Caring Homes Healthcare Group Limited

Claydon House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

About the service
Claydon House is registered to provide nursing care and accommodation for up to 49 people. There were 33 people living at the service at the time of the inspection. People that lived at Claydon House were mainly older people with a range of care and support needs that included diabetes and heart conditions. Several people lived with dementia and could show behaviours requiring support from appropriately trained staff.

People's experience of using this service and what we found
People who lived at the service were protected from the risk of harm and abuse. People told us they felt safe and this view was supported by relatives and loved ones. Staff had received training in safeguarding and were able to tell us the steps they would take if they suspected abuse. Care plans contained risk assessments relevant to people and their care needs. These included diabetes, wound care and living with dementia. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice. Medicines were administered safely by appropriately trained staff. Infection prevention and control measures were in place and the service was seen to be clean and well maintained throughout. Lessons were learned following accidents and incidents.

The registered manager had developed a positive culture at the service. Everyone spoke well of the registered manager who was a visible presence throughout the home. Robust auditing processes were in place, all of which were either carried out by the registered manger or had their full oversight. People and relatives were fully engaged with the service. There were a variety of ways that people and relatives could provide feedback about the service including regular meetings, questionnaires and daily interactions with managers. There were business plans in place for the future of the service and the registered manager had developed positive relationships with other health and social care professionals.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was good (published 1 November 2017)

Why we inspected
The inspection was prompted, in part, due to concerns received about the provider's approach to visiting, responding to concerns and risks of a closed culture. A closed culture is where a poor culture can lead to harm and abuse. A decision was made to inspect and examine the concerns across a number of Caring Homes' services.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Claydon House on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our well-led findings below.

Claydon House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection team consisted of two inspectors.

Service and service type
Claydon House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Claydon House is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

At the time of our inspection there was a registered manager in post.

Notice of inspection
This inspection was unannounced.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all of this information to plan our inspection.

During the inspection
We looked around the service and met and spoke with people who lived there. We spoke with seven people and 10 members of staff. Staff included the registered manager, the area manager of the provider, the deputy manager, the maintenance staff, registered nurses, health care assistants and agency staff.

We looked at a range of records relating to people's care and support. This included five care plans which contained a range of risk assessments, multiple medicine records and documents relating to infection prevention and control, accidents and incidents and auditing. We examined staff files and staffing rotas. We spoke with five relatives and two professionals.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question good. The rating for this key question has remained good.

This meant people were safe and protected from avoidable harm.

Systems and processes to safeguard people from the risk of abuse
- People were safe and were protected from the risk of harm and abuse. Staff knew people well and knew what steps to take if they suspected a person was at risk.
- People, their relatives and their loved ones told us they were safe. One person said, "I am comfortable here, they look after me very well." Another person told us, "All good, I feel safe, staff are kind." A relative told us, "It's brilliant. We live a long way away but we have friends that pop in. We know she is safe."
- All staff had received training in safeguarding, we were shown training records which confirmed this and included dates for refresher training sessions.
- Safeguarding and whistleblowing policies were in place and were accessible to all staff. Staff told us they were confident to use whistleblowing if needed. Whistleblowing allowed concerns to be raised anonymously.
- The registered manager had raised safeguarding issues with the local authority and informed CQC where appropriate.

Assessing risk, safety monitoring and management
- Risks to people were safely managed. Care plans and risk assessments identified specific risks to each person and provided written guidance for staff on how to minimise or prevent the risk of harm. These included risks associated with mobility, skin integrity and eating and drinking. For example, people with fragile skin had guidance for staff on how to prevent pressure damage using air flow mattresses, regular movement, continence promotion and monitoring. Daily record checks for air flow mattresses and continence care were up to date and reflected the care plan.
- People who had been identified as being at risk from dehydration had a daily goal set and people's fluids were monitored. Staff, when asked, knew who needed encouragement and support to drink.
- Staff told us how they managed risks while supporting people's rights and choices. One member of staff said, "We have people who are at risk of falls, we don't want people to be restricted or frustrated if they want to walk so we ensure they are supported by staff safely."
- The service had two points of access and close to each was a grab bag containing personal emergency evacuation plans (PEEPs). These documented the level of support people required in the event of an emergency. Fire safety checks had been completed and regular testing of fire equipment had been recorded. We were shown current safety certificates relating to electricity, gas and Legionella.

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 MCA 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 to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.
● The registered manager had applied for DoLS for people who lacked capacity to make a decision about bed rails and their risk of falling out of bed.
● Staff understood the importance of gaining consent from people. Several people living at the home were living with dementia. Staff took time to explain their tasks and to encourage people to make day to day choices where possible. A staff member told us, "We do try to encourage independence, but at the back of our minds, we also try to find the right way to keep them safe without restricting them." People were given the choice of receiving support from male or female care staff.
● Where appropriate, care plans contained decision specific capacity assessments and best interest meetings had been documented and placed the person concerned at the centre of any decision making. Relatives and professionals were also involved in these meetings.
● Staff had received training and understood the principles of the MCA and their responsibilities.

Staffing and recruitment
● During our inspection we saw enough staff available to support people. This included registered nurses, supervisors, care assistants and domestic staff. Registered nurses have to register with the Nursing and Midwifery Council (NMC) and these details had been checked and verified by the registered manager. Staff rotas confirmed that all staff numbers were up to strength and numbers required were reviewed daily.
● The service did use some agency staff but they were employed from the same agency and worked exclusively at the service. Agency staff were subject to the same recruitment checks as all staff.
● Staff were recruited safely. We looked at several staff files and found they all contained accurate and up to date documents. These included, references, employment histories, photographic identifications and Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.
● We witnessed call bells being answered promptly throughout our inspection.

Using medicines safely
● People did not have any concerns regarding how they received their medicines. One person said, "I have not had any issues and the GP checks my medicines with me," and "I could do my own I think but prefer the nurses to do it, they are very good."
● Medicines were stored, administered and disposed of safely. People's medication records (MAR) confirmed they received their medicines as required. We saw medicines were stored securely. The clinical fridges and the clinical room temperatures were checked daily to ensure medicines were kept at the correct/safe temperature to ensure their effectiveness. Systems that had been implemented ensured all medicines were disposed of safely.
● All staff who administered medicines had the relevant training and competency checks. Senior care staff (nursing assistants) had received support and training to ensure confidence in their extended role.
● There were protocols for 'as required' (PRN) medicines such as pain relief medicines, which included

recording the effectiveness of the medicine.
● People all had a recognised pain assessment tool that was used to assess people who were not able to verbalise their pain level. This was used in conjunction with their prescribed pain relief or homely remedy. Homely remedies are medicines that can be purchased over the counter and were subject to their own protocols.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

The registered manager had followed government guidelines throughout the recent pandemic relating to visitors to the service. Relatives told us they were always notified about changes in arrangements and even in times of lockdown were still able to communicate with their loved ones through video conversations. Any concerns or issues had been immediately addressed by the registered manager.

Learning lessons when things go wrong
● Accidents and incidents were recorded with details of what may have contributed to the incident These details were also recorded on a central incident tracker, which enabled managers to review individual incidents and to identify any emerging themes. If there was a discrepancy this was immediately investigated by the registered manager.
● There was evidence that learning took place when errors occurred. Details of immediate action taken was recorded and all information was shared with all staff.

Good

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has changed to good.

This meant the service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The service presented as homely with care, support and activities provided in a person-centred way. The service had a hair salon and a radio service which people could use and listen to if they wished. People told us they enjoyed these facilities and it made them feel at home.
- The registered manager was a visible presence throughout the service and people acknowledged and responded to them during our initial walk around the home. We saw positive interactions between the registered manager and people. People and relatives spoke highly of the registered manager. A relative told us, "They run the home well. Very knowledgeable and confident." The registered manager did a daily walk around with senior staff and observation sheets were kept so that changes could quickly be identified.
- Similarly, staff spoke positively about the managers at the home and the positive culture and supportive environment in which they worked. Staff told us they could approach managers at any time and were listened to when they reported issues. Each daily duty sheet had a message at the top stating, 'Thank you for all you continue to do.'
- Care plans and daily notes were handwritten and were available to all staff. How people were feeling each day and how their general health was presenting was recorded and handed over during staff changeovers so that up to date information about people was known to incoming staff. This ensured that people received the appropriate levels of support each day according to their needs.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The registered manager and deputy manager understood their responsibilities under the duty of candour. There is a legal obligation on managers to report certain significant events that happen at a service to the local authority and to CQC. This obligation had been met. The registered manager was open and honest with us throughout the inspection.
- The last CQC report was displayed in a communal part of the service and the full report was accessible from the service website homepage.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Auditing processes were in place to cover all aspects of service and were carried out at different levels. For

example, an independent company conducted a yearly audit covering issues under the five CQC domains. The most recent showed a 90% compliance with only minor issues being highlighted.

● Monthly audits were carried out by the registered manager in all areas including, for example, medicines, staff wellbeing, training and healthcare. Some auditing was done weekly and this included wound care and pressure sores.

● Infection prevention and control (IPC) audits were carried out by staff with oversight from the registered manager. This gave staff an insight into the importance of IPC whilst management overview was maintained. Any shortfalls or learning from auditing was shared with all staff. An example was where staff had found some higher, harder to reach areas to clean which were then added to the cleaning schedule.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Bi-monthly residents meetings took place and minutes from these meetings were recorded and made available to everyone. Residents were given an opportunity to raise issues and concerns and actions were recorded and feedback provided. Similarly, relatives' meetings took place bi-monthly. Again these minutes were circulated to all families and loved ones.

● Staff had regular opportunities to feedback about the service. Monthly meetings were held for both night and day staff along with daily handovers with senior staff. Staff had supervision meetings where they could discuss any issues with their managers. A staff member told us, "Good manager, always available if we need him. I get regular supervisions."

● Relatives consistently told us of well organised communication with the managers at the service. The registered manager sent out regular e-mail updates and called relatives and loved ones with information specific to their relative. A relative said, "Very good communication, improved further since (registered manager) arrived. I'm involved in reviews and regular surveys." Another told us, "The newsletter has been wonderful."

● People's equality characteristics and differences were respected. Some people followed certain faiths and others had dietary requirements based upon their culture. These were all supported and details were recorded in care plans.

Continuous learning and improving care. Working in partnership with others

● The registered manager kept up to date with changing guidance during the recent pandemic and bulletins sent out by the local authority, CQC and the UK Health Security Agency. The registered manager passed on key messages to staff and kept relatives and loved ones informed of any changes to visiting rules.

● Business and contingency plans were in place and the registered manager had a vision about the future of the service which placed people at the centre of any improvements. The service had plans to move to a computerised system for recording care plans which would enable faster auditing and quicker identification of issues.

● The registered manager had developed positive working relationships with statutory partners and professionals. Comments from professionals included, "They contact me with any concerns," "Good communications by e-mail", and "(registered manager) is very positive, great working relationship."