Clarence House (Ferndown) Limited

Clarence House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out on 4 May 2017 and was unannounced. The inspection continued on the 5 May 2017 on an announced basis.

Clarence House is registered to provide accommodation for up to 29 people who require personal care. At the time of our inspection there were 23 older people living at the service some of which were living with a dementia. The home provides single room accommodation over two floors with the facilities to provide shared accommodation when required. Rooms have en-suite facilities and there is also a specialist bathroom on each floor.

The service had 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.

People were not consistently protected from the risk of harm in relation to dehydration, malnutrition or skin damage. Actions and processes had been put in place to minimise these risks but these were not being consistently followed. People were not being protected from the risk of deteriorating skin or health conditions that were treated with topical creams and other medicines as these were not being managed as prescribed. Although there were auditing systems to ensure risks were safely managed they were not operating effectively.

Reportable incidents such as skin damage had not always been shared with other external agencies. This meant that processes designed to provide oversight and additional safeguards for people were not always being followed.

People using the service told us they felt safe and that their right to make choices about the risks they lived with were respected.

People were supported by enough staff that had been recruited safely as checks had been made to ensure they were safe to work with vulnerable adults. Induction, on-going training and supervision provided staff with the skills to carry out their roles.

The service was working within the principles of the Mental Capacity Act. This meant that people were supported to make decisions and when they had been assessed as not being able to decisions were made in their best interest with the involvement of family and other professionals.

People were supported to eat and drink when required. They were offered nutritious meals with snacks and light meals always available. People had choices of what to eat and where to take meals. When it was assessed that people required specialist equipment this was provided to support people to eat and drink

independently.

People and their families described the staff as caring and kind. Staff had a good knowledge of people and the ways they were able to communicate which meant they were able to support people appropriately to make choices and decisions about their day to day lives.

Care and support plans provided clear information to care workers about how people needed to be supported. People felt involved in their care and supported by staff who understood their care needs. Activities were available both in the home and the community and were often linked to people's interests. A complaints process was in place which people and their families were familiar with and felt able to use if needed.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not consistently protected from the risk of harm in relation to dehydration, malnutrition or skin damage.

People were not being protected from the risk of deteriorating skin or health conditions that were treated with topical creams and other medicines as these were not being consistently administered as prescribed.

Reportable incidents had not been shared with external agencies that provide oversight and additional safeguards for people.

People were supported by staff who understood how to recognise signs of abuse and the actions they would need to take if they suspected people were at risk.

People were supported by enough staff that had been recruited safely including checks to ensure they are safe to work with vulnerable adults.

Is the service effective?

Good

The service was effective.

Staff received an induction and on-going training that provided them with the skills to carry out their roles effectively.

People were supported to make decisions in line with the principles of the Mental Capacity Act.

People were supported by staff that understood their eating and drinking requirements, including likes, dislikes and allergies.

People had access to health care when it was required.

Is the service caring?

Good

The service was caring.

People had positive relationships with staff and described them

as kind and caring.

People and their families felt involved in decisions about their care and advocacy services were available for people when needed.

People had their dignity, privacy and independence respected.

Is the service responsive?

Good

The service was responsive.

People had individual care and support plans that were regularly reviewed.

Activities were tailored to people's interests and hobbies and included maintaining links with the local community.

A complaints process was in place which people were aware of and felt able to use.

Is the service well-led?

Requires Improvement

The service was not always well led.

Audits had not been effective in identifying shortfalls in systems and processes which were failing to protect people from risk.

Senior staff did not always understand their responsibilities for reporting incidents which meant that they were not shared with external agencies such as safeguarding and CQC.

Staff felt positive about the service, the teamwork and felt appreciated. This empowered them to share ideas and suggestions with the management team.

Quality assurance systems were in place to gather feedback from people, families and staff and the information was used to improve outcomes for people.

Clarence House

Detailed findings

Background to this inspection

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

The inspection took place on the 4 May 2017 and was unannounced. It continued on the 5 May 2017 and was announced. The inspection was carried out by one inspector.

Before the inspection we looked at notifications we had received about the service and we spoke with social care commissioners to get information on their experience of the service. We had received a Provider Information Return (PIR) in October 2016 and gathered an update on the information during the inspection. 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 our inspection we spoke with five people who used the service and three relatives. We spoke with a director, registered manager, activities co-ordinator, three care workers the chef and a kitchen assistant. We also spoke to a community nurse who had experience of the service. We reviewed five people's care files and discussed with them and care workers their accuracy. We checked three staff files, care records and medication records, management audits, staff and resident meeting records and the complaints log. We walked around the building observing the safety and suitability of the environment and observing staff practice.

Requires Improvement

Is the service safe?

Our findings

People were not consistently protected from the risk of harm. Assessments had been carried out to determine the risks people lived with but plans in place to minimise those risks had not been consistently followed.

One person had been assessed by a Speech And Language Therapist (SALT) as being at risk of choking. They had a diet and fluid plan in their room folder that had been produced by the therapist. It stated that drinks needed to be given in an open cup. The person had been given their drink in a lidded beaker. Another person assessed as at risk of choking had a diet and fluid plan which stated 'Avoid Straws'. The person had been given their drinks in a beaker with a straw and had a box of straws in their room. This meant that people were being placed at risk of harm of choking.
We discussed our findings with the registered manager who told us they would immediately review and discuss with the care team.

SALT plans also included information about the consistency of drinks and food and how a person needed to be positioned to minimise the risk of choking. Staff were able to tell us the consistency of food and drinks people required and we observed them supporting people who were positioned correctly at mealtimes.

People who had been assessed as at risk of dehydration or malnutrition had food and fluid charts in place so that a person's intake could be monitored. We found these had been completed each day but had not been reviewed regularly and that processes in place to manage changed risks were not being followed. Charts used to record how much a person had drunk did not include details of the minimum amount of fluid needed to support hydration. We looked at one person's charts for the previous five days and the maximum intake had been 600ml and the lowest 300mls. When we checked the daily notes it had been recorded 'good intake' although the person's charts had recorded a poor intake. This meant that people were at risk of harm as records did not provide accurate or consistent information to enable safe monitoring of peoples risk.

We looked at food charts with the registered manager for the month of April 2017 for five people who were being cared for in their beds and required a soft textured diet. Morning and mid-afternoon snacks had not been consistently offered. We discussed this with the head cook who agreed suitable snacks had not routinely been made available other than yogurts. They told us they would review this immediately with the registered manager. On the second day of our inspection the registered manager showed us a revised food and fluid chart they would introduce. The fluid chart included a minimum fluid intake figure and a section had been put on the food charts to reflect mid-morning and afternoon snacks.

People had their weight measured at least monthly. The recordings for two people in April 2017 showed a significant weight loss. One person had a loss recorded of 6kg and another person a loss of 4kg. The review had not included information recorded from the food and fluid charts or considered what may have led to the weight loss. The review action stated 'monitor and encourage'. We discussed this with the registered manager who organised for the people to have their weights re taken as they felt the recordings were not

correct. When re-weighed the new weights indicated there had not been the previous recorded weight losses. They explained that some people found using the chair scale uncomfortable and they would look at investing in a scale that could be used in conjunction with the hoist to ensure more reliable weight monitoring.

Information detailing peoples assessed risk of malnutrition was not available to the kitchen staff. This meant that they did not know people's individual level of risk. People assessed as being at high risk required a fortified diet in order to add additional calories to their meals. We received conflicting information from kitchen staff. On the first day of our inspection a cook told us "We have no fortified diets. People have supplement drinks but the care staff deal with them". On the second day of our inspection we spoke with the head cook who told us "We add cream to everybody's meal". This meant that the kitchen staff did not always know people's individual risks or consistently take the actions needed to reduce the risk. The kitchen had information about people's likes and dislikes, food textures needed and any related chronic health conditions such as diabetes.

Assessments had been carried out to determine people's risk of skin damage. Actions to reduce risk of skin damage had included using air flow mattresses. These needed to be set to match the person's weight to maximise their effectiveness. We checked air mattress settings of five people who were in bed and they had not been set correctly. One person was set at 80kg who weighed 38kg. Another person's had been set at 60kg and they weighed 41.3kg. We spoke with a care worker who told us "The mattresses on beds are set by a senior. If the bed doesn't look right or is soft we go to a senior and they sort it out". We spoke with the registered manager who told us the process was that air mattresses were checked weekly but agreed this had not been happening. This meant that people were at risk of harm as actions and processes put in place to minimise risks of skin damage were not being followed. Other measures in place to reduce risk of skin damage included supporting people to change position regularly. Records confirmed this was consistently happening and we observed staff carrying this out as described in peoples care plans. On the second day of our inspection the registered manager had revised the repositioning chart form. Additional information had been added to the form to record the mattress setting had been checked each time a person's position was changed. The form had information added about the person's weight and the corresponding air mattress setting required.

People were at risk of not having their topical creams administered safely. The creams that were stored in people's rooms and applied by care workers had no supporting records to demonstrate this was happening in line with people's prescriptions. There were no body charts or instructions indicating where a cream needed to be applied. Medicine Administration Records (MAR) had not been completed. One person had a nebuliser prescribed for as and when they required it to help manage a breathing problem. Another person had ear drops prescribed to help manage an ear problem. These medicines had not been entered on to the MAR. This meant that people were not being protected from the risk of deteriorating health conditions due to prescribed creams and medicines not being managed and administered appropriately.

Risks identified for people in relation to skin damage and malnutrition had not been consistently managed or actions taken in order to minimise the risks. People were at risk as medicine administration was not always carried out in a safe way. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We read three separate records of incidents were people potentially had been placed at risk. We read an accident form that had recorded the person had had told a carer bruising on their arm had been caused by staff'. We checked records with the registered manager and found a body map had been completed marking

the position of the bruising. No record of the incident had been recorded in the person's daily notes and the unexplained bruise had not been investigated or reported to external agencies as a safeguarding concern. We saw two separate records of a person having a pressure ulcer assessed by a tissue viability nurse. Although actions had been put in place to minimise further risk these incidents had not been shared with the local authority safeguarding team. The safeguarding team have the responsibility of determining how a concern should be investigated and whether by the agency or an external organisation such as a social worker or health professional. This meant that people were at risk as systems and processes were not being followed that were in place to protect them. We discussed our findings with the registered manager who contacted and shared the information with the local authority safeguarding team.

Systems and processes were not being operated effectively to prevent abuse of people. This is a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had received safeguarding training which had included recognising signs of abuse and where aware of external agencies they could report concerns to if abuse was suspected. People and their families told us they felt the care was safe. One relative told us "I have no sleepless nights about (relative) being safeguarded". We spoke with a person who told us "I feel safe in my room, I'm comfortable and I like all the people who come to help me. They are all so kind". People had personal evacuation plans which meant staff had an overview of what support each person would require if they needed to leave the building in an emergency.

People were supported by enough staff that had been recruited safely. Relevant checks were undertaken before people started work. For example references were obtained and checks were made with the Disclosure and Baring Service to ensure that staff were safe to work with vulnerable adults. We spoke with a Director who told us that staffing levels were reviewed each month with the registered manager. In response to an increased level of support needed in the evening an extra member of staff had been recruited to work the twilight shift. This meant that staffing levels were reviewed and altered to meet identified changing needs of people using the service. We were told this would enable additional staff time to support with evening drinks and snacks. Processes were in place to manage unsafe practice and we saw evidence these had been followed when appropriate.

Good

Is the service effective?

Our findings

People were supported by staff that had completed an induction and on-going training that enabled them to have the skills needed to carry out their roles effectively. Induction included some staff completing the Care Certificate. The Care Certificate is a national induction for people working in health and social care who do not already have relevant training. People and their families told us the staff were well trained. One person said, "The staff are always having training sessions for one thing or another here". Staff had undertaken dementia training and were able to share with us how this had impacted their practice. One care worker told us "It helped me understand the problems people face getting through their day to day lives. It has given me a better understanding of a person's body language. You can tell a lot by looking at a person's eyes". Another told us "I've had some dementia training. It's made me more aware of how we communicate with people when we're trying to understand their needs".

Staff told us they felt supported in their roles and had monthly individual supervision sessions with the registered manager. Opportunities were available for professional development. One care worker told us "You get lots of training opportunities. I've just finished my level 2 Diploma in Health and Social Care. It's really made me more confident". The registered manager had just completed an advanced dementia course. They told us "It was fantastic and has really given me so many ideas particularly about how we can make changes to the environment to make it more dementia friendly with the use of colours".

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.

Deprivation of Liberty Safeguards had been applied for where a person who needed to live in the home to be cared for safely did not have the mental capacity to consent to this. People who were able to consent to their care had done so and told us they directed the care they received. Staffs knowledge of people meant they were able to ensure people who had variable capacity were supported to be involved in decisions about their care. One relative told us "They know (relatives) mood swings and if there is an issue they know how to work with it. If (relative) is in a bad mood they walk away and come back 10 minutes later. They are assessing (relative) all the time".

The principles of the Mental Capacity Act 2005 (MCA) had been followed in relation to people who were not able to consent to decisions about their care. Staff provided care in people's best interests when they had

been assessed as unable to consent. Best interest decisions had included input from people's families, GP's and other health and social care professionals. Decisions included the use of bed rails, administering medicines and providing personal care. Some people were cared for the majority of time in their bed. Decisions had been recorded but not fully in line with MCA guidelines. However care records demonstrated that decisions had included families and other professionals, had been regularly reviewed and had considered the least restrictive actions. An example included a person who had declining mobility and found being moved and transferred uncomfortable. Through discussions with family and an occupational therapist they had initially been supported in a wheelchair, as this became more difficult the decision was reviewed and a specialist chair provided. When this had no longer been suitable the decision had been reviewed again and it had been decided it would be in the person's best interest to be supported in bed. We discussed this with the registered manager who agreed the decisions needed to be recorded in line with the MCA and told us they would complete this immediately.

Information about people's food and drink likes and dislikes were understood by both the catering and care staff. People and their families spoke positively about the food. One person said "The food is very nice; we always get two hot choices". People living with dementia or people who had a visual impairment had modified crockery to support them remain independent at meal times. Lunchtime was a calm and social event for those that wanted to eat together. When people needed support with eating or drinking staff provided it discreetly and gave people time whilst promoting independence and dignity.

Records and feedback from healthcare professionals reflected that staff responded appropriately to both on going healthcare needs and health emergencies.

Good

Is the service caring?

Our findings

People and their families all spoke positively about the staff team and described them as caring. One person told us "They (staff) are kind all the time". Another told us "Everybody is really nice – I feel it's important to tell you that". We spoke with a relative who said "The staff are really nice. Nothing is too much trouble, they're always happy to help you out". Another said "The staff are lovely, nothing is too much trouble. They often have a joke with (name), and (they) really like that". We spoke with a community nurse who told us "People seem happy here and if I had to put my parents into a home this is the one. I think people are safe, the surroundings are homely and they seem happy".

Staff had a good understanding of people's interests, likes and dislikes. This meant that staff could have conversations with people about things that were important and of interest to them. We observed staff interacting with people and their families in a friendly but professional way. People shared laughter and fun with staff and received their support in a personalised and individual way. A relative explained "The staff are lovely. They (staff) deal with everybody really well. Everybody has their different needs and you can see the staff dealing with them all".

Staff used appropriate non-verbal communication to demonstrate listening and to check people understood them. For example, talking with people at eye level and using hand gestures and facial expressions. One care worker explained "Some people can't communicate verbally. You have to be really patient and work out what their telling you. Perhaps when you're helping somebody with their eating and they stop opening their mouth it's a sign they've had enough. Or if somebody is in pain perhaps if you touch their feet they might wince". One person explained how they had poor sight and how staff understood how to support them. They told us, "Staff helped me with a bath. (Name) was marvellous; told me what she was going to do before she helped me. She was very good".

We observed staff involving people in decisions about their day to day activities. A care worker explained, "We offer people choices. There is one person I sit with her, I talk slower, clearer, short sentences, make it simple. I encourage (name) to choose what they wear, what they would like for lunch, decisions about their environment and activities. All the everyday needs that we have choices about". Another care worker explained, "When (name) first came they were in bed all the time. We encouraged (name) to get up and agreed the times. They like to go back to bed about three". People who needed an independent representative to speak on their behalf had access to an advocacy service.

People told us that staff respected their privacy and dignity. We observed people being supported at their pace, discreetly and with patience. People had their personal space respected. Staff were observed knocking on doors and waiting to be invited in to people's rooms. People's clothes and personal space were clean and reflected a person's individuality. Dementia friendly signage was available around the building for toilets and bathrooms which enabled people more opportunity to be independent when in public areas of the home.

Good

Is the service responsive?

Our findings

Assessments had been completed before a person moved into the service and this information had been used to form their care and support plan. The plans contained clear information about people's assessed needs and the actions staff needed to take to support people. Staff had time to read people's care and support plans and were able to tell us about the ways they supported people. Care plans were reviewed monthly or more frequently if required. One example had been a care and support plan being reviewed following a person having a fall and extra measures being introduced to keep the person safe. We spoke with a community nurse who said "They (staff) do take on board our advice. When we suggest things they are on the ball. There almost ahead of us, they seem to know what they are doing". The staff kept daily records which included some references to personal care people had received; how they had spent their time and physical health indicators and reflected peoples care and support plans.

Throughout our inspection we observed people engaged in activities of their choice. Some people chose to spend their time in the main communal area. Activities observed included a group chat about items in the daily newspaper. The conversations initiated by staff demonstrated a good understanding of people's life histories and backgrounds. They provided an opportunity for people to reminisce and share stories. We observed people enjoying a chair exercise session which included lots of friendly banter and laughter. One relative told us "(Name) loves the activities and there is enough going on. (Staff name) organises things brilliantly, they get people motivated". Another person had a box of photographs and a care worker was helping sort them out. The person told us "We've been around the world in photographs".

We visited people who preferred to spend most of their time in their own room. One lady had lots of audio books they enjoyed, another told us how they preferred their own company and enjoyed word games and the TV. Some people were cared for in bed and had limited mental and physical abilities. We discussed with a care worker how their need for interaction was met. They told us "One person enjoys holding different objects and it brings on smiles. We made Easter bonnets and some people enjoy watching and holding textures. (Name) has lots of visitors and loves Max the dog that visits". We saw records in their rooms which recorded daily interactions the person had experienced and included both practical interventions and pop in checks and chats.

People were supported to maintain links with family, friends and the local community. We observed staff supporting a person make a telephone call to a friend. Special occasions such as birthdays and wedding anniversaries were celebrated. Weekly trips took place to local places of interest, garden centres and coffee shops. A care worker told us "Gardening seems a great way of involving people and most have had gardens of their own. We go to garden centres or shopping; it's a link with normality". Other links included visits from people's churches and local schools. The local community were invited to fund raising events. A care worker told us "The residents get involved folding raffle tickets, sorting out prizes etc.".

A complaints process was in place that people and their families were aware of and felt able to use if necessary. One relative told us "(Registered manager) is lovely and always willing to listen. Will sit and listen and will get things done". One person explained "If I had a complaint I just tell the staff. (Name) sits with me

and always asks how I am and is there anything we can do to put it right."

Requires Improvement

Is the service well-led?

Our findings

Auditing systems were in place and had been monitored by the registered manager but they had not always recognised areas that needed improvement to ensure the best outcomes for people. This included areas of risk in relation to people's weight, skin care and medicine administration as identified at this inspection. Audit tools showed a checklist of content but had not been expanded in order that areas for improvement could be identified. This meant that the management oversight to ensure competencies and practice were safe had not been effective.

Systems and processes were not effectively monitoring and reducing risks to people related to their health and welfare. This is a breach of Regulation 17of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Statutory notifications had not always been made to CQC in relation to potential safeguarding incidents. A statutory notification is a legal requirement for the provider to inform CQC of certain situations as part of their oversight of care provision. This meant that CQC had not received information to support their monitoring of the service.

We observed a positive and inclusive culture. Interactions between the registered manager and staff team were relaxed and professional. Staff spoke positively about both the organisation and the home. One care worker said "I love working here; it's an amazing team. We are like one big family. If somebody is struggling we help each other". Staff told us they felt empowered to raise concerns and share ideas about the service. A care worker explained "If I had a concern and something could be done I would happily approach the manager or a senior carer". Another told us "Communication between the management and staff is really good. I feel I can talk to (registered manager); I know it wouldn't get repeated. If I have any worries I can address it as I know it will be dealt with". Staff were able to explain their roles and responsibilities and demonstrated a good understanding of their boundaries of decision making.

Staff told us they felt appreciated and that their achievements had been recognised. One care worker told us "(Registered manager) is fantastic, I really feel appreciated; sends thank you texts". Staff achievements had been recognised by the organisation. A 'perks box' scheme was in place and included coffee shop vouchers and cinema tickets for staff as an additional reward. The scheme included an accreditation for when extra efforts by staff had been recognised. The registered manager explained "The kitchen achieved a 5* rating (environmental health rating) and we presented them with a bottle of champagne".

Quality assurance processes were in place that enabled people, their families and staff to provide feedback about the service. We looked at the outcomes of surveys and the overall feedback was positive. Evaluations of responses had been shared with the staff team and used to improve outcomes for people. Examples had included changes to the menu and the activities programme.

We spoke with a Director who explained that they carried out a director's inspection bi-monthly. This included three issues, people using the service, room vacancies and staffing issues. They also had an on-

going programme of home maintenance which included a fire safety inspection and an upgrade of the electrical installation.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks identified for people in relation to skin damage and malnutrition had not been consistently managed or actions taken in order to minimise the risks. People were at risk as medicine administration was not always carried out in a safe way.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems and processes were not being operated effectively to prevent abuse of people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not effectively monitoring and reducing risks to people related to their health and welfare.