Care Quality Commission

Warrington Homes Limited(The)

Claremont Residential Home

Inspection report

The Linleys
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Corsham
Wiltshire
SN13 9PD

Tel: 01249713084

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11 January 2019

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

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

The home is registered to provide accommodation and personal care for up to 34 older people. At the time of the inspection 29 people were living at the service.

The inspection took place on 11 January 2019 and was unannounced.

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

At our last inspection we rated the service Good. At this inspection we found the evidence continued to support the rating of Good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

Staff understood their responsibilities to keep people safe from harm and people told us they felt safe. Care plans contained risk assessments and informed staff how to reduce the risk of harm to people.

Safe recruitment procedures were followed and there was enough staff on duty to meet people's needs.

In the main, medicines were managed safely.

Staff had been trained to carry out their roles and received regular support.

People were supported to have enough to eat and drink. Although people gave mixed feedback about the quality of food, this was an issue the provider was aware of.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People and their relatives spoke highly of the staff. Staff understood how to maintain people's privacy and dignity.

Care plans were person centred and included details of people's preferences for how they wanted to be supported. People were supported to maintain relationships with family and friends.

All the people and visitors we spoke with and all the staff spoke highly of the registered manager and the level of support and leadership they provided. There were quality assurance processes in place.

Regular feedback was sought from people and staff.

Further information is in the detailed findings below.

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 remains Safe.	**Good** ●
Is the service effective? The service remains Effective.	**Good** ●
Is the service caring? The service remains Caring.	**Good** ●
Is the service responsive? The service remains Responsive.	**Good** ●
Is the service well-led? The service remains Well-led.	**Good** ●

Care Quality Commission

Claremont Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 11 January 2019 and was unannounced. The inspection team consisted of one adult social care inspector and one expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed other information we held about the service, including previous inspection reports and notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us. We also looked at information in the 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.

During the inspection we spoke with six people, two relatives, seven members of staff, the head of care and the registered manager. We reviewed four people's care plans and three staff files. We also looked at records relating to the management of the service such as incident and accident records, meeting minutes, recruitment and training records, policies, audits and complaints.

Good

Is the service safe?

Our findings

The service remained safe.

People and their relatives told us they felt safe. One person said, "I feel safe because of the way [staff] behave. I know if I forget something they'll remind me and I don't have to worry." One person's relative told us, "At home, [family member] had a pendant [to call for help], but once they didn't wear it and was on the floor for hours. Here, they can get help straightaway."

Staff had been trained and understood their responsibilities to keep people safe. One member of staff said, "If I saw unexpected bruises. I would go and report it to the care office and ask about it. I'd check the care plan see if it had been reported." Staff were familiar with the term whistleblowing and said they felt confident to challenge and report poor care. One member of staff said, "I would report any concerns to [head of care]. I wouldn't stand for it."

Care plans contained risk assessments for areas such as falls, mobility, skin integrity and malnutrition. When risks had been identified care plans provided clear guidance for staff on how to reduce the risks. Mobility plans informed staff of any mobility aids people used and people were encouraged to remain as mobile as possible. One person told us, "I must use the frame and my walking isn't so good now. I'm not as mobile, so [staff] told me I must ring the bell." When people needed staff to move them using equipment, this was listed, such as hoist and sling details.

The provider had procedures in place to ensure staff had checks undertaken before commencing their employment. These included inviting them for a formal interview and carrying out pre-employment checks. Within these checks the provider asked for a full employment history, references from previous employers, proof of staff's identity and a satisfactory Disclosure and Barring Service clearance (DBS). The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with adults.

There was enough staff on duty to meet people's needs. All the staff we spoke with told us they did not believe the service was short of staff. One member of staff said, "We always have enough staff, at weekends too." Some people said they felt that on occasions there were not enough staff. One person said, "There's a shortage of help at certain times, especially lunch time. I do understand that several people can ask for help at the same time and it's not easy for them. It's just very upsetting when I need the loo and I can't walk on my own now. I don't like
the waiting." However, other people said they felt there was always enough staff and they rarely had to wait for assistance. One person told us, "I often need the toilet at two in the morning and they're here pretty much immediately. It's usually very good."

In the main, medicines were managed safely. We looked at medicine administration records (MARs) and these had all been signed by staff to indicate people had received their medicines as prescribed. One person was self-administering their medicines. They had been assessed by staff to ensure they were able to do this

safely and had signed the competency form to confirm they understood how to do this. However, the competency assessment stated the person would keep their medicines in a locked cupboard in their room. The head of care asked the person's permission to show us how they stored their medicines, which were not locked away. They were left unattended on the person's bedside cabinet. We discussed with the head of care the risks associated with this and they said they would address it with immediate effect. Other medicines were stored in locked trolleys in a locked room. Controlled medicines were stored safely and regular stock balance checks were carried out.

Some people had been prescribed additional medicines on an as required (PRN) basis, but there were no PRN protocols in place. Having protocols in place ensures that staff can see when and why people might require additional medicines. The provider's medicines policy also referred to, "a specific plan for administration" of PRN medicines. We discussed this with the head of care who said they would implement protocols for people.

Some people had been prescribed topical medicines such as creams and lotions. There were instructions in place for staff which meant it was clear to see where they needed to apply these. Topical charts had been signed by staff to indicate they had applied these as prescribed. There was a process in place to monitor expiry dates of topical medicines. This meant out of date creams and lotions were disposed of in a timely manner.

Staff were trained to reduce the spread of infection. Personal protective equipment including gloves and aprons were available for staff to use. The environment was clean and free of odours. One person said, "I think it's exceptionally clean." One member of housekeeping staff told us, "We do regular deep cleans and spot cleaning as well as day to day cleaning. We have enough staff to deal with spillages quickly."

Incidents and accidents were reported and analysed to identify trends. There was evidence that lessons were learned when incidents happened and care plans and risk assessments had been updated when incidents had occurred.

The premises were well maintained and safe. Safety reviews and regular servicing of utilities such as electrical checks, regular fire alarm testing and drills were carried out.

Good

Is the service effective?

Our findings

The service remained effective.

Staff had been trained to carry out their roles. One person's relative said, "I think [staff] have got the right skills and knowledge and they manage [family member's] care very well." There was a training plan in place which showed which training staff had completed and when refresher training was due. New staff completed an induction programme. One new staff member said, "It [induction] was good and thorough. I did all my training. This is my first care home job, but I feel prepared for it. There is always someone I can ask for help or advice if needed. They've been more than happy to answer my questions."

Staff had regular supervision sessions with their line manager. This meant there was an opportunity for staff to discuss their performance, their training needs and access support in their roles. Regular staff meetings took place and annual appraisals were also undertaken. All the staff we spoke with said they felt supported in their role. One staff member said, "I feel really supported. But if I need extra, I can talk to [registered manager] and [head of care]; their doors are always open. They're nice and willing to help."

People were supported to have enough to eat and drink. People's weights were monitored and when people lost weight, advice was sought. Some people had 'graze bowls' in their rooms. These contained crisps, fruit and chocolate. Staff said these were for people who needed extra calories or for those that liked to "nibble" throughout the day. The kitchen manager told us, "There is a form that people fill in on admission, so we get to know their likes/dislikes, allergies. Kitchen staff go around to meet people too." We received mixed feedback from people about the food quality, although everybody we spoke to said they had enough. One person said, "It's not as good as home cooking. Sometimes it's nice and sometimes quite a bit gets sent back. There's always two choices and there's plenty to eat." Another person said, "I like the food. You can have as much as you want and [staff] always ask if you want more." We discussed this feedback with the registered manager who said this was an issue they were aware of and were working with the kitchen manager to resolve it.

People had access to ongoing healthcare. Records showed people were seen by the GP and the community nurse for example. One person said, "The community nurse comes in to dress my legs a few times a week and the doctor comes round. I saw [them] yesterday." Another person said, "I've got some very good friends who go with me to appointments, but if they can't, in the past I've gone with a carer from here. For example, they took me to audiology and it worked well."

The environment was light and spacious. There were several small seating areas as well as larger communal areas and a secure garden which people could enjoy during warmer weather. The registered manager told us people used the garden for tea parties and barbeques and that the service grew their own vegetables.

Consent to care and treatment was sought in line with legislation and guidance. People were assessed for their capacity to consent and when people lacked capacity best interest decisions had been made. We did note that people had not always formally consented to the use of bedrails. We discussed this with the head

of care who said they would address this with immediate effect. Staff remained knowledgeable about the Mental Capacity Act and could explain how they applied it when supporting people to make decisions. One member of staff said, "I always ask people what they want to do. We have some people who like to stay in bed later than others and that's fine, it's their choice." One person said, "You're not forced to do anything, but you are given encouragement sometimes and that's important when you're getting a bit withdrawn and you feel better for it." Another person's relative told us, "They do ask [family member] every day if they would like to go to the dining room. That's not because they want to impose it, but in case [family member] has changed their mind."

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and the associated Deprivation of Liberty Safeguards (DoLS). People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The provider was meeting the requirements.

Good

Is the service caring?

Our findings

The service remained caring.

In the main, people and their relatives were positive about their relationships with staff and spoke warmly of the support they received. One person said, "The staff are very, very good and kind. For example, I can't get to the shops and I wanted some cards, so one of them got them for me." Another person said, "There are one or two staff whom I'd rather didn't look after me, but they're few and far between. Most staff are attentive, respectful and kind."

The atmosphere during the inspection was relaxed and friendly. People appeared relaxed around staff; we saw they were smiling and talking with staff. One person told us, "The staff are very nice. They're friendly and we have a laugh and a joke together." One person's relative told us, "Staff remembered that my [family member] liked dancing, and introduced [them] to someone else with the same interests."

Staff spoke highly of their roles. One member of staff said, "Care is good here. My experience is that it's of a really high standard. I wouldn't mind being cared for here." Another staff member said, "Everyone takes extra time with residents, rather than rushing around." Staff told us they worked well as team. One staff member said, "The camaraderie amongst staff is brilliant. I love working here."

People's views were actively sought. Regular 'resident meetings' took place as well as annual surveys. The resident's meetings followed a regular agenda to gain feedback in relation to care, food, cleaning and laundry. The activities co-ordinator told us attendance was usually good and that people who were unable to attend were seen individually to gain their views. Family members could attend if they wished. One person said, "[Activities co-ordinator] does come round and ask if I want to raise anything at the meeting and comes to see me afterwards to tell me what was discussed." The minutes of meetings were published in the newsletter and heads of departments received feedback as well.

Other feedback received was positive. An example of this included, "I have been delighted with the help and support [relative] has received since moving to Claremont a couple of months ago. This along with the friendliness of the staff and the other residents has helped [relative] to cope with the transition and settle in. I have found that any requests or enquiries that both [relative] and I have made, have been dealt with promptly and efficiently. I have appreciated being consulted about any health concerns or changes to [relative's] treatment or medication."

People said that although most staff protected their privacy and dignity, a few staff didn't always knock before entering their rooms. Comments included, "They just come in; some of them don't ask but some will always knock" and, "Staff mostly tap on the door, but some just come in and it can be a bit of a shock if you're in the bathroom and don't hear them." Staff understood how to maintain people's privacy and dignity. One member of staff said, "I always ensure doors are shut, curtains closed, put a towel over people's laps, leave people alone when they're on the toilet. Things like that." One person said, "They're mostly very good and cover you up when washing you."

Good

Is the service responsive?

Our findings

The service remained responsive.

Care plans were person centred and included details of people's choices and preferences for how they wanted to be supported. People's life histories were documented. Personal care plans detailed whether people preferred a bath or shower, their daily routines and how they liked to dress. For example, in one person's plan it was documented, "Likes to wear trousers and to look neat and tidy with hair done." One person's relative said, "[Staff name] came to assess [family member] at [another care home] and I think they learned more about [family member] in half an hour than the old care home did in several weeks. I was very pleased that all of that information seemed to be remembered when [family member] came here."

Plans in relation to people's health needs were clear and informed staff how people's condition might affect their day to day living. Staff could describe to us how they supported people. One member of staff said, "[Person's name] needs extra support some days, depending on their [condition]. Every day I ask what kind of support [they] need that day." Another member of staff said, "I'm a bit of a chatterbox so I just chat to people and get to know them. I've read the care plans and we have a handover every day."

Regular care plan reviews were carried out and where able, people were involved in these. For example, we saw that some people had signed their plans to confirm their agreement.

People were supported to maintain relationships. People and their relatives told us that visiting was unrestricted. There was an IT room which people could use to video call relatives or email them. In one person's plan it was written it was important to them to maintain contact with a family member in another country, which they could do using their own electronic device. The same person had their own telephone line in their room to keep up with other friends and family.

There was a range of activities for people to participate in which included regular input from community groups. This included a local knitting circle, a gospel choir, a pre-school group and a volunteer who visited with a dog. Holy communion was provided monthly. There were also various planned activities such as quizzes, weekly light chair based exercises to music, and a weekly hairdressing service. There were also groups such as an art group, a men's group and a seasonal gardening club. People who chose not to attend group activities, or were unable to said they had regular one to one sessions with the activities co-ordinator. One person said, "[Activities co-ordinator] comes to see me a few times a week and makes a point of letting me know what's going on, or we talk about my interests. It's difficult for me to take part in some things because of my disability."

There was a complaints procedure in place. One complaint had been received and this had been investigated and resolved appropriately. One person said, "If I've needed to talk to the manager, [they've] been very good, and the deputy is also very very good. They sort things out well." The head of care said, "I discuss with residents when any issues are raised. It's an open house here. We try and resolve things swiftly."

End of life plans were in place. These are plans which enable people and their families to inform staff of any special wishes around how they want to be cared for at the end of their lives. This includes information such as whether people wish to be admitted to hospital and if they have any spiritual preferences. One person's relative told us, "We recently discussed [end of life care] together; myself and [family member] with [staff name]. It was done very well, as we were helped to make those decisions which are difficult to talk about. [Staff name] was lovely, and approached it very compassionately and gently, but without putting words in our mouths."

Good

Is the service well-led?

Our findings

The service remained well-led.

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

A range of audits were regularly undertaken, including medicines, infection control and the environment. Regular 'homes committee' visits were carried out by the provider. We saw the latest commissioning contract monitoring report from August 2018, when no areas of concern were identified. When issues had been noted during audits, action plans were implemented and reviewed. There was an improvement plan in place which included details of work planned to the building including timelines for completion.

There was a culture of providing high standards of care to people in an open and transparent environment. The registered manager's office was adjacent to the main entrance and they said this ensured people's relatives could see them whenever they came to visit. They told us, "My door is always open to resident, relatives and staff." The registered manager was visible throughout the inspection, spoke to people by name and introduced us to them. Several of the people and relatives we spoke with mentioned the warmth and friendliness of the registered manager which two people said had influenced their choice of moving to the home. One person's relative said, "[Registered manager] was the main reason that we came here. [They] convinced us and gave us so much confidence."

Regular feedback was sought from people, their families and staff. This included regular resident meetings, staff meetings and annual satisfaction surveys. Results of surveys were shared with staff. We saw the latest survey results which showed a high level of satisfaction.

Regular staff meetings took place. One member of staff said, "We have meetings every six months or so. We get an update and we're encouraged to speak up. If we don't want to speak up in front if everyone we can speak to [registered manager] on a one to one."

Staff told us morale was, "up and down." They said this was because the registered manager was leaving the service at some point in the future. One member of staff said, "Most of the time it [morale] is lovely, but with [registered manager] going it's had a knock-on effect on us."

The service had good links with the local community. This included visits from the local church, school and a line dancing group.