Kirklees Metropolitan Council

Claremont House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 26 June and 03 July 2017 and was unannounced on the first day and announced on the second day.

The location is registered to provide accommodation and personal care for up to 40 older people, some of whom are living with dementia. The accommodation is over two floors linked by a passenger lift. Accommodation is in single rooms with each room having ensuite facilities. Lounge and dining facilities are situated on two floors with two units on each floor. One of the four units is used to provide respite care. At the time of our inspection there were 28 people using the service permanently and one person staying for respite care. Nine people used the service for respite care regularly.

The service had 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.

At our last inspection on 14 February 2016 we found the service was not meeting the regulation related to managing medicines. At this inspection we found medicines were managed in a safe way for people, although there were some gaps in recording of the application of topical creams.

We found sufficient numbers of staff were deployed to meet people's assessed needs. This meant people's needs were met in a timely manner.

People told us they felt safe. Staff had a good understanding of how to safeguard adults from abuse and who to contact if they suspected any abuse. Risks assessments were individual to people's needs and minimised risk whilst promoting people's independence.

Effective recruitment and selection processes were in place.

Staff had an induction, and received supervision, appraisal and role specific training. This ensured staff had the knowledge and skills to support people who used the service.

People had choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service promoted this practice. Whilst people's mental capacity was usually considered when decisions needed to be made, this had not been evidenced where people needed to consent to the use of bed sensor mats. This was addressed by the registered manager immediately.

People's nutritional needs were met and they had access to a range of healthcare professionals to maintain their health and well-being.

Staff were caring and supported people in a way that maintained their dignity and privacy. People were supported to be as independent as possible throughout their daily lives.

Individual needs were assessed and met through the development of detailed, personalised care plans and risk assessments.

People and their representatives were involved in care planning and reviews. People's needs were reviewed as soon as their situation changed.

People engaged in activities both inside and outside the service.

Systems were in place to ensure complaints were encouraged, explored and responded to in good time and people told us staff were always approachable.

The manager knew the needs of people who used the service and people and staff were positive about her input in to the service.

The manager had taken action to improve the quality of the service and planned to make further improvements to their auditing system.

The registered provider had oversight of the service. They audited and monitored the service to ensure the needs of people were met and the service provided was of a high standard, however some of the issues we found had not been picked up and addressed.

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.

Medicines were managed in a safe way for people.

Staff had a good understanding of how to safeguard people from abuse.

People's dependency levels were assessed to ensure their needs were met by sufficient staff.

Risk assessments were individual to people's needs and provided direction for staff.

Is the service effective?

Requires Improvement

The service was not always effective.

People's mental capacity was considered when decisions needed to be made, with the exception of the decision to use bed sensor mats.

Staff had received training to enable them to provide support to people who lived at Claremont House.

People were supported to eat a balanced diet and had access to a range of healthcare professionals

Is the service caring?

Good

The service was caring.

Staff interacted with people in a caring and respectful way.

People were supported in a way that protected their privacy and dignity.

People were supported to be as independent as possible in their daily lives.

Is the service responsive?

Good

The service was responsive.

People's care plans contained sufficient and relevant information to provide person-centred care and support.

People had access to activities in line with their tastes and interests.

People said they knew how to complain and told us staff were always approachable.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People and staff were positive about the registered manager, who was visible within the service and knew people's needs.

The culture was positive, person-centred, open and inclusive.

Systems were in place to improve the quality and safety of the service. Improvements had been implemented by the registered manager, however further improvements to auditing systems were required.

Claremont House

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 26 June and 03 July 2017 and was unannounced on the first day and announced on the second day. The inspection was conducted by two adult social care inspectors and an expert by experience on the first day. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their experience was as a family carer of a person living with dementia. One adult social care inspector conducted the second day of the inspection.

Prior to our inspection we reviewed all the information we held about the service. This included information from notifications received from the registered provider, and feedback from the local authority safeguarding and commissioners. We also contacted Healthwatch to see if they had received any information about the provider or if they had conducted a recent 'enter and view' visit. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help plan the inspection.

Some people who used the service communicated non-verbally and as we were not familiar with their way of communicating we used a number of different methods to help us understand people's experiences. We spent time with them observing the support people received. We spoke with five people who used the service and five relatives. We spoke with three care staff, two team leaders, two deputy managers, the cook, the registered manager and the area manager. We looked in the bedrooms of five people who used the service with permission.

During our inspection we spent time looking at four people's care and support records. We also looked at

two records relating to staff recruitment, three training records, incident records, maintenance records, feedback from people and a selection of the service's audits.

Good

Is the service safe?

Our findings

People we spoke with said they felt safe at Claremont House and the relatives told us they felt confident their relation was safe. A relative said, "I feel (my relation) is safe here. (My relation) can't go out on their own."

People and relatives said there were enough staff on duty. The manager told us a dependency tool was used to assess people's dependency levels and allocate staffing within the service. We saw each person's dependency level was assessed every week and staffing hours adjusted accordingly. Extra care staff hours were allocated according to the needs of people using the service for respite care. Staff told us staffing levels were more appropriate since the dependency tool was put in place, and they were able to meet people's needs in a timely manner. One staff member said, "We are using a dependency tool and there are now enough staff." Another staff member said, "Having a full staffing level does improve the service. If we are short staffed we have to skimp on showers." A further staff member told us there were enough staff, but not always enough activity hours to spend time with people who used the service.

We saw appropriate staffing levels on the day of our inspection which meant people's needs were met promptly and they received a good level of support to meet their assessed needs.

The registered provider had their own bank of staff to cover for absence and asked permanent staff to do extra shifts in the event of sickness. Regular agency staff were also used. One staff member told us they use regular agency staff but staff who have not worked at the home before would 'float' between the units and be guided by the team leader on the specific unit. This meant people were normally supported and cared for by staff who knew them well.

Staff we spoke with were clear about their responsibilities to ensure people were protected from abuse and they understood the procedures to follow to report any concerns or allegations. Staff knew the whistleblowing procedure and said they would be confident to report any bad practice in order to ensure people's rights were protected. One staff member said, "You can tell if there is something wrong from emotional changes in people. If I was concerned I would go to the manager and if I was concerned about the manager I would go to CQC (the Care Quality Commission) or phone (name of area manager)." Another staff member said, "Dignity is respected but if anything is reported to the management team this is dealt with." We saw information around the building about reporting abuse and whistleblowing.

Records showed safeguarding incidents had been dealt with appropriately when they arose and safeguarding authorities had been notified. This evidenced the registered provider was aware of their responsibility in relation to safeguarding the people they cared for. The registered manager had notified CQC of the majority of incidents reported to the local authority safeguarding team. We clarified with the registered manager which incidents to notify to CQC to ensure they were meeting their responsibilities.

Systems were in place to manage and reduce risks to people. The members of staff we spoke with understood people's individual abilities and how to ensure risks were minimised whilst promoting people's

independence. In people's care records we saw comprehensive risk assessments to mitigate risk in areas including moving and handling, skin integrity, choking, verbal or physical aggression, personal care, falls, finances and medication. We saw these assessments were reviewed regularly and up to date. This showed us the service had a risk management system in place which enabled staff to deliver safe care to people.

Staff told us they recorded and reported all incidents and people's individual care records were updated as necessary. We saw in the incident and accident log that incidents and accidents had been recorded in detail and an incident report had been completed for each one. Staff were aware of any escalating concerns and took appropriate action. We saw the registered provider had a system in place for analysing accidents and incidents to look for themes. This demonstrated they were keeping an overview of the safety of the service.

We saw from staff files recruitment was robust and all vetting had been carried out prior to staff working with people. For example, the provider ensured references had been obtained and Disclosure and Barring Service (DBS) checks had been carried out. The DBS helps employers make safer recruitment decisions and reduces the risk of unsuitable people from working with vulnerable groups. This showed staff had been properly checked to make sure they were suitable and safe to work with people.

At our last inspection the registered provider was not meeting the regulations related to medicines management. This was because medicines were not always administered in a safe way for people, care plans were not always in place for 'when required' medicines and staff did not complete regular medicines competence assessments in line with current National Institute for Clinical Excellence (NICE) guidelines. At this inspection we found improvements had been made, however some topical creams were not always being recorded as administered.

Following our last inspection one staff member told us the home had changed to a different pharmacy. The number of medicine trolleys had increased so each unit had their own trolley and medication administration records (MAR) and small locked cabinets had been securely fitted in each person's bedroom to store topical creams. A monthly audit was also carried out on each unit.

At this inspection we looked at how medicines were managed in the home. We checked the room where medicines were stored and found this was clean and tidy. We noted the medication room was locked when not in use. There were arrangements in place for obtaining medicines and adequate stocks of medicines were maintained to allow continuity of treatment.

Most medication was supplied in a monitored dosage system directly from a pharmacy. This meant the medicines for each person for each time of day had been dispensed by the pharmacist into individual trays in separate compartments. Appropriate arrangements were in place in relation to the recording of medicines. People's medicine administration records (MARs) showed staff were signing for the medication they were giving. MARs contained a profile for each person which included a photographic record, any allergy information, how the person preferred to take their medication and a list of current medicines. We saw MARs also contained a 'discrepancies' sheet which was used by all staff to record any errors or issues at the start of each shift. This helped staff respond to concerns in a timely way and seek help and support if needed.

Arrangements for the administration of 'when required' medicines, also known as PRN, protected people from the unnecessary use of medicines. We saw records which demonstrated when and under what circumstances PRN medicines should be given. We saw the date and time were recorded when PRN medication had been administered. This ensured further administration of PRN medicines could be completed within the recommended timeframe. One staff member told us if people routinely refused their

medication they would contact the GP for advice.

Controlled drugs (medicines susceptible to misuse) were locked securely in a cupboard. MAR and controlled drugs records were completed and no gaps were noted.

We saw all staff had completed medicines training with the new pharmacy and most staff had completed the provider's internal medicines training. We saw competency checks were routinely carried out which also included the observations of the administration of medicines. This meant people received their medicines from people who had the appropriate knowledge and skills.

We were told four people had covert medication, which meant it was hidden in their food or drinks. Protocols were in place for this, which included a letter from the GP and instructions from the pharmacy, along with a mental capacity assessment and best interest decision.

Daily records were kept for the medication room and fridge temperatures. We noted on three occasions in June 2017 the room temperature had slightly exceeded 25°C, which is the maximum recommended temperature for most non-refrigerated medicines. Two staff members told us they used a fan when the temperature got too hot, although we saw this had not been recorded. One of the staff members told us they would produce guidance immediately for all staff to follow. Following our inspection the registered manager sent us evidence this had been implemented and they were monitoring its use.

We looked at how staff administered prescribed creams. Topical medicine administration records (TMARs) were used to record the administration of creams. We looked at four people's TMARs and found three out of four of these had not always been completed appropriately. For example we saw one person's TMAR stated Conatrane cream 500g tub 'Use twice daily, following personal care', but on 10 occasions in June 2017 the cream had been recorded as only applied once, and on seven days in June 2017 the TMAR had not been completed as applied at all.

We spoke with three staff from different units who told us peoples creams were applied as prescribed but the TMARs were not always completed. One staff member said, "There could be a tendency not to complete the form but cream is applied each day, it is just part of the person's personal care." Another staff member said, "I always complete the TMAR but potentially this is not completed by all staff." We did not find any concerns about people's skin integrity and concluded this was an issue of recording and governance. We spoke with the management team about this who told us they would look at different ways of recording this information, how this should be monitored and would remind staff about the completion of relevant records. Following this inspection the registered manager forwarded an updated medicines audit which was used to ensure TMARs were completed as required.

People who used the service, staff and visitors were protected against the risks of unsafe or unsuitable premises. We saw evidence of service and inspection records for gas installation and portable appliance testing. We noted the electrical safety certificate for the service had expired in April 2017. The registered manager told us they were aware of this and had sent a reminder to the external company that would complete the safety check. This was due to take place in August 2017. This certificate is advisable, but is not mandatory requirement and we had no concerns about electrical or fire safety at our inspection.

Checks had been completed on fire safety equipment and fire safety checks were completed in line with the provider's policy. A series of risk assessments were in place relating to health and safety. Each person had a detailed personal emergency evacuation plan (PEEP) in place. PEEPs are a record of how each person should be supported if the building needs to be evacuated. Fire drills occurred regularly and the staff we

spoke with knew what to do in the event of a fire or if the building needed to be evacuated. This showed us the home had plans in place in the event of an emergency situation.

One person told us, "The staff do use gloves. They keep them in the drawer." We found the service was clean and odour free and personal protective equipment (PPE) was available for staff to use.

Requires Improvement

Is the service effective?

Our findings

Relatives told us they were confident the staff team at Claremont House could meet their relation's needs.

Staff had received training and support to ensure they were able to meet people's needs effectively. We saw evidence in staff files that new staff completed an induction programme when they commenced employment at the service. We asked staff what support new employees received. They told us new employees completed initial induction training and then shadowed a more experienced staff member, as well as completing further training, before they were counted in the staffing numbers. The shadowing focused on getting to know people's individual needs and preferences. This demonstrated new employees were supported in their role.

One staff member told us, "I am doing extra management training in July this year. All my training is up to date and it is helpful. It is always good to have a refresher." We saw from one staff member's file they had completed a moving and handling test sheet, an infection control booklet and a Deprivation of Liberty Safeguards (DoLS) workbook.

We looked at the training records for three staff and saw training included infection prevention and control, emergency aid, food hygiene, moving and handling, dementia awareness, The Mental Capacity Act and DoLS, and safeguarding adults. We saw from the training matrix almost all training was up to date and further training was planned onto the rota. This demonstrated people were supported by suitably qualified staff with the knowledge and skills to fulfil their role.

Staff we spoke with told us they felt supported by managers and had supervision every few months, an annual appraisal and regular staff meetings. One staff member said, "I feel supported and we have regular team meetings." Another staff member told us, "My 'one to one' is every eight weeks. My last meeting was in April. I have had an appraisal for 2016/2017." Another staff member said, "I have supervision meetings frequently." Staff files contained evidence each member of staff had received individual supervision and an annual appraisal. Staff supervisions covered areas of performance and provided an opportunity for staff to raise any concerns or ideas. This showed staff were receiving regular management supervision to monitor their performance and development needs.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation 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 principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff at the service had completed training and had an understanding of the MCA. We asked the manager about the MCA and DoLS and they were able to describe to us the procedure they would follow to ensure people's rights were protected. We saw 13 people were subject to DoLS authorisations and 14 people were awaiting authorisation. One further person had been assessed as having mental capacity to decide to live at the home. We saw in one person's DoLs authorisation conditions were attached to ensure the use of covert medicines was regularly reviewed. The registered manager told us the GP usually reviewed covert medicines regularly but they would contact them to ensure this was completed.

In the care records we sampled we saw mental capacity assessments and best interest decisions had been completed in relation to restrictions such as the use of bed rails, being supported with personal care, coming to live at the home and the administration of medicines.

Each person at Claremont house had a sensor mat on their mattress to alert staff to their movements. Staff told us one person didn't use the bed sensor as they didn't want it and so they kept it under their bed. We asked about people's consent to the use of the bed sensors and found a mental capacity assessment and best interest discussion had not been recorded, where people may lack capacity to make this decision. The registered manager told us they had consulted with people and representatives about the use of bed sensors; however they would complete the relevant mental capacity assessments and best interest discussions immediately.

We found in one of the four care records we sampled one person had been assessed as having the mental capacity to make their own decisions with regard to medication, personal care tasks, restricted movement, bedroom doors being locked when not in use and to consent to photographs being taken. Their record stated 'Currently does not require any best interest decisions.' We found a DoLS authorisation had been authorised for this person in March 2017 and managers of the service agreed it was likely this person now lacked the mental capacity to make these decisions and the record was incorrect. One of the deputy managers told us this was a one off mistake and they rectified this by putting in place the required documentation by the second day of our inspection.

One relative said, "The meals are beautiful. (My relation) was thin when they came here. Now look at them!" People told us they enjoyed their meals and could choose what they wanted. Meals were planned around the tastes and preferences of people who used the service. Pictorial menus were on display with a choice of two meals and dessert.

We spoke with the chef who told us they had a four weekly menu which had two options at lunch time and two options at tea time. They said the meals are varied and they always had enough produce, which included fresh fruit, vegetables and meat.

Meals were served from a hot trolley brought up from the main kitchen to small kitchen areas off the dining room. We heard staff offering people a choice of meal and drink and we saw they received the meal and drink of their choosing.

We observed staff supported and encouraged people to eat and drink. Interactions between staff and people were friendly, respectful and supportive.

The cook had a file in the kitchen with special dietary requirements and tastes and this information was also

available on each unit to guide staff where food was being served. We saw some people helped themselves to a drink, and snacks and drinks were offered to people throughout the day. For example, we saw one person who had declined their lunch was offered a banana, which they ate all of; they were also offered a meal later that day. A staff member offered people a cup of tea or coffee and some fruit or a chocolate biscuit.

Individual dietary requirements of people were catered for and meals were recorded in people's daily records. This included a record of food consumed, including where food intake was declined and details of the food eaten. People were weighed monthly or weekly, if needed, to keep an overview of any changes in their weight. We saw the deputy managers kept an overview of weights to look for any patterns or changes and contacted the GP if action was required. This showed the service ensured people's nutritional needs were monitored and action taken if required.

One relative said, "If (my relation) is not well they ring straight away." People had access to external healthcare professionals as the need arose. Staff told us systems were in place to make sure people's healthcare needs were met. Staff said people attended healthcare appointments and we saw from people's care records a range of healthcare professionals were involved. This included GPs, psychiatrists, community nurses, chiropodists, dentists, speech and language therapy and physiotherapists. This showed people who used the service received additional support when required for meeting their care and treatment needs.

People's individual needs were met by the adaptation, design and decoration of the service. We saw the service was homely and spacious and comfortably furnished. There were pictures, handicrafts, wall hangings and photographs in the communal areas and the lounges were arranged in a way that encouraged social interaction. Contrasting colours were used in bathrooms to support people to identify rails and seats and promote their independence. People had access to the well-kept secure gardens with seating. This meant the design and layout of the building was conducive to providing a homely but safe and practical environment for people who used the service.

Good

Is the service caring?

Our findings

People and relatives told us the staff were caring. One person said, "They are all nice here, none get clever with you, couldn't get a better home. They tell you in a proper way if you're a bit untidy, like if you have a spill." Another person said, "Very pleasant here. Can't tell it's a care home, not told do this, do that."

One relative said, "Everybody speaks to me very friendly. All the staff are lovely, they ring me straight away if (my relation's) not well." Another relative said, "The staff are very thoughtful and kind and looking after (my relation) well. There was one carer who was a 'little star'. She stayed with (my relation) because (they) had a stomach upset. Couldn't do enough for (my relation)."

People who used the service told us they liked the staff and we saw there were warm and positive relationships between staff and people. Staff we spoke with told us they enjoyed working at Claremont House and supporting people who used the service. One staff member said, "I love it." Staff told us they would be happy for a relative of theirs to use the service at Claremont House. One staff member said, "I treat the client as if they were my mother. I enjoy talking with the clients and singing and dancing with them."

Staff we spoke with had a good knowledge of people's individual needs, their preferences and their personalities. They used this knowledge to engage people in meaningful ways, for example, by engaging them in conversations about activities or playing music they knew the person liked. We saw people laughing and smiling with staff.

Staff worked in a supportive way with people and we saw examples of kind and caring interaction that was respectful of people's rights and needs. We saw one person was reassured in a kind and supportive way when they became upset. Staff used appropriate touch and spoke kindly to the person offering them a cup of tea and spending time with them.

People were supported to make choices and decisions about their daily lives. People told us they had a choice of meals, what time to get up or go to bed, their clothing, activities or when to have a bath. Staff used speech, gestures, and facial expressions to support people to make choices according to their communication needs. Staff told us they showed people a choice of clothing or meals to support them to make everyday decisions if their verbal communication was limited, and we saw this was the case.

We heard staff give good explanations to people to help them understand how they were being supported. We saw they waited patiently for people to respond and people were not rushed in their interactions.

People appeared well groomed and looked cared for, choosing clothing and accessories in keeping with their personal style.

Some people had a key to their bedroom door if they wished to lock it depending on any risk factors. We saw staff knocked and asked permission before entering bedrooms and staff told us they kept people covered during personal care and ensured doors were closed. People's private information was respected and

records were kept securely in the office and in locked cupboards on each unit.

People's individual rooms were personalised to their taste with personal items, photographs, ornaments, music and bedding they had chosen. Personalising bedrooms helped staff to get to know a person and helped to create a sense of familiarity and make a person feel more comfortable.

People were encouraged to do things for themselves in their daily life. One staff member said, "We promote independence and encourage people to wash and dress themselves, but we know their limits and support them." Care plans detailed what people could do for themselves and areas where they might need support. This showed us the home had an enabling ethos which tried to encourage and promote people's choice and independence.

Care plans included people's equality and diversity needs and choices, for example, 'Roman Catholic – [name of person] is visited at Claremont House for communion.' and '[name of person] has expressed no issues or preferences with support required been provided by either male or female staff.'

Staff were aware of how to access advocacy services for people if the need arose and some people who used the service had independent mental capacity advocates. An advocate is a person who is able to speak on a person's behalf, when they may not be able to do so for themselves.

People and their representatives had been consulted regarding end of life plans and wishes, where appropriate, and these were recorded. The registered manager told us the service was working toward the Gold Standard Framework for end of life care. This is national framework recommended by government and professional organisations to support good practice in end of life care. Night staff and deputy managers had recently attended a workshop to support good practice in this area.

Through speaking with people who used the service and relatives we felt confident people's views were taken into account in planning their care.

We saw from care plans there was a record of 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions where appropriate. This included an assessment of capacity (if required), communication with relatives and the names and positions held of the healthcare professional completing the form.

Good

Is the service responsive?

Our findings

Relatives told us they could speak to staff anytime and staff kept them informed and up to date.

One person told us, "It's a very good service here. They go out of their way to do things." A relative said, "(Relation) is turned regularly. They always ring us if there's a change."

We found care plans were person-centred and explained how people liked to be supported. For example, entries we looked at included, "Enjoys being pampered. Likes to go to the hairdressers if in the mood." This let care staff know what was important to the people they cared for and helped them take account of this information when delivering their care. This is important as some of the people who used the service had memory impairment and were not always able to communicate their preferences.

Care plans covered areas such as medication, sleep, physical health, skin integrity, finances, moving and handling, making choices, and hobbies. They contained detailed directions for staff including the persons preferred routines and details of how to support the person. For example, if the person required repositioning using a hoist care plans included which sling to use. Care plans were evaluated and updated monthly or when people's needs changed. Regular informal reviews of care plans were held with people or their representatives. These reviews helped monitor whether care plans were up to date and reflected people's current needs so any necessary actions could be identified at an early stage.

People's care plans also contained information about how staff would care for people when they exhibited behaviours that may challenge others, and the action staff should take in utilising de-escalation techniques. When we spoke with members of staff they were aware of this information. This showed the service responded to changes in the behaviour of people who used the service and put plans in place to reduce future risks.

Staff told us communication was good. Three handovers a day were held between shifts and a daily handover report was used to share information such as visitors, medication, nutrition, health issues, activities and incidents or concerns. We saw daily report and handover records for people using the respite care service had been improved with links to each person's care plan to ensure information was relevant and up to date.

Daily records were kept recording peoples activities, personal care delivered, food and fluid intake (where required), position changes and room checks when people remained in their rooms.

We saw staff were responsive to people's emotional needs, for example helping people to make new friendships within the home and maintain shared interests. Relatives were free to visit any time and told us they were always welcomed. This meant staff supported people with their social and relationship needs.

One person said, "We all get on and have concerts and films. You can do what you want. Can't grumble, it's a lovely place."

One relative said, "They allow (my relation) to do what (my relation) wants. They don't try to persuade (my relation) to join in if (my relation) doesn't want to. (My relation's) not one for joining in really."

Staff spoke with good insight into people's personal interests and we saw from activity records some people had taken part in activities both inside and outside the service. One staff member said, "We have three very good volunteers but could do with an increase in activity hours." Another staff member said, "Activities is really good now. We have volunteers."

We saw people were able to access the secure garden and one person told us how they enjoyed growing vegetables and had been involved in planning the garden. The activity coordinator worked with some people to grow vegetables in raised beds and the food was used in the kitchen.

We saw activities in May 2017 had included planting vegetables, book reading, bible stories, baking sessions, sing-a-longs and coffee mornings. We noted the activities for June 2017 included a bus trip to Batley, a ukulele group, a motivation session and one to one sessions.

The home employed an activity coordinator for ten and a half hours a week and they supported three volunteers who offered various activities to people. We saw some feedback comments which had been completed by the people who volunteered. These included, 'gardening [name of person] helped, walking round the garden, chatting to [name of person], throwing the ball and chatting about sports people did when they were younger.' The activity coordinator told us they were developing a calendar of activities but it was difficult to cover due to their limited working hours and they appreciated there were gaps.

The service used a set of books and DVD's for reminiscence with people living with dementia to provide sensory stimulation, and music from the past was playing in the lounges. An electronic organ was present in one room, which was used for a monthly church service.

People told us they enjoyed entertainment such as choirs and singers, and films that were shown on the wall in the conservatory. On the days of our inspection we saw people joined in with throwing soft balls into a basket and the activity coordinator engaged people by reading a book and chatting with them on a one to one basis. This meant people engaged in some social activities which were person-centred and included measures to protect them from social isolation.

People we spoke with told us staff were always approachable and they were able to raise any concerns. A relative said, "One agency staff had a bad attitude and I went straight to the office to tell them, don't think [they have] been back and they sorted it." Another relative said, "They are good if [my relative's] lost anything they help me try to find it." One relative told us they had complained about the use of continence products and the home had requested a continence re-assessment for their relative.

We saw there was an easy read complaints procedure on display. Staff we spoke with said if a person wished to make a complaint they would facilitate this. We saw the complaints record showed where people had raised concerns these were documented and responded to appropriately. Learning from complaints was also documented and shared at staff meetings in order to ensure improvements were embedded in the service. Compliments were also recorded and available for staff to read.

Requires Improvement

Is the service well-led?

Our findings

People and their relatives told us the service was well-led. One person said, "It's more like a hotel than a home."

When asked what could improve one relative said, "I can't think of anything. It's everything I hoped it would be."

Staff we spoke with were positive about the registered manager and told us the home was well-led. One staff member said, "I love working here. The staff are lovely and the manager is really approachable." Another staff member said, "You can speak to the manager any time." A third staff member said, "(Name of manager) has improved things. There is a good atmosphere and staff are a lot happier. It's running lovely." Another staff member said, "Yes it's well-led. I feel very supported. If we have a problem (name of deputy manager) will try to support you in any way [they] can. People are safe and well looked after."

The registered manager had commenced employment as acting manager in 2014 and was registered as manager in October 2015. They had previously been the deputy manager of the service. Three deputy managers worked on rotation during the day shifts and a team leader was on duty every night. The registered manager told us they would like to increase management training for the deputy managers to support them in the role.

The management team were visible in the service and the deputy managers and team leaders regularly worked with staff providing support to people who lived there, which meant they had an in-depth knowledge of the needs and preferences of the people they supported.

The manager said they operated an 'open door policy' and people were able to speak to them at any time. People we spoke with confirmed this. The senior staff told us they felt supported by the registered provider, and were able to contact a senior manager at any time for support. They said they enjoyed working for the organisation; they all worked well as a team and supported each other.

The registered manager was proactive in identifying and addressing issues and making progress with improving the service. They told us they were planning to introduce 'safety huddles' to ensure risks to people were prioritised and easily communicated with staff.

The registered provider had consulted with people and relatives on future plans for their services, including Claremont House, over the last year and used this feedback to gain people's views about the service at Claremont. Twenty two relatives responded to the survey and feedback was very positive about the caring staff and the homely atmosphere of Claremont House. This meant people's views were taken into account and they were encouraged to provide feedback on the service provided.

One person said, "There used to be residents' meetings every month. Don't know now. I haven't been to one recently." The registered manager told us residents and relatives meeting had been arranged at Claremont

House, however nobody attended. They said people were consulted on a daily basis regarding their care and we saw this was the case.

Staff meetings were held quarterly. Praise was given to staff and recorded as well as areas to improve. Topics discussed included welcoming new staff, handover records, learning from complaints, end of life care, care plans, continence aids and the action plan for the service. Actions from the last meeting were discussed and goals were set from the meeting. The registered manager had introduced a weekly senior care workers' meeting which had recently discussed an art project with a local school, a working group on personal emergency evacuation plans (PEEPs), medicines and the staffing dependency tool. Meetings had also been held with housekeeping and kitchen staff. Staff meetings are an important part of the provider's responsibility in monitoring the service and coming to an informed view as to the standard of care for people.

The registered manager told us they attended training and good practice events in areas such as dignity in care and end of life care as well as manager's forums. They often used the Social Care Institute of Excellence (SCIE) website to source good practice for their team. This meant they were open to new ideas and keen to learn from others to ensure the best possible outcomes for people who used the service.

The home had links with local schools, volunteers and church groups and was planning a 10th anniversary garden party.

During this inspection we found the water temperatures in some communal hand basins to be hot to the touch. The maintenance person checked the temperatures and found some were slightly over the recommended limit for communal facilities for vulnerable people. Water temperature records showed previous slightly high temperatures had been acted on, however the problem had re-occurred. The registered manager took immediate action to ensure this was rectified. They also purchased digital thermometers to ensure temperature readings were accurate.

We saw an audit of medicines management had been carried out by the pharmacy the home used in January 2017. Recommendations they highlighted had been completed, for example, small locked cabinets had been fixed in people's bedrooms to store topical creams. The home's monthly medicines audit was last completed prior to this inspection on 23 June 2017. However, we noted this had failed to highlight the medication room temperature had exceeded the recommended guidelines. A staff member told us they would review the audit document and introduce a more robust check. Following this inspection the staff member sent us evidence this had been completed.

We saw observations of staff practice in hand-washing and dignity in care were completed. This showed staff compliance with the service's procedures was monitored. Audits were completed in relation to premises and equipment, finances, nutrition and hydration, and infection control. Medicines, care plans and documents were reviewed and audited regularly, however this system had not picked up and addressed problems we found with the recording of the administration of topical creams, medicines room temperatures, water temperatures and consent. On the second day of our inspection the registered manager showed us they had addressed all the issues from the first day of our inspection and the recording of the application of topical creams was being checked on a daily basis by senior staff.

Information was passed to the registered provider by the manager every month regarding incidents, complaints, supervision, health and safety and other issues. The area manager had completed regular visits to the service to support the manager and complete audits to ensure compliance with the registered providers' policies and procedures. We saw the registered manager and registered provider had responded

to their action plans to improve the service. This demonstrated the senior management of the organisation were reviewing information to drive up quality in the organisation, although this system had not picked up and addressed some of the problems we found.

The registered manager had notified CQC of the majority of incidents reported to the local authority safeguarding team in line with legislation, however some incidents between people has not been notified. The registered manager told us they would address this.

The previous inspection ratings were displayed on the registered provider's website and at the service. This showed the registered provider was meeting their requirement to display the most recent performance assessment of their regulated activities and showed they were open and transparent by sharing and displaying information about the service.