Care Quality Commission

Crosscrown Limited

Clifton Court Nursing 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?	Requires Improvement
Is the service well-led?	Good

Overall summary

We inspected Clifton Court on 20 November 2014 as an unannounced inspection. At the last inspection on 27 January 2014 we found there were no breaches in the legal requirements and regulations associated with the Health and Social Care Act 2008.

Clifton Court is registered to accommodate a maximum of 40 people. It provides nursing care to older people and people living with dementia. On the day of our inspection there were 33 people living at the home.

A requirement of the service's registration is that they have a registered manager. 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. At the time of our inspection there was not a registered manager working at the service. This was because the previous registered manager had left in July 2014. The provider had recruited a new manager who told us they would register with us.

Summary of findings

People who lived at the home told us they felt safe and were happy living there. People were protected against the risk of abuse, as the manager and staff understood their responsibilities to protect people from harm.

The manager assessed risks to people's health and welfare and wrote care plans that minimised the identified risks. Care records were up to date. We saw that care was planned so that people received care and support that met their needs.

We found that there were enough staff to meet people's health and care needs. People could not always access hobbies and interests that met their individual preferences.

Staff received induction and training that met their needs when they started work at the home. The provider had procedures in place to keep staff training up to date.

The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (D0LS) to ensure that people who could not make decisions for themselves were protected. People had access to advocacy services when they needed to. An advocate is a designated person who works as an independent advisor in another's best interest.

People were offered nutrition that met their individual dietary needs. People were supported to main good health and access the services of other healthcare professionals when they needed to.

People told us they liked the staff and made their own decisions about their care and support. We saw staff offered people a choice in how they spent their day and what they would like to eat.

The provider obtained feedback from people and their relatives about the service to identify where improvements were needed to the quality of service provision. People were able to make complaints or raise concerns with the provider when they needed to.

The provider conducted regular quality assurance checks to highlight where areas may need improvement, and acted to improve the service where issues had been identified. Some issues regarding the management of medicines had not been identified in audits by the provider.

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 safe. People were supported by appropriate numbers of staff that met their health and care needs.

People were protected against the risk of abuse, as the manager and staff understood their responsibilities to protect people from harm.

The manager assessed risks to people's health and welfare and wrote care plans that minimised the identified risks.

Good

Is the service effective?
The service was effective. People were offered nutrition that met their individual dietary needs.

People were supported to maintain their health and wellbeing through access to healthcare professionals.

We saw that there were appropriate policies and procedures in relation to the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) to ensure that people who could not make decisions for themselves were protected.

Good

Is the service caring?
The service was caring. Staff knew people well and understood their likes, dislikes and preferences for how they should be cared for and supported.

People we spoke with told us they could spend their time how they wanted, which helped them maintain their independence.

We saw people had access to advocacy services, and that they could speak to an advocate when they needed to.

Good

Is the service responsive?
The service was not always responsive. People were not always supported to take part in interests and hobbies that met their preferences.

People and their relatives were asked to give feedback about the service, and could comment on where improvements were required. The provider acted responsively to feedback to enhance the service.

Requires Improvement

Is the service well-led?
The service was well led. The provider obtained feedback from people and their relatives about the service to identify where improvements were needed to the quality of service provision. People were able to make complaints or raise concerns with the provider when they needed to.

Good

Summary of findings

The provider conducted regular quality assurance checks to highlight where areas may need improvement, and acted to improve the service where issues had been identified.

Care Quality Commission

Clifton Court Nursing 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.

We inspected the service on 20 November 2014 as an unannounced inspection.

This inspection was undertaken by three inspectors, and an expert-by-experience. An expert-by-experience is someone who has knowledge and experience of using, or caring for someone, who uses this type of service. The expert-by-experience that supported us had experience of caring for someone living with dementia.

Before our inspection we asked the provider to send to us a Provider's Information Return (PIR). The document allows the provider to give us key information about the service, what it does well and what improvements they plan to make. The provider had not been able to send this information to us before our inspection, because the deadline for the information had not been reached before our inspection took place. The provider later submitted this information to us, and we were able to review the information as part of our evidence when writing this report.

We also reviewed the information we held about the service. We looked at information received from relatives, from the local authority commissioners and the statutory notifications the manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We spoke with 14 people living at the home, four relatives or visitors of people who lived at the home, an activities co-ordinator, five care staff, two members of staff involved in cleaning and housekeeping duties, and one nurse. We also spoke with the operations manager of the home, the provider, and the manager of the home.

Many of the people living at the home were not able to tell us, in detail, about how they were cared for and supported because of their health conditions. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We observed care and support being delivered in communal areas and we observed how people were supported to eat and drink at lunch time.

We looked at a range of records about people's care including four care files, daily records and charts for four people.

We reviewed management records of the checks the manager and the provider made to assure themselves people received a quality service.

We looked at personnel files for four members of staff to check that suitable recruitment procedures were in place, and that staff were receiving appropriate support to continue their professional development.

Good

Is the service safe?

Our findings

All the people we spoke with told us they felt safe living at Clifton Court. One person told us, "I'm safe here, I get a bit down, but they try to help me." We saw people were relaxed with staff and the atmosphere at the home was calm. We saw people approaching staff for assistance if they needed to. This showed people were comfortable with staff. Staff members we spoke with told us that the home was a 'nice place to work.' One staff member we spoke with told us, "It's a friendly atmosphere."

All the staff we spoke with knew and understood their responsibilities to keep people safe and protect them from harm. They explained all staff attended regular safeguarding training which included staff whistleblowing procedures. Staff we spoke with had a good understanding of what abuse was and what action they would take if they had concerns about people.

The provider notified us when they made referrals to the local authority safeguarding team where an investigation was required to safeguard people from harm. They kept us informed with the outcome of the referral and actions they had taken. This meant the provider took appropriate action to protect people.

Staff told us they had several checks completed before they started work at the service to check they were of a suitable character to work with people. We reviewed staff recruitment records and saw the provider had recruitment procedures in place to ensure people who worked at the home were suitable.

There was a system in place to identify risks and protect people from harm. Staff members we spoke with told us people had a risk assessment in their care file for each risk to their health or wellbeing. The assessments detailed what the risk was and guidance for staff on how the risk should be managed. Staff we spoke with were able to demonstrate they had read and understood the information provided in the risk assessment and knew what to do to manage the risk.

Emergency plans were in place to keep people safe, for example around what to do in the event of a fire. This plan detailed the actions to take in an emergency if the home could not be used. This meant there were clear instructions for staff to follow, so that the disruption to people's care and support was minimised.

The manager explained they used a dependency tool to determine the number of staff they needed at the home to keep people safe. The care plans we looked at included a dependency needs profile. These were used to calculate how many staff were needed to support people safely, according to their care and health needs. Staffing numbers at the home matched the information in the dependency tool.

We saw that people's health and support needs were met by staff. We saw staff responded to people when they asked for assistance. For example, one person called out that they were cold, and we saw a member of staff responded by getting them a blanket. They then reassured the person, and offered to assist them with becoming more comfortable.

We observed a medicines administration round and spoke with two members of staff who were responsible for the administration of medicines. They told us only staff trained in the safe handling of medicines could administer them. We saw that medicines were kept in appropriate locked cabinets. We saw there was a protocol for administering medicines prescribed on an 'as required' (PRN) basis. For example, pain relief drugs may be offered to people if they are in pain, but are not given when people do not require the medicine. We saw people received their prescribed medicines when they needed them. Medicines were managed safely.

Good

Is the service effective?

Our findings

People told us staff had the skills they needed to meet their needs. One person said, “They are good. I have not complaints about anybody.”

Staff told us they received induction and training that met people’s needs when they started work at the home. Staff said the provider and manager encouraged them to keep their training up to date. One member of staff told us, “There’s a lot of training.” Another staff member described to us how the provider had supported them through regular supervision meetings, to reach a nationally recognised qualification. One member of staff us about the training they received in dementia care and how the training assisted them to understand the condition and how it affected people in their care. They explained the training offered them advice on techniques they could use to help people. For example, by trying to engage people in activities or changing their environment, to stimulate the person. One staff member told us, “The training helps us to understand the condition.” We observed staff using these techniques during our visit.

All staff had opportunities to discuss their practice and share ideas outside of their daily routine, as team meetings took place every month, and staff training was arranged for staff across all of the homes in the provider’s group. The manager attended monthly managers’ meetings with other managers in the group, to discuss services and gain support.

The provider informed us they planned to improve the support and training they provided to nursing staff. A new member of staff had been recruited to oversee clinical and nursing activities at the home. The provider also had in place a plan to introduce more specialist nursing training.

We saw care staff used appropriate moving and handling equipment when they assisted people. We heard Staff explained to the person what they were intending to do, and offered them reassurance, asking them to assist with placing their hands and feet so that they were encouraged to be as independent as possible.

The Care Quality Commission is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The MCA sets out the requirements that ensure decisions are made in people’s best interest when they are unable to do this for themselves. DoLS are part of the Act, they aim to make sure that people in care homes are looked after in a way that does not inappropriately restrict or deprive them of their freedom.

Care plans we looked at included mental capacity assessments where people did not have the ability to make decisions themselves. We saw the assessments for one person. The person’s doctor and their personal representatives had discussed what was in the person’s best interest, and these discussions were recorded. This meant the provider acted appropriately in making and recording decisions about people’s health and support needs, where the person could not make their own decisions.

The manager was able to explain to us the principles of MCA and DoLS, which showed they had a good understanding of their responsibilities to people. No-one at the home had a DoLS.

We saw dietary requirements and allergies were recorded which ensured people were offered a diet according to their needs. We saw that separate information regarding people’s dietary and fluid needs were available. One person’s care record showed that they required assistance to drink fluid in a specialist cup so that they could maintain their independence. We saw that this was provided for them and staff gave discreet encouragement to the person to drink as described in the care plan.

We saw people were asked to order their meals during the morning so that they could be prepared at the lunchtime meal. People could make alternative choices at the lunchtime meal if they did not like their pre-ordered meal choice. Staff told us, “The kitchen will always make an alternative for someone if they don’t like their meal on the day.” People told us they enjoyed the food they were offered at the home. One person said, “I have no problem with the food.” Another person told us, “I like the meals here.”

Staff we spoke with told us they had a handover meeting at the start of their shift which updated them with people’s care needs and any changes since they were last on shift. Staff explained this supported them to provide appropriate care for people. A record of what had been discussed was recorded. Staff not present during handovers could refer to the records. We saw staff coming in to work, and accessing the records in the manager’s office during our inspection.

Good

Is the service effective?

We looked at the health records of the people who used the service. We saw that each person was provided with regular health checks, and they were supported to see their GP, optician, dietician, and dentist where a need had been identified. We saw the district nurse visited the home regularly to assist people at the home when needed. We spoke with a visiting healthcare professional, who explained they were asked to visit people at the home to assess their health requirements in a timely way. This meant people were supported to maintain their health and wellbeing through access to healthcare professionals.

Good

Is the service caring?

Our findings

We asked people if the staff were caring, and talked to them appropriately. One person told us, “They are good girls.” They added, “I get on with all of them, they are kind.” A relative we spoke with told us, “[Name] is happy here,” they added, “It’s nice to see regular staff.”

Staff showed a caring and dignified approach to people when they assisted them to move around the home. For example, we saw one person being assisted to move by two members of staff. Staff members explained what they were doing and used encouraging language to request the person to do some tasks for themselves, which helped them to maintain their independence. Staff said ‘please’ and ‘thank you’ when helping people.

We saw staff respected people in the way that they spoke with them, and in their actions. For example, staff knocked on people’s doors and announced who they were before entering, which respected people’s privacy.

We saw care staff approaching people discretely when they offered them personal care. We observed staff asked people if they would like assistance, and their wishes were respected. Where people had refused personal care we observed staff returning later. We read daily records which described the support people had received; where care was refused we could see the staff had returned later in the day. This meant people were supported to make day to day decisions on when they would like to receive care and these were respected.

We asked people if they were able to choose how they spent their time. People we spoke with told us they could spend their time how they wanted. One person told us they liked to get up at different times. Staff we spoke with knew people should be given the choice to stay in bed or in their room if they wanted to. One person told us, “I choose whether to stay in my room or go downstairs. I go downstairs for my meals, but I could have them in my room.”

We saw advocacy information was available on display in the reception area of the home. People told us they had access to advocacy services which meant the provider enabled people who had difficulty representing their interests to exercise their rights.

Requires Improvement

Is the service responsive?

Our findings

People told us there was not enough time dedicated to supporting them in accessing interests and hobbies that met their needs. People we spoke with told us they were happy at the home, but wanted more access to their local community. One person told us, “There used to be a ‘mini bus’, but not anymore.” Three people told us they felt organised trips and planned events were limited, and those on offer didn’t meet their specific needs, as they would like to go out more frequently on organised activities. We asked the member of staff about access to the ‘mini bus’, they told us, “I’m sorry I can’t take people out much as before, as they were now without access to the ‘mini bus’.”

We saw the activities co-ordinator spent time assisting people at breakfast and lunchtime meal services. This meant the staff member could not devote all their time to providing support to people so that they could access interests and hobbies. One person told us, “I like to join in but no one asked me today, so I didn’t get involved on this occasion.”

We looked at the care records for four people who lived at the home. Care records were written for each person according to their support requirements, skills and wishes. Care records showed people’s likes and dislikes, and how they wanted to receive care. We saw care plans were reviewed and updated regularly. Care planning and care reviews involved the person or their relatives. We saw that care was planned so that people received care and support that met their needs. Staff told us they looked at care records to find out how people wanted to be supported. One member of staff said, “Care plans are our bible, we always look at them.” Another member of staff told us, “We get good information there.”

Staff were able to explain the interests and preferences of people who lived at the home, as detailed in their care plans. One member of staff told us about a person who liked to go out several times a week with their relative.” Another member of staff told us, “I love my time with people, either during group sessions or during trips out.” They explained how they supported two people to access books and music and spent time with them on an individual basis as they preferred this.

When we arrived at the home we saw that most people were up and around. Some people were still in bed, and during the morning we saw that when people asked for assistance to get up, staff offered them support to do so. The manager explained that some people preferred to stay in bed until later in the morning. This meant people were able to choose whether they spent time in their rooms or in the communal areas of the home.

People told us staff responded to their requests for assistance. One person we spoke with told us, “I have a call bell and they come in about five minutes, I don’t have to wait too long.”

People told us they could offer feedback to the provider in resident’s meetings, when these were held. One person told us, “There used to be a residents committee where we could raise issues, but we haven’t had one recently.” Another person told us, “We haven’t had a residents meeting for about twelve months.” They added, “We are not kept informed about events in the home, for example, if someone passes away. We need more communication.” We saw the manager had a plan in place to introduce more frequent resident’s meetings in response to this.

We saw there was information about how to make a complaint available on the noticeboard in the reception area of the home. It was also contained in the service user guide that each person received when they moved to the home. People and their relatives told us they knew how to raise concerns with staff members or the manager if they needed to. One relative we spoke with told us about a recent complaint they had made that was not yet resolved. The manager explained that the complaint was still being investigated. We saw that there was a complaints log, and that previous complaints had been investigated and responded to in a timely way.

Good

Is the service well-led?

Our findings

People who used the service told us the provider had recently recruited a new manager, and they felt the management at the home had improved since their appointment. One person told us, “Leadership is getting better, and the manager is trying to address any concerns.”

At the time of our inspection there was not a registered manager at the home. A new manager had been recruited promptly by the provider. They told us the operations manager visited the home regularly to offer them support. The operations manager explained they were on hand to support the manager whenever they were required.

We saw the operations manager conducted regular checks to ensure the home provided a good quality service. This included recorded observations of staff interactions and the environment at the home. We saw that where these observations had identified an area needed improvement, changes made been made. For example, the provider had drawn up a refurbishment plan, and a programme of planned maintenance to improve the environment.

We saw the provider conducted regular audits to maintain and improve the quality of the service. We saw that some issues had not been identified in recent audits, where we felt improvements were required. For example, the provider conducted regular medicines audits. These had not identified medicine storage temperatures, and the recording of when medicines were opened, needed improvements to ensure medicine remained effective.

We saw that when issues had been identified in audits action plans had been drawn up. For example, a recent care plan audit had highlighted the need to update care records. This included the introduction of new fluid and food monitoring forms, to measure whether people were receiving the correct amount of fluid and nutrition to maintain their health. We saw new documents had been introduced just prior to our inspection.

One member of staff told us, “The manager is very approachable.” Another member of staff told us, “It’s the best company I’ve worked for, the management are approachable, you are not just a number.” One member of staff explained how staff supported each other. They said, “Staff work as a team, we all have our roles to play, but we pull together.”

We saw the manager operated an ‘open door’ policy which meant people, their relatives and staff could speak to the manager when they needed to. Staff told us that the manager worked alongside staff at the home and they had the opportunity to talk with them if they wished. We observed staff taking time to enter the office and speak with the manager during our inspection. Staff told us the manager asked them about their views regarding the care provided at the home, and any changes they would like to see to improve the quality of care for people. For example, specialised training for nursing staff at the service was being implemented following feedback.

The operations manager regularly accessed our website and was a member of a local association for care home providers, which meant they kept up to date with changes in the care sector.

We saw that people or their relatives were asked to give feedback about the service. We saw the service ran yearly quality assurance questionnaires which were completed by people who used the service and their relatives. We saw a range of different meetings took place to gather views from people and staff. People at the service had commented that they would like to have more frequent resident’s meetings. We saw from the provider’s information return (PIR) that an increase in meetings was planned. We saw that previous meetings were recorded and where improvements or changes had been suggested these improvements had been written into an action plan, which was followed up by the manager. This provided evidence of how the provider responded to people’s views.