Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Clifton Court Nursing Home

Lilbourne Road, Clifton-upon-Dunsmore, Rugby, CV23 0BB

Tel: 01788577032

Date of Inspection: 04 February 2013

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We inspected the following standards as part of a routine inspection. This is what we found:

Consent to care and treatment	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Management of medicines	✓ Met this standard
Requirements relating to workers	✓ Met this standard
Records	✓ Met this standard

Details about this location

Registered Provider	Crosscrown Limited
Registered Manager	Mrs. Nicola Helen Pepper
Overview of the service	The service is registered to provide accommodation with nursing and personal care for up to 40 older people.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 4 February 2013, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and reviewed information sent to us by commissioners of services.

What people told us and what we found

We spoke with four people who lived at the home and two relatives. They all told us that the home was a nice place to live. They told us that staff were kind and understood them well. One person said, "It is lovely here, the people are very nice, very kind they couldn't be more helpful." A relative told us, "We have family meetings and give feedback and share ideas and staff always follow up."

In the four care plans we looked at we saw that people or their relatives had signed to say they had agreed how people should be cared for and treated. The care plans were detailed and had clear instructions for staff to follow.

We found that there were policies and procedures in place to make sure that medicines were managed appropriately and safely. We saw that the clinical lead person regularly checked that staff followed the procedures.

We saw that staff recorded every time they asked for advice from other health professionals. A visiting health professional that we spoke with told us they had confidence in staff's ability to notice when people when became unwell. They said, "Staff recognise the subtle changes in people."

We looked at three staff files and found the manager recorded the checks they made before staff started working at the home, as well as the ongoing training and support staff were given. A member of care staff told us they had regular one to one meetings with the manager and that both the manager and deputy were very approachable and supportive.

You can see our judgements on the front page of this report.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Consent to care and treatment ✓ Met this standard

Before people are given any examination, care, treatment or support, they should be asked if they agree to it

Our judgement

The provider was meeting this standard.

Before people received any care or treatment they were asked for their consent and the provider acted in accordance with their wishes.

Reasons for our judgement

In the four care plans we looked at, we saw that the manager undertook an assessment of people's capacity to consent to their care and treatment when they moved into the home. This was clearly recorded so staff delivering care knew when they should involve people's relatives in agreeing decisions.

We saw that people or their relatives were asked to sign to say they consented to their care and treatment being provided by the staff. In one care plan we saw that staff had recorded, "X unable to sign but has given verbal consent" and another was marked, "All decisions to be made in consultation with relative."

We saw records of how people and their relatives made individual decisions about how they would prefer to be cared for and treated in the future, in case they became too ill to make those decisions at the time.

We asked care staff how they knew that people who may not communicate verbally, consented to care and treatment on an ongoing daily basis. They told us they would tell the person what they planned to do before they did it. One member of care staff said, "You explain and ask and then it is 'implied consent' if they do not decline. If a person declines, we must record, 'Declined'."

In the records we looked at, we saw that staff had clearly recorded when one person declined to have monthly health checks and when another person declined to be weighed, for example.

During our visit we saw care staff continuously encouraging people who lived at the home to make decisions about what they did, where they sat and what they ate and drank, for example. A relative we spoke with told us that their relative would only do what they wanted to do, and could not be persuaded into any 'unwanted' care and treatment. They told us that care staff and nurses respected their relative's wishes, and were as flexible as possible in supporting their relation.

Care and welfare of people who use services ✓ Met this standard

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

Reasons for our judgement

In the four care plans we looked at, we saw that people's needs were assessed when they first moved into the home. We saw that information about people's previous care, support and treatment needs was kept on file. The manager made an initial plan of care by reviewing information from the previous provider, and senior staff conducted an in-depth assessment of needs within 24 hours of the person moving into the home.

The second assessments we saw were detailed and covered all aspects of a person's needs, such as, mobility, diet, communication, social and spiritual needs. Staff who made the assessments looked at the risks to a person's health and wellbeing and put control measures in place to minimise the identified risks. For example, where a person was at risk of falling, specialised equipment was obtained to help them walk, and where another person who needed nursing in bed was at risk of getting sore skin, a timetable was prepared for staff to re-position the person at regular intervals. Care plans we looked at specified the kind of training that staff needed, to be able to care for and support each person effectively. This meant that care and treatment was planned and delivered in a way that ensured people's safety and welfare.

During our visit we saw staff helping people to move from the dining room to the lounge. We saw this was done in a thoughtful way, as staff explained what was happening at each stage of the move. Staff asked people where they would like to sit and considered such details as whether people preferred to see out of the window, or to see the television, or to sit next to their friends. People we spoke with told us the staff were always kind and considerate to their preferences.

People we spoke with told us there were regular, planned activities, but they didn't always want to join in. One person said, "Mostly we like to sit here chatting, watching everyone going in and out and seeing what's going on." Another person we spoke with said they preferred to sit in their own room as the view was so lovely and they had their own possessions around them.

A relative we spoke with told us that they had signed their relation's care plan and they thought the staff were very good at keeping them informed about any changes that might be needed. The relative showed us the daily records that staff made, about how they cared for and supported their relation. Another relative we spoke with told us that staff had

made lots of changes to their care plan to make sure their relation's need for independence was met. They said their relation had not wanted to be checked on every two hours during the night and this had been agreed. They said, when their relation was ill, their care plan was changed and staff did make two hourly checks, because their relation was at greater risk due to their ill health. This meant that care, support and treatment was planned and delivered in line with people's individual care plan.

Management of medicines ✓ Met this standard

People should be given the medicines they need when they need them, and in a safe way

Our judgement

The provider was meeting this standard.

People were protected against the risks associated with medicines because the provider had appropriate arrangements in place to manage medicines.

Reasons for our judgement

The provider had policies and procedures for administering medicines, which included a list of named staff who had been trained and assessed as competent to handle and administer medicines. The list of named staff, included their usual signatures, which meant that the deputy manager was always able to check which staff had administered medicines. This meant that medicines were handled and administered appropriately.

We found that medicines were kept safely in locked medicines' trolleys in a locked room, and only the nurse in charge had a key. We saw posters in the medicines room, reminding staff of their cleaning and maintenance responsibilities for the room. Staff recorded the highest and lowest temperature of the fridge every day to make sure medicines were stored appropriately.

We saw that everyone who lived at the home had their own record of the medicines they had been prescribed, which included their photo and instructions to staff for the times of day and amount of medicines each person should be given. In the records we checked we saw that staff signed to say 'medicines administered' at the prescribed times. The clinical lead staff that we spoke with showed us the codes staff used to explain if a medicine was not administered, for example, if a person declined to take them. This meant there were appropriate arrangements in place in relation to recording of medicine.

We asked staff how they would know if a person needed pain relief medicines if they were not able to communicate verbally. Staff told us they would offer the person pain relief if they noticed changes in the person's behaviour, or the expression on their face. The clinical lead staff said, "I know just by the way X is sitting in her chair, and I ask if she has any pain and how much pain relief she wants. I use my professional judgment." A member of care staff we spoke with told us, "We know when a person is poorly because we see how they change, perhaps they are not chatty, when they usually are. It usually means they are feeling poorly."

We saw that staff checked at the beginning and end of every shift, to make sure that the amount of medicines still in the trolley matched the records of medicines received and administered. We saw that two staff signed the controlled drugs records to ensure that the check and record was validated.

A visiting health professional told us they were confident that staff knew people very well, and nursing staff were able to carry out appropriate tests at home, which enabled them to diagnose the person's condition over the phone, and prescribe appropriate medicines. They told us that if they had any doubts, they could visit the person to confirm their diagnosis. This meant that medicines were prescribed and given to people appropriately.

Requirements relating to workers ✓ Met this standard

People should be cared for by staff who are properly qualified and able to do their job

Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

Reasons for our judgement

Relatives we spoke with told us they thought the staff supported their relations' needs very well. One relative said, "It is not easy and they bend over backwards for her." People who lived at the home told us the staff were kind and thoughtful. One person said, "The staff here are very nice."

We saw that the manager checked that staff were suitable to work with vulnerable people before they started working at the home. We saw that the manager checked staff's understanding of relevant issues, such as, abuse, how to raise concerns and how to care for people with challenging behaviour, so they could identify staff's training needs. This meant that appropriate checks were undertaken before staff began work.

In the three staff files we looked as, we saw records of staff's induction at the home, which included a health questionnaire, a staff handbook and being assessed in practice, before being signed off as competent to work. A care staff team leader we spoke with told us when they had applied for the role they had been interviewed and observed in practice before a decision was made to promote them. This meant there were effective recruitment and selection processes in place.

The team leader told us their responsibilities included making sure that care staff followed the agreed practices and procedures while carrying out their duties. They told us, "I demonstrate how to use equipment and check how staff use it. I tell them straight away if they are not following correct practice." The team leader was clear about the different responsibilities of care staff and nurses. They said, "Generally, care staff look after people's personal care and rooms and nurses do medicines and wound care."

The clinical lead staff we spoke with told us that nurses were involved in people's personal care if they were nursed in bed, because, "They will have first sight of any clinical issues. It is about prevention, not just cure."

Staff we spoke with told us they had regular one to one sessions with the manager and this was an opportunity to talk about timekeeping, their practice, communication, people's needs and team working. The care team leader said, "It is the best chance to express myself, an opportunity to say things, it's kept confidential, it's working." We saw that notes of one to one supervision sessions were kept on staff's files, which meant that agreed actions could be followed up.

Records ✓ Met this standard

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was meeting this standard.

People were protected from the risks of unsafe or inappropriate care and treatment.

Reasons for our judgement

We looked at four care plans and found they were well ordered and easy to understand. We could trace the history of people's relationship with the service from their date of admission to the present day. Care staff we spoke with knew the details recorded in people's care plans and understood how people preferred to be cared for and treated. We found that people's medical histories and current medical needs were described and changes in people's medications were recorded in their care plans. This meant that people's personal records, including medical records, were accurate and fit for purpose.

People's care plans were kept in a lockable cabinet in the staff office, where only staff could access them. Contact sheets and daily reports for each person who lived at the home were kept in folders in the staff office. This meant staff could find the information they needed quickly and could update the daily reports easily.

We looked at three staff files and found they contained a full history of the staff's employment with the service, including the results of checks the manager made, staff's training certificates and records of their ongoing supervision and support. Staff files were kept in a lockable cabinet in the manager's office, so that only the manager could access them. This meant the records were kept securely and could be located promptly when needed.

We saw records of the monthly checks that the clinical lead staff made on staff who administered medicines. For example, they checked that staff understood the medicines policy, that staff had medicines training and understood adverse drug reactions and they observed staff in practice, to make sure they were competent.

We saw records of other monthly checks that were made on equipment, like mattresses, slings and mobility equipment. We saw that staff noted any faults and signs of wear and arranged for equipment to be repaired or replaced.

The manager kept a separate record of all staff's training so they could make sure that staff attended refresher training when they needed to. The manager recorded accidents and incidents and analysed the possible causes, so they were able to take action to reduce the risk of incidents re-occurring. This meant the staff records and other records relevant to the management of the services were accurate and fit for purpose.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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