areas indicated by the information that triggered the concerns. During this inspection we looked at the key questions of 'safe' and 'well-led'.

We last inspected Claremont Lodge on 11 and 12 August 2015. At that time the service was rated as 'Good'. Claremont Lodge is a care home registered with the Care Quality Commission (CQC) to provide personal care and accommodation for up to 18 people. At the time of our inspection the service had full occupancy.

Claremont Lodge is situated in a residential area of Salford, Greater Manchester and is close to local amenities and a park. Accommodation is mainly provided in single rooms with shared lounges and a dining area. Claremont Lodge is an older building with some of the décor worn and traditional in presentation.

During this inspection we found two breaches of the Health and Social Care Act (Regulated Activities) Regulations 2014 in regard to safe care and treatment and good governance. We are currently considering our enforcement options.

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We looked at care plans and associated documentation and found a variety of issues. These included a lack of pre-admission assessments, baseline assessments that did not provide sufficient information to demonstrate how identified risks were mitigated and existing risk assessments that were contradictory and not easy to understand. We also found newly emerging risks were not always recognised and responded to effectively.

We found the service did not always complete their own pre-admission assessment to ensure they could meet peoples' individual needs before they were admitted into Claremont Lodge. This meant the risks to the health and safety of people who used the service were not always fully assessed which exposed people to a risk of avoidable harm.

The service had failed to recognise and respond to changes in a persons physical health, and failed to update relevant care plans and associated risk assessments for a condition that was likely to deteriorate.

We found confidential personal identifiable records relating to people who used the service were not stored securely.

We found the way in which accidents and incidents were recorded across two separate systems was inconsistent and fragmented.

Systems for audit, quality assurance and questioning of practice were ineffective. In particular for falls, medication and care plans.

Registered managers are required by law to notify CQC of certain events in the service such as serious injuries, deaths or events that stop the service from operating. Records we looked at confirmed the registered manager had failed to notify CQC of an event that stopped the service from operating.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not consistently safe.

Pre-admission assessments were not always completed.

Individual risks to people who used the service were not always assessed, updated and acted upon.

The service did not always recognise and respond to people who used the service suffering from a condition that was likely to deteriorate.

Is the service well-led?

Requires Improvement

Aspects of the service were not well-led.

Audit, quality assurance and questioning of practice were not effective.

The registered manager had failed to provide a statutory notification to CQC which was required by law.

Claremont Lodge

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 was an unannounced focused inspection carried out in response to specific concerns. Focused inspections do not look at all five key questions of safe, responsive, caring, effective and well-led, they focus on the areas indicated by the information that triggered the concerns. During this inspection, we looked at the key questions of 'safe' and 'well-led'.

The inspection team consisted of one adult social care inspector from the Care Quality Commission.

As part of inspection process, we reviewed all the information we held about the service including statutory notifications and safeguarding referrals. We also liaised with external professionals from the local authority and NHS hospital and community services.

During the inspection we looked at six care plans and associated documentation, individual risk assessments, daily handover records, accident & incident reports and audit & quality assurance tools.

Inadequate

Is the service safe?

Our findings

Throughout the inspection we spoke with the registered manager to understand how risks to people who used the service were identified and acted upon. We were told that a variety of baseline assessments would be completed when a person was first admitted into Claremont Lodge. We were told these baseline assessments sought to identify particular risks such as mobility, falls, skin integrity, nutrition, and continence.

The registered manager told us that once the baseline assessments had been completed, appropriate action would be taken when a risk was identified. For example, if a person was assessed as being a falls risk, a referral would be made to the falls team and safety equipment would be put in place such as a falls alert mat next to a persons bed. We were also told that baseline assessments were reviewed and updated in response to specific events.

We asked the registered manager about pre-admission assessments and whether or not these were routinely completed before a person was admitted into Claremont Lodge. We were told that pre-admission assessments were not always completed, and that in most cases, the service was reliant on the information provided to them by other professionals involved in those peoples' individual placements, or through information obtained from relatives once people who used the service had been admitted.

We looked at a sample of six care plans and associated documentation. As described by the registered manager, we found a variety of baseline assessments were present. However, in three care plans we found a variety of issues which gave cause for concern. This included a lack of pre-admission assessments, baseline assessments did not provide sufficient information to demonstrate how identified risks were mitigated, existing risk assessments were contradictory and not easy to understand and newly emerging risks were not always recognised and responded to effectively.

We looked at the care and support records of one person who had recently been admitted into Claremont Lodge. We found no pre-admission assessment had been completed to ensure the service could meet this persons needs. A local authority support plan assessment was present in the care records and this had formed the basis for Claremont Lodge's own initial baseline assessment once the person had been admitted.

However, we found contradictory and confusing information had been recorded in this persons care plan. This was because elements of the original local authority support plan did not reflect the needs of this person as documented by Claremont Lodge. For example, this person who used the service had been described as requiring the use of a wheelchair around Claremont Lodge when in fact they were able to mobilise with the use of a walking frame and the support of one carer. This person had also been described as requiring a pureed diet when in fact they were found to be able to eat a normal diet. This person who used the service was also living with a diagnosis of dementia so was not always able to express their needs to staff. Accurate information relating to this persons actual mobility and diet status was not revealed until after their admission.

Despite staff at Claremont Lodge assessing this person as requiring a pureed diet at the time of their admission, we found the service had failed to seek further professional advice in respect of the consistency to which the food should be pureed. For example, no referral had been made to a Speech and Language Therapist or Dietician. Staff also served this person normal fluids without any consideration to the potential risks associated with aspiration or choking.

When we spoke with the registered manager about this and they acknowledged the service was over reliant on information provided to them by a third party and that in this case, the service had not done enough to establish key facts about this persons support needs prior to them being admitted into Claremont Lodge.

This demonstrated the service had failed to assess the risks to the health and safety of this person before they received care and therefore exposed them to a risk of avoidable harm.

We looked at daily handover records for the whole of March and early April 2016. These demonstrated that staff had noted one person who used the service had been complaining about being constipated for five consecutive days during early April. A written entry had been made on one particular day which also indicated this person was having other associated problems relating to their bowel function. We looked at a 'care plan for constipation' and found this had not been updated since November 2014. A continence assessment had also not been updated since November 2014. We also found this persons latest mobility assessment had not been updated since September 2015. We looked at 'progress reports' and found generalised comments indicating 'all information remains the same' or, 'no change to information as it remains the same'.

We found that throughout this person's care plan, no updated risk assessment or associated support plan had been implemented to reflect the continued issues with constipation and associated problems; this included a failure to demonstrate how this risk had been mitigated. For example, chronic constipation can be linked to poor mobility and poor nutrition and hydration yet these assessments were also out of date.

This demonstrated the service had failed to recognise and respond effectively to a condition that was likely to deteriorate; failed to assess the risks to the health and safety of people using the service; and failed to do all that is reasonably practicable to mitigate any such risks.

In respect of these two people who used the service, we shared our concerns with the local authority adult safeguarding team by raising two safeguarding alerts.

By looking at accident and incident records, we identified one person who used the service who had fallen on multiple occasions between September 2015 and February 2016. These falls were a combination of witnessed and unwitnessed events. We then looked at this person's care plan to compare information detailed in the accident reports against information detailed in the care plan. This person had been admitted into Claremont Lodge in late November 2014. The care plan contained historical mobility assessments with the most recent having been completed in May 2015. We saw that documentation entitled 'care plan for falls risk assessment' were not aligned with when this person who used the service had actually fallen. We also found insufficient information was provided in respect of preventive strategies being used by the service to reduce the likelihood of such events occurring again in future.

We also found contradictory information in the way this persons level of falls risk had also been assessed. For example, on multiple occasions this person's risk of falling had been documented as both a 'high' and 'medium' risk. Additionally, when a review of this person's falls risk was completed, this would often involve the last assessed risk simply being scribbled out and overwritten with a new risk score. We spoke with the

registered manager about this and they acknowledged the falls risk assessments appeared confusing and contradictory in nature.

We found Claremont Lodge was not consistently demonstrating that the care being provided to people who used the service was safe. This was because the service did not always assess the risks to the health and safety of people who used the service and failed to demonstrate the service was doing all that was reasonably practicably to mitigate such risks.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in regard to safe care and treatment.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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 looked at how accidents and incidents involving people who used the service were reported and recorded. We found two different systems were in use and staff were expected to complete both a standard 'accident book' and a separate incident report form with 'tick boxes' to prompt staff to complete information such as body maps and to update care records. However, we found the way in which information was being recorded across both systems was inconsistent and fragmented. The registered manager told us they would frequently be required to cross reference both recording systems to ensure staff were recording events correctly.

We looked at systems for audit & quality assurance and questioning of practice and found these to be ineffective. We looked at falls audits for 2015 and found that records were missing for four months. In the records we did see, there was no overarching analysis in order to identify trends or contributory factors. This demonstrated the service was not able effectively assess, monitor and improve the quality and safety of the service and was unable to effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of people who used the service.

We found the registered manager did not complete audits or quality assurance checks on the quality of information being recorded in peoples' care plans. This was of particular concern with regards to how information was recorded as part of peoples' daily records. We found multiple examples of where contemporaneous records had simply been handwritten on plain pieces of A4 paper and inserted in peoples' care plans. The way in which this type of information was presented was difficult to understand and it was not always clear which written entry referred to a particular date.

We looked at medication audits for March and for early April 2016 and found discrepancies in the way the audit tool had been completed. For two days during April a member of staff completing the audit had ticked the box and signed the audit form to indicate that checks for controlled drugs had been completed when in fact no controlled drugs where stored on the premises at that time. The second member of staff signed to verify the audit had failed to recognise this error.

We found confidential records relating to people who used the service were not stored securely. Care plan documentation and hospital appointment letters were found to be mixed up with the personal belongings of staff which had been placed on the office worktop and confidential personal identifiable information was found stored in an unlocked cupboard located near to the office door.

We found the service had failed to effectively assess, monitor and mitigate the risk relating to the health, safety and welfare of people who used the service; failed to maintain an accurate, contemporaneous record

in respect of people who used the service; and failed to securely maintain records relating to the management of the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in regard to good governance.

Registered managers are required by law to notify CQC of certain events in the service such as serious injuries, deaths or events that stop the service from operating. Records we looked at confirmed the registered manager had failed to notify CQC of an event that stopped the service. We are following this up outside the inspection process.