Dryband One Limited

Cloverdale Care Home

Inspection report

68 Butt Lane
Laceby
Grimsby
Lincolnshire
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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

Cloverdale Care Home is registered with the Care Quality Commission (CQC) to provide care and accommodation for 40 older people, some of whom may be living with dementia. The home is on the outskirts of Laceby village, and is about six miles west of Grimsby.

The building is purpose built, with accommodation provided at ground level. All bedrooms are single and thirty-nine have en-suite facilities. Cloverdale Care Home is set in its own grounds and has pleasant views of open countryside. There is ample car parking available.

This inspection took place on 09 March 2017 and was unannounced. The service was last inspected on 18 September 2015 and was found to be compliant with the regulations inspected at that time.

At the time of the inspection 26 people were living at the service.

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

People were cared for by staff who understood they had a duty to report any abuse so people were protected from harm. Staff had received training in how to identify and report abuse, and knew they could contact outside agencies if they wished. Staff, who had been recruited safely, were provided in enough numbers to meet the needs of the people who used the service. The service was kept clean and tidy and all areas were free from offensive odours. People's medicines were handled safely by staff who had received regular training.

People received a wholesome, well balanced and nutritious diet, their likes and dislikes were catered for and there was a choice of food at all meals times. Staff monitored people's dietary intake and made referrals to health care professionals when required. People who needed support with making informed decisions were protected by the use of legislation. Meetings were held with all those who had an interest in the person's welfare to ensure any decisions made on their behalf where in their best interest. Staff had received training which equipped them to meet the needs of the people who used the service.

People were cared for by staff who were kind and caring. Staff understood people's needs and respected their privacy and dignity. People, who used the service, or those who acted on their behalf, were involved in the formulation of care plans; this ensured people received care which met their needs and was of their choosing. Staff understood the importance of keeping personal information about the people who used the service confidential.

Staff had access to detailed information which described the person and their preferences for care; this

ensured the care people received was person centred and met their needs. People had access to a variety of activities both inside and outside of the service. The registered provider had an accessible complaints procedure which was displayed around the service.

Systems were in place which gathered the views of the people who used the service and those who had an interest in their welfare about the quality of the service provided. The registered manager was accessible and approachable. The quality of the service was audited regularly and any short falls were addressed through time limited action plans.

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 were cared for by staff who had been trained to recognise the signs of abuse and how to report this.

Enough staff were provided to meet the needs of the people who used the service.

The registered provider had systems in place to ensure staff were recruited safely and checks were made before they started working at the service.

People's medicines were handled, stored and administered safely by staff who had received training.

Is the service effective?

Good

The service was effective.

People were cared for by staff who had received training in how to effectively meet their needs.

Staff were supported to gain further qualifications and experience.

The registered provider had systems in place to protect people who needed support with making decisions.

People were provided with a wholesome and nutritional diet; staff monitored people's weight and dietary wellbeing.

The service was clean and well maintained.

Is the service caring?

Good

The service was caring.

People were cared for by staff who understood their needs.

People were involved with their plan of care and staff respected their dignity and privacy.

Staff maintained people's independence.

Is the service responsive?

Good

The service was responsive.

The care people received was person centred and staff respected their wishes and choices.

People were provided with a range of activities and pursued individual hobbies and interests with the support of staff.

People who used the service could raise concerns and make complaints if they wished.

Is the service well-led?

Good

The service was well led.

People who used the service could have a say about how it was run.

Other people who had an interest in the welfare of the people who used the service were consulted about their views as to how the service was run.

The registered manager undertook audits to make sure people lived in a safe, well run service.

Cloverdale Care 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 registered provider was 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 09 March and was unannounced. The inspection was completed by one adult social care inspector and an expert by experience. An expert by experience is someone who has had experience of the type of service provided.

The local authority safeguarding and quality teams and the local NHS were contacted as part of the inspection, to ask them for their views on the service.

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

We looked at the notifications we received from the service and reviewed all the intelligence CQC held to help inform us about the level of risk for this service.

On the day of the inspection we used the Short Observational Framework for Inspection [SOFI]. SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with five people who used the service and two of their relatives who were visiting during the inspection. We observed how staff interacted with people who used the service and monitored how staff supported people throughout the day, including meal times.

We spoke with seven staff; this included care staff, ancillary staff and the activities coordinator. We also spoke with the registered manager.

We looked at four care files which belonged to people who used the service. We also looked at other

important documentation relating to people who used the service such as incident and accident records and 16 medicine administration records (MARs). We looked at how the service used the Mental Capacity Act 2005 and Deprivation of Liberty code of practice to ensure that when people were deprived of their liberty or assessed as lacking capacity to make their own decisions, actions were taken in line with the legislation.

We looked at a selection of documentation relating to the management and running of the service. These included three staff recruitment files, training records, staff rotas, supervision records for staff, minutes of meetings with staff and people who used the service, safeguarding records, quality assurance audits, maintenance of equipment records, cleaning schedules and menus. We also undertook a tour of the building.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe. Comments included, "Oh yes! There are no problems here. Everyone looks after you" and "Yes, it's okay. I don't like these [bed rails] but I suppose they stop me falling out."

Visitors we spoke with during the inspection told us they felt their relatives were safe at the service. Comments included, "Yes, I think [relative's name] is in a good safe place here."

Staff told us they were aware the registered provider had a policy on how to report abuse and they could describe this to us. They told us they would report any abuse to the registered manager and were confident they would take the appropriate action. Staff were also aware they could report any abuse or safeguarding concerns to outside agencies, for example, the local authority or the CQC. Staff had received training in how to recognise and report abuse. They could describe to us what signs would be apparent if someone was the victim of abuse; this included low mood, depression or physical signs like unexplained bruising. Staff understood they had a duty to respect people's rights and not to discriminate on ground of race, culture, sexuality or age.

People's care plans contained assessments of areas of daily living which might pose a risk to the person; this included mobility, skin integrity, falls, nutrition and behaviours which might put the person or others at risk. The assessment described how staff were to support people to eliminate, as far as possible, these risks. For example, assisting with mobility by using lifting equipment or monitoring behaviour and redirecting people. The risk assessments were updated on a regular basis. Each person had their own specific evacuation plan and this described how staff were to support the person to leave the premises in an emergency, taking into account their level of understanding and mobility.

The registered manager undertook safety audits of the environment and repairs were undertaken by in house maintenance staff. Any faults were reported and rectified quickly. They had also devised a plan of action if the service was flooded or there was failure in the electricity, water or gas supply.

Staff told us they had a duty to raises concerns to protect people who used the service, and understood they would be protected by the provider's whistleblowing policy. They said they felt confident approaching the registered manager and felt they would be taken seriously and would be protected. The registered manager told us they took all concerns raised by staff seriously and would investigate. They told us they would protect staff and would make sure they were not subject to any intimidation or reprisals for raising concerns.

All accidents which occurred at the service were recorded and action taken to involve other health care agencies when required, for example, people attending the local A&E department. The registered manager audited all the accidents and incidents which occurred at the service to establish any trends or patterns, or to identify if someone's needs were changing and they needed a review of their care. They shared any finding with staff and these were discussed at staff meetings or sooner of needed.

People were cared for by staff who were provided in enough numbers to meet their needs and who had been recruited safely. We saw there were rotas in place which showed the amount of staff that should be on duty daily and the skill mix. Staff told us they thought there were enough staff on duty and we saw staff going about their duties efficiently and professionally. The registered manager told us they used the dependency levels of the people who used the service to calculate the appropriate staffing levels. We looked at the recruitment files of recently recruited staff. We saw these contained references, an application form which covered gaps in employment and experience, a check with the Disclosure and Barring Service (DBS), a job description and terms and conditions of employment.

We saw people's medicines were stored and administered safely. Staff received training about the safe handling of medicines and this was updated annually. Records we looked at were accurate and provided a good audit trail of the medicines administered. We saw any unused or refused medicines were returned to the pharmacist. Controlled medicines were recorded, stored and administered in line with current legislation and good practice guidelines. The supplying pharmacist undertook audits of the medicines system as did the registered manager. Records were kept of the temperature of the room the medicines were stored in and the refrigeration storage facilities to ensure medicines were stored at the correct temperature.

At the last inspection it had been noted that some of the equipment used to assist people had not been cleaned. At this inspection we found this had been addressed and equipment was cleaned and serviced at regular intervals. We found that overall the service was clean and there no malodours.

Good

Is the service effective?

Our findings

People who used the service told us they enjoyed the food. Comments included, "She's a beautiful cook. The food is brilliant", "The meals are exceptional. It's all homemade and it is quality food" and "The cook spends as much time with us as she does in the kitchen." They also told us they could access health professionals when needed, "If I want the doctor they get him", "It's no trouble whatsoever, if you're not well they do their best for you" and "If I need the hospital, someone always comes with me."

Staff told us they received training which equipped them to meet the needs of the people who used the service. They told us some training was updated annually; this included health and safety, moving and handling, fire training and safeguarding vulnerable adults. We saw all staff training was recorded and there was a system in place which ensured staff received refresher courses when required. Staff also told us they had the opportunity to further their development by undertaking nationally recognised qualifications. They told us they could undertake specific training, for example, dementia and how to support people who displayed behaviours which challenged the service.

Induction training was provided for all new staff; their competence was assessed and they had to complete units of learning before moving on to new subjects. New staff shadowed experienced staff until they had completed their induction and had been assessed as being competent.

Staff told us they received supervision on a regular basis; they also received an annual appraisal and we saw records which confirmed this. The supervision session afforded the staff the opportunity to discuss any work related issues and to look at their practise and performance. Staff told us they could approach the registered manager at any time to discuss issues they may have or to ask for advice. The staff's annual appraisals were held to set targets and goals for the coming year with regard to their training and development.

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 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).

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. Three people were subject to DoLS and more applications had been made; the registered manager was awaiting the outcome of these.

We saw the food was well presented and looked wholesome and nutritious. People could choose where to

eat their meals and this was accommodated; the majority of people ate in the dining rooms. We saw these were social occasions and an opportunity for people to catch up with friends and have a chat. Staff were heard encouraging people to eat and asking people if they would like more to eat. Staff provided assistance to those who needed it discreetly and sat next to people to support them. Food had been prepared to accommodate people's needs and pureed diets were provided where needed. People's food and fluid intake was recorded daily and they were weighed each week. If the staff identified any fluctuation in the person's weight they made referrals to the appropriate health care professionals for advice and assessments; they also made referrals if someone experienced other difficulties such as swallowing. Records we looked at showed staff were recording the information required by the health care professionals so they could provide ongoing support and assessments.

Staff monitored people's health and welfare and made referrals to health care professionals where appropriate. Care files showed staff made a daily record of people's wellbeing and what care had been provided. They also recorded when someone was not well and what action had been taken, for example, contacting their GP to request a visit. There was also evidence of people attending hospital appointments and the outcome of these. Care plans had been amended following visits from GPs and where people's needs had changed following a hospital admission.

At the last inspection it had been noted that the service was in need of a full refurbishment. At this inspection we saw the service had been redecorated and all areas looked well maintained. Pictures of trees had been painted on the walls of the corridors to provide stimulation for those people living with dementia. Letters, pictures and messages had been pinned to the trees. The registered manager told us these were a talking point as people walked down the corridors. The nurse station had been converted into a shop and people could purchase sweets and other small items. Communal areas had been redecorated and now looked much brighter and welcoming, and worn furniture had been replaced. All bedrooms had been redecorated and new furniture fitted.

Good

Is the service caring?

Our findings

People we spoke with during the inspection told us they found the staff kind and caring. Comments included, "They are very, very good to me", "They could not do better, I love them all", "I can't say anything wrong about them", "They are all friends to me", "I can trust them here, they seem to know me", "They don't talk to you like you're an infant, they talk like you're normal", "I can always go to them for help" and "There are no faults at all with this place."

We saw staff treated people with kindness and respect. They explained any caring tasks they were undertaking to the person and asked for their permission. For example, when using a lifting hoist staff explained what they were doing and what they wanted the person to do, and then checked if this was acceptable to the person and that they had understood what had been said. Staff described to us how they would maintain people's dignity and ensure their choices were respected. They told us they would ask people and make sure they had understood what had been said and they would allow people time to answer.

The registered provider had a range of policies and procedures in place for staff to follow which reinforced the need for staff to be mindful of people's background and culture. This was also recorded in people's care plans along with their preferences about how they chose to be cared for and spend their days.

We saw staff were sensitive when caring for people who were living with dementia and had limited communication and understanding. They spoke softly and calmly and gave the person time to respond. They used various ways of communicating including verbal and non- verbal, for example, smiling and nodding, to make sure people understood what had been asked of them. We saw staff caring for people in a relaxed and unhurried manner. Care staff were supported by ancillary staff that included catering, laundry and domestic staff, so they could concentrate on caring for the people who used the service.

Staff knew the people they were caring for and supporting, including their preferences and personal histories. Care plans we looked at contained information about people's preferences, likes and dislikes and their past lives. Staff we spoke with were able to describe people's needs and how these should be met. Staff had a good knowledge of the person's past history and were able to engage with people about their previous jobs, where they used to live, their families and their hobbies and interests. This was seen to be enjoyed by the people who used the service and was done in a spontaneous way by the staff. Staff told us they enjoyed spending time with people and learning about them; they told us it gave them a better understanding about the person.

Care plans we looked at demonstrated people who used the service, or those who acted on their behalf, had been involved with its formulation. We saw reviews had been held and people's input into these had been recorded. Those family members who we spoke with and who had an input into the care and welfare of their relatives told us they knew what was in their relative's care plans and the registered manager kept them well informed about their relative's welfare.

One person who used the service had an advocate. This was well documented in their care plans and we saw evidence they had been consulted during best interest meetings. Information was available for others if they wished to access advocacy services.

Staff understood the importance of keeping people's personal information confidential. They told us, "We can't talk about the residents outside of work", "All the information we keep has to kept safe and only those who have a right to see it can look at it" and "We're not allowed to talk about the residents to anyone else."

Staff could describe to us how they would maintain someone's dignity and ensure their privacy was respected. They told us, "I always knock on the residents doors and wait to be asked to come in", "I make sure residents are covered over if I'm doing any personal care" and "I always ask the residents what they want, it's their choice and we have to respect that."

Good

Is the service responsive?

Our findings

People who used the service told us, "I take a lot of daily papers and I like to spend my time reading them. My friends take the same papers so we have discussions when they visit" and "Yes, I love doing the activities and the entertainment." One person told us they would be confident in raising any concerns or complaints. They said, "I'd be happy to complain if I needed too. Yes, I feel confident about that, it's just I've never needed to."

Visitors told us, "I like the way they [people who use the service] have such personal care, [relative's name] always has her nails done and they look after her feet too."

Care plans we looked at contained information about the person and their likes and dislikes. They also contained information about how the person's needs were to be met by the staff. Assessments had been undertaken by the placing authority prior to the person moving into the service and care plans had been developed from these assessments. The care plans were updated and reviewed regularly and changes made where required, for example, following a stay in hospital or deterioration in the person's needs. Assessments had been undertaken about aspects of daily living which might pose a risk to people, for example, poor mobility, tissue viability and behaviours which might put the person or others at risk. These instructed staff in what areas to monitor and what action to take to keep the person safe.

The service employed a dedicated activities coordinator. They worked closely with people who used the service and made sure everyone could be involved. This included one to activities with those who were living with dementia, group activities such as bingo, listening to music and reminiscence sessions. During the inspection we saw that activities were being provided which included crafts and painting. Following the activities the coordinator completed a document which described what each person had done that day and also showed examples of their work. They told us they had an adequate budget and could purchase items to be used for activities if they wished. They also told us "I make sure residents who are cared for in their rooms are involved in activities even if it's just painting their nails or sitting to read to them, they still need to have some kind of contact."

The registered manager had started to use social media to keep people's relatives updated about the service and had set up a profile on Face Book. They told us that prior to setting up the profile they had discussed this at relatives meetings. They had gained consent from people who could give consent, and from those relatives who acted on behalf of people who used the service. The Face Book page showed activities and gave a daily update as to what the service was providing, such as outings. One relative we spoke with told us "I used the Face Book page and was reassured while away on holiday that mum was okay."

Staff told us they knew they had a duty to respect people's choices. They told us, "I would always ask the residents if it was their choice, I would never assume anything", "You can't make choices on their behalf, it's not right, they have to have some choice even if it just what to eat or wear" and "We always ask the residents what they would like to eat or wear or if they would like to do any activities." We saw people's choices and

preferences had been recorded in their care plans and these had been signed to indicate the person had agreed that these were their choices. This detailed things like how they preferred to be cared for, their daily routines and preference for meals drink and clothing.

The registered provider had a complaints procedure which people could access if they felt they needed to make a complaint. This was displayed around the service and provided to people as part of the service user guide. The registered manager told us they could supply the complaint procedure in other formats which were appropriate for people's needs, such as in another language or large print. They told us they would read and explain the procedure to those people who had difficulty understanding it.

Good

Is the service well-led?

Our findings

Staff told us they could approach the registered manager and felt their views were taken seriously. One member of staff said, "[The registered manager's name] is very supportive and approachable, I can go to them about anything and they will try and help", and another said, "We have team meetings and we can discuss whatever is bothering us and [the registered manager's name] provides us with information about anything that's new."

The registered manager told us they tried to create an open culture at the service where staff were enabled to share their knowledge and experience and feel empowered to approach them. This was achieved through regular staff meetings and staff supervision where their practice and issues which might be affecting the smooth running of the service were discussed. The meetings were also used as a time to celebrate achievements and good things about the service, for example, what went well and any events which enhanced the quality of life for the people who used the service.

The registered manager told us they had links with the local schools; the children had been to the home to sing for the people who used the service over Christmas and there was a visit planned for Easter. The local churches and other facilities were used by the people who used the service for recreational purposes.

The registered manager told us they understood their responsibility to notify the CQC of any allegations of abuse or any other incidents which might affect the smooth running of the service. Our records showed notifications had been sent to us as required.

At the last inspection it was noted that, whilst the registered manager undertook a quality audit of the service, there were gaps and some areas had not been identified. For example, the décor of the building. We found that a more robust system had been implemented since the last inspection and this had been used to identify areas of improvement. It also checked the quality of recording, staff training and the environment. This had been completed up until February 2017 and any short falls had been rectified. Action plans had been time limited and checks had been done to ensure these had been completed.
People who used the service had been asked for their views; this had been in the form of meetings and surveys. Others who had an interest in people's welfare had also been consulted. All the responses had been collated and reports produced which detailed the findings and the outcomes of the consultations. The findings were displayed around the service. The registered manager told us the registered provider was intending to introduce a new system of quality monitoring and they were in the process of implementing this.