Kirklees Metropolitan Council

Claremont House

Inspection report

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Date of inspection visit:
24 July 2018

Date of publication:
11 September 2018

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This was an unannounced inspection carried out on 24 July 2018. At our last inspection in June 2017, we rated the home overall as 'requires improvement', although no breaches of the regulations associated with the Health and Social Care Act 2008 were found.

Claremont House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Claremont House is registered to provide accommodation and personal care for up to 40 older people. The home has two floors and each floor contains two units which are known as Orchid, Rose, Iris and Lavender.

Recruitment processes were safe, although clearer recording of staff identification seen by the registered provider was needed. Staff we spoke with were able to describe the identification they provided which meant this was safe.

People told us staff were suitably skilled in their roles. Staff were supported through a programme of induction, supervision and training. There were sufficient numbers of staff in the home to meet people's needs.

Care plans were concise, although they contained sufficient information for staff to provide effective care. People received timely access to healthcare and they had a positive mealtime experience.

Fire safety was sufficiently managed and the building was well maintained. The home had impressive gardens which people were able to freely access. Dementia friendly adaptations had been made to the home. The home was found to be clean and free from odour.

People consistently told us they felt safe living at Claremont House and systems in place ensured people were prevented from being at risk of harm. There was a calm atmosphere in the home throughout the duration of our inspection.

Although no complaints had been received since our last inspection, there were systems in place to show complaints would be dealt with effectively. People told us they knew how to make a complaint.

There was a programme of activities taking place and people told us they received sufficient stimulation which meant they were prevented from being socially isolated.

The registered manager was able to demonstrate how the home met the Accessible Information Standard. People's equality, diversity and human rights were respected. Staff were seen to be kind and compassionate in their interactions with people. People told us staff respected their privacy and dignity.

Governance systems were effective in identifying areas for improvement and we saw action was taken where needed. People and staff were complimentary about the registered manager who was approachable.

The registered manager responded to concerns and specific incidents and took lessons learned to staff meetings to reduce the risk of them happening again.

The management of medicines was found to be mostly safe, although we have made a recommendation regarding time specific medicines. We have also made a recommendation around engagement with people and their representatives through meetings and surveys.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe and there were systems in place to protect people from harm.

There were sufficient numbers of staff in the home. Infection control was well managed.

Medicines, with one exception, were managed appropriately. Lessons were learned and improvements made in response to concerns.

Is the service effective?

Good

The service was effective.

The principles of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS) were being followed.

People received access to a range of healthcare professionals. People had a positive mealtime experience.

Staff received ongoing support as part of their personal development.

Is the service caring?

Good

The service was caring.

Staff knew the people they provided care for and demonstrated empathy and kindness in their interactions.

Privacy and dignity was consistently maintained.

Is the service responsive?

Good

The service was responsive.

Care plans were concise, yet they contained sufficient detail to meet people's needs.

People enjoyed an activities programme and they had access to an impressive garden space.

Systems were in place to ensure people's complaints were responded to appropriately.

Is the service well-led?

Good

The service was well-led.

Regular meetings were taking place with staff, although engagement with people and relatives required improvement.

Systems used to monitor the service were effective.

People and relatives were complimentary about the registered manager.

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 was carried out by two adult social care inspectors. Our inspection was unannounced and there were 29 people living in the home.

We spoke with a total of five people who lived in the home as well as two relatives; one who was visiting the home and a further relative in the days following our site visit. We also spoke with the registered manager, deputy manager, service manager and a further six members of staff. We observed care interactions in communal areas of the home. We spent some time looking at the documents and records that related to people's care and the management of the service. We looked at two people's care plans in full as well as reviewing a further care plan regarding specific areas of care.

Before the inspection, the registered provider had 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.

Before our inspection, we reviewed all the information we held about the home. We contacted the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Good

Is the service safe?

Our findings

People we spoke with consistently told us they felt safe living at Claremont House. One person said, "My money is in the safe, I just ask and they get it for me." We spoke with a relative who said their family member was safe.

Staff we spoke with were able to identify signs of abuse and knew how to report any safeguarding concerns. One staff member said, "I know I can go above them (management) if they don't listen, but I am confident they would listen."

We looked at safeguarding records and found appropriate action had been taken in each case. For example, follow up meetings with family members had taken place and care plans had been updated. These systems helped to ensure people living at Claremont House were protected from harm.

During the morning we overheard a staff member talking to a person and making them aware they had a lot of food in their mouth and encouraged them to slow down. This demonstrated the staff member was aware of the risk of choking for this person.

People's care and support was planned and delivered in a way that reduced risks to people's safety and welfare. Care and support plans contained a range of person-centred risk assessments. These included, moving and handling, skin integrity and falls. Where a risk had been identified, action had been taken to reduce future risk, such as using bed sensors, low height beds and pressure reducing mattresses. Where people required the use of a hoist their records noted the equipment staff needed, how it was to be applied, fitted and used. This level of detail reduces the risk of harm to both the person and the staff supporting them.

Some people who lived at the home had the potential for exhibiting behaviour which could challenge others. We saw care and support plans detailed potential triggers, how to reduce risk and how staff were to respond in the event the person's behaviour escalated. Having this information enabled staff to ensure their response was appropriate to individual people's needs.

At the time of our inspection, the registered provider told us some staff had resigned due to uncertainty over the future of Claremont House under its current ownership. This meant agency staff were used on a weekly basis and there were vacancies for five care assistants for day shifts and three night-care assistants.

People were satisfied there were sufficient staff levels to meet their needs. One person said, "If I want to go out, they (staff) come out to the shop with me." We saw staff had a visible presence throughout the home during our inspection. The registered manager tracked how quickly staff responded to call bells and told us people usually waited for two to three minutes for staff to respond.

One staff member told us, "Here you have time to spend to sit and chat and that's so nice." Another staff member who told us there were sufficient staff numbers said, "Yes, at the moment. When short stay is full

there is added pressure." The registered provider used a dependency tool which was updated weekly to identify people's care needs and ensure sufficient staffing cover was in place. Where a new admission was accepted, the registered manager updated the dependency tool.

We looked at the management of medicines and found this was well managed, with one exception which the registered manager said they would address immediately.

We recommend that the registered provider requires staff to record the time of administration for medicines which have been prescribed for specific times of the day. We informed the registered manager that one person who was prescribed a medicine to be given before food had this 15 minutes after their breakfast. They told us they would take immediate action to remedy this.

Medicines were stored safely and securely. Each person had a medicines profile which recorded the medicines they were prescribed and how they preferred to take them. Where people were prescribed medicines to be taken 'as required' their profile included guidelines to ensure the medicine was administered in a safe and consistent manner.

We checked a random sample of medicines and found the stock tallied with the recorded number of administrations. Where people were prescribed creams, these were stored in a locked cupboard in people's own bedroom. There was a topical administration record (TMAR) stored with the cream which provided information to staff as to when and where to apply the cream.

One person was prescribed a medicine which was classified as a controlled drug. These are medicines that have additional requirements around storage and recording. We found the medicine was stored and administered appropriately. The medicine was in the form of a patch which staff applied to the person's skin. Staff told us they rotated the area of skin where they applied the patch, although they did not record this. The registered manager told us they would ensure this was recorded following our inspection.

Staff we spoke with told us they had received medicines training and regular assessments of their competency was completed. This meant people received their medicines from people who had the appropriate knowledge and skills.

Throughout the day of our inspection we found the building was clean and there were no unpleasant odours.

We found the certificates and other records relating to the supply of water, electricity and gas were all up-to-date and in order. In addition, the thorough examination of all equipment had been carried out in the last six months as per the lifting operations and lifting equipment regulations (LOLER).

We saw staff had access to a grab sheet showing people's personal emergency evacuation needs in the event of a fire. Fire drills had taken place in January and July 2018 and we saw an up-to-date fire risk assessment dated June 2018. A fire alarm inspection had taken place in November 2017. An internal ventilated smoking room had been fitted with laminate flooring and seats upholstered with a plastic finish. This meant fire safety had been considered.

The registered manager told us they looked to take learning opportunities from incidents which had not gone as planned. For example, they took concerns passed on to them to staff meetings to discuss preventative action needed to reduce the risk of them happening again. We saw evidence of this in meeting minutes and a staff member we spoke with confirmed this happened. Also, the registered manager

acknowledged issues they had experienced in managing the use of incontinence pads. Staff had received clear guidance on the use of these products and improvements were subsequently seen.

We looked at three staff files and found the recruitment process followed had been safe, although clearer recording of staff identification seen by the registered provider was needed. We spoke with a staff member who had commenced their employment with the registered provider in the last 12 months. They confirmed the different forms of ID they were required to produce before commencing employment which demonstrated staff identification was appropriately checked. Staff files showed suitable references had been taken and checks had been made with the Disclosure and Barring Service (DBS) before staff commenced their employment. The DBS assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people.

Good

Is the service effective?

Our findings

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 we spoke with said they had received training on mental capacity and consent. One staff member told us, "We can't assume they (people) can't make decisions." Staff answers demonstrated an understanding of the principles of the MCA and how this impacted on their role. One staff member said, "(MCA) it is about who makes decisions, many people here can't make decisions. If they don't have capacity we act in their best interests."

People's care plans recorded the specific decisions people were unable to make. We saw evidence of decision specific capacity assessments and best interest decision making. Following this process demonstrates openness and transparency for people who lack capacity as prescribed in the MCA.

One staff member told us, "Everybody goes to bed at different times." One person we spoke with confirmed they chose their waking and bed times. Staff were also able to describe suitable action they would take in response to people refusing care.

The registered manager showed us their DoLS tracker and we saw everyone either had an up-to-date authorisation or alternatively a DoLS application had been submitted to the local authority prior to our inspection. The registered manager was able to tell us about the conditions they needed to meet for some of the approvals and they were managing this. This meant people were lawfully deprived of their liberty.

We spoke with one person who told us, "The staff know what they are doing."

The registered manager told us staff new to Claremont House completed an induction which included mandatory training and opportunities to shadow experienced staff. At the time of our inspection, one staff member was completing the Care Certificate. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

One staff member said, "I think the support is really good." They added that supervisions were useful and provided an opportunity to discuss training and other aspects of their personal development. Another staff

member confirmed they had received supervision as part of settling into working at Claremont House.

At the time of our inspection the overall training completion rate was 79 per cent. The registered manager demonstrated gaps were being followed up and staff were booked on to the necessary training. We saw evidence of ongoing support for staff through one to one and group supervision, appraisals and staff development meetings held by the registered manager. Due to the absence of one of the deputy managers, there had been a gap in some staff supervisions at the beginning of 2018, although steps had been taken to catch up on these supervisions. Staff told us they could bring their supervision forward if needed and they felt the registered manager could be approached at any time.

One person told us, "I've always enjoyed my meals." Another person said, "It's very eatable." Two members of staff we spoke with told us they thought the quality of food served was good.

Staff recorded food and fluid intake for people at risk of weight loss. We reviewed the records for the week prior to our inspection for one person who lived at the home and found they lacked some detail. For example, their care plan recorded 'encourage high calorie snacks' but there was no evidence a mid-morning snack had been offered or consumed. The registered manager told us they would address this. We saw people had a nutritional risk assessment in place and were weighed on a regular basis. We found people had stable weights and appropriate action was taken in the case of any exceptions.

People were supported to eat and drink. Drinks were available throughout the day and staff prompted people to eat and drink at regular intervals. At lunchtime we saw staff show people the two meal choices on offer to enable them to choose which they would prefer to eat. There were condiments on the table and we heard staff asking people if they wanted them adding to their meal. People had a drink of juice with their lunchtime meal and we heard a member of staff offering people a hot drink towards the end of lunch.

Where people had a specific dietary need, they had an eating and drinking profile. These were detailed and person centred. Where people's care files instructed staff to provide a specific food consistency, for example, soft, we saw this was provided.

People told us they were supported to access healthcare services by staff. One person said, "I've not been well, but they get the doctor for me."

The registered manager told us they had good working relationships with a range of professionals who visited the home, such as district nurses, the care home liaison team, a local rehabilitation unit, chiropodists and opticians. They added, some people had their own dentists and staff supported people to access dentistry where they did not. We saw evidence of the timely involvement of health professionals in people's care records.

Each unit was clearly signposted and specific items such as the tv and radio in the activities lounge had a retro appearance to help people living with dementia recognise these items. Newspaper articles of interest from the 1940s, 1950s and 1960s were on display to help people reminisce. We saw a bus stop sign and a post box in the garden, which meant staff supporting people living with dementia were able to redirect people if they became anxious by using this as a conversation topic or going for a walk to these places in the garden.

We found the mirror in one of the communal toilets was fixed at the level for a wheelchair user which demonstrated adaptions had been made to the premises to protect people's protected equality rights. The service manager and registered manager told us they would be replacing some of the worn chairs in the

conservatory.

The Accessible Information Standard came into force in 2016 with the aim of ensuring people with disabilities, impairments or sensory loss get information they can understand, plus any communication support they need when receiving healthcare services. The registered manager told us they were able to offer care for people with different communication needs and gave an example of accessing interpreting services for people whose first language is not English. This meant this standard was being met.

Good

Is the service caring?

Our findings

One person told us, "They're all good (referring to staff)." The same person confirmed staff always knocked on their door to respect their privacy and dignity. Another person said, "They're very caring, they do a good job. If you need help, you get it. I think they (staff) do very well for us." A third person told us they would recommend Claremont House and commented, "You can't get any one better." They also said, "The staff are all helpful." One relative said, "[Family member] doesn't seem to want for anything."

One staff member said, "All the staff here are very dedicated to the people. You can't fault the agency staff, they're also dedicated." Another staff member who told us staff had time to sit and talk with people said, "It is lovely here. We had a person who just liked us to sit and hold her hand, it made her happy."

We saw staff working at eye level with people sat down or using wheelchairs. This is good practice as it demonstrates personalised, one to one care through the attention given and helps people feel comfortable. People were able to walk throughout communal areas of the home unrestricted. Throughout the day of our inspection we found the home was relaxed and calm. We observed people and staff chatting to each other and friendly natured humour exchanged.

We saw staff welcoming a person as they entered a communal area on the morning of our inspection. They were heard asking the person if they had a good night. Later, we heard staff complimenting one person on their choice of top which they said suited the person.
On the day of our inspection, the weather was particularly warm and when one person wanted to go into the garden, staff ensured they had sun cream and a hat to protect them from the effect of the heat.

One relative told us, "They know [family member] well." Staff were able to demonstrate their knowledge of people and their care preferences. One staff member said, "We try to encourage people to do what they can. You get to know their routines, how they like things to be done. It was evident from their interactions with people that staff knew them well. For example, staff called people by their name and they were familiar with risks to individual people.

One person told us they assisted with making beds and washing up which meant they felt valued through their contribution. We asked a staff member about when people were able to access baths and showers. They replied, "Most people have a shower on a morning."

One staff member told us people's representatives had been involved in care planning, including assessments of people's capacity. We saw evidence of relatives signing care plans which meant they had an opportunity to see and review these records.

Staff we spoke with knew how to respect people's privacy and dignity. One staff member said that before providing personal care to people, they ensured doors and curtains were closed and people were covered where possible. They also said they knocked on people's doors before entering and we saw staff doing this during our inspection.

At the time of our inspection, no one living at Claremont House needed access to advocacy services, although the registered manager was aware of who they needed to contact to request this support. Advocates are independent people who assist people in making decisions where they are unable to manage this on their own and they do not have family or friends to represent them.

We saw religious meetings were held on a weekly basis where people came to listen to readings. The registered manager told us Claremont House was able to meet people's dietary needs based on culture and religion and shared an example of how they had met this requirement in the past. This meant people's equality, diversity and human rights were respected. Staff were able to demonstrate how they supported people in their sexual relationships and expressed how this was done in a non-discriminatory way.

We looked at two compliments which stated 'I always felt part of an extended family when I visited Claremont. Everyone was so cheerful' and 'I would like to thank you and your team for the excellent care [name] received from you all'.

Good

Is the service responsive?

Our findings

We looked at two care plans in detail and found they were concise, although they contained sufficient information for staff to be able to provide safe and effective care for people.

Care plans we looked at included people's religious needs, communication, skin integrity, behaviour management, continence, dietary needs, infection control and moving and handling needs which contained a good level of detail. We also saw people's end of life wishes were included in their care plans. Care plans contained evidence of person-centred care and showed people were encouraged to retain their independence. For example, one care plan stated, 'Show [person] flannel and soap as visual prompt as to what they (need to do)'.

A staff member told us they were encouraged to read care plans. They added that when team leaders made a change to a care plan, they usually communicated these details to care assistants. We saw evidence of recent reviews having taken place and care plan audits were effective in identifying areas for improvement.

We looked at how the registered provider ensured people were prevented from becoming socially isolated. One person told us, "I'm never bored." Another person said, "They're lovely (staff). We've got a lot of things to do."

During the afternoon of our inspection we saw a 1940's singer had visited the home and a number of people joined in and enjoyed this. We saw a pool table on the first floor and a projector in the conservatory which was used to play movies. A piano in the same area was able to automatically play to entertain people. We saw an activities planner which listed events such as arts and crafts, active minds and beauty treatments.

We looked at the gardens which were substantial and well kept. Garden furniture including parasols to protect people from the sun were in use. People were able to freely access this area and where a person needed support, we saw a staff member accompanying them. One staff member told us the activities coordinator took people out to the garden. We saw a greenhouse and were told people were supported with gardening and growing different items. At the time of our inspection the activities coordinator was working with people and their representatives on life histories.

We looked at the systems in place to support people and their representatives if they wanted to make a complaint. One person commented, "If I have a complaint, you tell them, they sort it out, they are good." One relative said, "Any issues, I will speak to someone and I'm happy they will listen." We looked at the record of complaints and found none had been received since our last inspection. People we spoke with told us they knew how to make a complaint and felt comfortable if they needed to do this.

At the time of our inspection, no one at Claremont House had been assessed as needing a sensor mat. However, bed sensors were used and staff used a pager system which they were seen operating. This helped to demonstrate how technology was used to benefit people living in the home.

Good

Is the service well-led?

Our findings

At the time of our inspection, Claremont House had a manager in post who had been registered with the Care Quality Commission since October 2015.

We looked at how the registered provider involved people in the running of the home. The last 'resident and relative' meeting took place in October 2017. We saw the possible sale of Claremont House was discussed during this meeting, along with staffing levels, complaints and the activities programme. A further meeting was scheduled for February 2018, although this was cancelled due to severe weather conditions. In May 2018, people and their representatives were updated regarding the future of the home.

Relatives we spoke with gave different feedback about how effective communication was at Claremont House. One relative said, "As soon as I get here, they tell me about [family member]." However, another relative made us aware they had not been told about their family member's health appointments.

The registered manager expressed they were working through a challenging period relating to the future of the home and how this had impacted on staff. One staff member told us, "I think most people are in high spirits." Staff added that they felt they worked in a home with a positive culture where staff worked well together. Comments included, "We do have a good team and we are good at communicating", "It's been good. The staff are pleasant" and "I would recommend this home."

We looked at records of comprehensive staff meetings which had taken place in November 2017, February and May 2018. We saw these contained details about current legislation related to data protection and training for this, as well as wide-ranging issues such as medication, infection control, bad weather planning and dignity in care. Each meeting recapped key points from the previous meeting which provided continuity. We saw staff were briefed on details of infection control external meetings attended by the management team. This meant knowledge was openly shared with the staff team to improve the service.

People and staff we spoke with said the registered manager was approachable. One person said, "[Registered manager] comes and sits and talks with me a lot." Staff comments about the registered manager included, "[Registered manager] is very approachable to speak with", and "I talk to [registered manager] quite a lot. [Registered manager] takes her time and interacts with you." The registered manager felt well supported and told us, "What I like about my present manager is he does walk around the home. I feel quite comfortable about picking the phone up."

We saw names and photos of all staff in the home was on display. This helped people and their representatives understand who was responsible for providing care.

We saw evidence of audits which covered finances, hand washing, medication, activities, care plans, nutrition, home observations and staff files. Each month the registered manager completed a quality assessment framework. Each aspect was given a red, amber or green rating and we saw this was an effective assessment of the state of the home based on our inspection findings. For example, action was being taken

to ensure relevant staff had an up-to-date assessment of their competency to administer medicines. At the time of our inspection, only two staff members still needed to complete this.

We looked at records of accidents and incidents and saw dates, times, who was involved and where they occurred were recorded. We saw evidence of one person being referred to an occupational therapist for additional support around equipment needed to reduce their risk of falls.

The registered manager had identified they wanted to build on local partnership working. They said volunteers had been coming into the home with one playing the piano and another bringing in a 'pat dog' which has been shown to have therapeutic benefits for people.