Clarence House (Ferndown) Limited

Clarence House

Inspection report

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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

The inspection took place on the 11 June 2018 and was unannounced. The inspection continued on the 12 June 2018 and was announced.

At our previous inspection in May 2017 we found breaches in regulation of safe care and treatment and good governance. People had not been protected from the risk of avoidable harm and medicines had not been administered safely. We also found that systems and processes to safeguard people were not being followed. Also systems and processes had not been effective in monitoring and reducing risks to people related to their health and welfare. We asked the provider to take action to make improvements and this action has been completed.

Following the last inspection we asked the provider to complete an action plan to show us what they would do and by when to improve the key questions, is the service safe and is the service well led, to at least good.

Clarence House is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. The home is registered to provide care for up to 29 people. At the time of our inspection 23 older people, some of whom were living with a dementia, were residing at the service.

The home had a registered manager. 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.

Assessments had been completed that identified risks to people such as malnutrition, dehydration, skin damage and falls. Actions in place to manage risk to prevent avoidable harm were understood by the staff team and being followed. Risks were reviewed at least monthly and included input from people and their families. When risks were being managed people's freedom and choices had been respected.

People had their medicines ordered, stored, administered and recorded appropriately. When people had medicines prescribed for 'as and when required', protocols were in place with detailed information to enable medicines to be administered appropriately. A new process for topical creams had been introduced which included a body map and clear instructions for care staff as to where creams needed to be applied and how often. Staff had completed records to demonstrate this had taken place in accordance with people's prescriptions.

Staff had completed safeguarding training and understood their role in identifying and reporting concerns.

Accidents and incidents were reviewed by the registered manager who understood their role in reporting safeguarding concerns to external agencies when appropriate.

Auditing processes had been strengthened and included the registered manager evaluating risks to people weekly. Auditing tools had been reviewed and were effective in highlighting areas where improvements were needed. When actions were identified they took place in a timely way.

People were supported by staff who had undertaken a recruitment process that included checks on their suitability to work with vulnerable people. Staffing levels were regularly reviewed and met people's care needs. Staff had inductions, on-going training and support that enabled them to carry out their roles effectively.

Prior to admission, assessments had been completed with people to gather information about their care needs and choices. The information had been used to develop person centred care plans that reflected people's individuality and included end of life wishes. Staff had a good knowledge of people and their communication needs and provided care with kindness, patience and empathy. People had their privacy, dignity and independence respected.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. A complaints process was in place and people felt if they raised concerns they would be listened to and actions taken.

People had access to healthcare when needed and working relationships with health and social care professionals enabled effective sharing of information and care and support outcomes for people.

The management of the home was visible and provided proactive leadership promoting an open and transparent culture. Staff described great teamwork and spoke enthusiastically about their roles.

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 had their risks understood and actions in place minimised the risk of avoidable harm.

Accidents and incidents were reported and reviewed appropriately and when things went wrong appropriate actions and reporting to external agencies had been taken.

Staff were recruited safely and staffing levels were regularly reviewed to meet the changing needs of people.

Medicines were ordered, stored, administered and recorded safely.

People had been protected from avoidable infection.

Is the service effective?

Good

The service was effective.

People had their needs and choices assessed which included any specialist equipment requirements prior to admission.

Staff had an induction and ongoing training and support to enable them to carry out their roles effectively.

People had their eating and drinking needs understood and met.

People had access to healthcare for both planned and emergency care and working relationships with professionals enabled effective care across services.

The building and environment met the needs of people and promoted independence.

People had their choices and freedoms respected in the least restrictive way in line with the principles of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring.

People received kind, caring, compassionate care.

People were involved in decisions about their care and day to day lives'.

People had their privacy, dignity and independence respected.

Is the service responsive?

Good

The service was responsive.

People had their care planned around their needs and choices and care plans reflected a person's individuality.

A complaints process was in place and people and their families felt listened to when they raised concerns.

People had an opportunity to plan for their end of life and had their wishes respected.

Is the service well-led?

Good

The service was well led.

Auditing systems and processes had been reviewed and were effective in identifying and driving improvements in service delivery.

Leadership was visible and promoted an open, positive culture where people and staff felt involved and engaged in service development.

Staff understood their responsibilities, worked as a team and felt appreciated in their roles.

Information was effectively shared with other agencies which enabled seamless care.

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 checked 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 was carried out by one inspector and began on the 11 June 2018 and was unannounced. The inspection continued on the 12 June 2018 and was announced.

Before the inspection we looked at notifications we had received about the service. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We also spoke with local commissioners to gather their experiences of the service.

The provider had completed a Provider Information Return prior to our inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During our inspection we spoke with three people who used the service and four relatives. We spoke with the registered manager, four care staff, the activities co-ordinator and cook. We reviewed seven peoples 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.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

After our inspection we requested additional information in relation to the Mental Capacity Act 2005 which we reviewed alongside information collected at inspection. The registered manager provided this.

Good

Is the service safe?

Our findings

When we last inspected the service in May 2017 we found breaches in regulation in relation to safe care and treatment and protecting people from the risks of abuse. People had not been protected from the risk of avoidable harm and medicines had not been administered safely. We also found that systems and processes to safeguard people were not being followed. We asked the provider to take action to make improvements and this action has been completed.

People and their families spoke positively about the care and felt safe. One person told us "I feel safe; when the staff help me I feel I'm amongst friends". A relative said "(I) feel (relative) is absolutely safe and they do everything you would want them to do". All staff had completed safeguarding training and understood their role in reporting any concerns including reporting poor practice. The registered manager understood their responsibility to ensure concerns were raised appropriately with external agencies such as the local authority and CQC. People were protected from discrimination as staff had completed training in equality and diversity and recognised and respected people's individuality.

Assessments had been completed that identified risks people experienced. Staff understood the actions needed to minimise the risk of avoidable harm and were vigilant at reporting changes to senior staff. Risks were reviewed at least monthly and people and their families had been involved in decisions about how risks were managed.

Some people were at risk of skin damage. Where people had specialist air mattresses, a system had been introduced that checked that the mattress was set correctly according to the person's weight We found all the air mattresses had been set correctly. Some people had turning charts in place which recorded when staff had helped a person change position. These had been completed in line with people's care plans.

Some people had swallowing difficulties and speech and language therapists had carried out assessments and produced safe swallowing plans. These had been made available to both catering and care staff. We observed people being supported in line with their individual swallowing plans. When people were at risk of malnutrition they had been prescribed supplement drinks and their food had been fortified with extra calories. The cook explained how they provided additional calories throughout the day for people at risk of malnutrition. "For people who need pureed food we have vanilla yogurts and fruit mousses with no bits and milkshakes and I make a smoothie daily with cream, fruit and complan". Food and fluid intake charts had been redesigned and included mid-morning and afternoon snacks and records showed us they were being provided to people.

Where people had been assessed as at risk of falls, actions taken had included using alert alarm mats, referrals to a falls management clinic and involving physiotherapists. One family explained how they had been involved in decisions about risk "On one occasion after (relative) had a fall we discussed taking (relative) off medicine prescribed for anxiety. It was stopped to see if it would help reducing falls but (relative) went back to being anxious which potentially increased the risk so we decided it needed reinstating".

Records showed us that equipment was serviced regularly including the lift, boiler, fire equipment, and hoists. 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 had their medicines ordered, stored, administered and recorded safely. Some people had been prescribed controlled drugs which are medicines that require additional storage and administration safeguards. These were being stored and administered in line with legislation. When medicines had been prescribed for 'as and when required' (PRN) protocols were in place. These provided details of what the PRN medicine had been prescribed for and how it should be administered. One person self-administered two medicines prescribed PRN. Staff explained the person had taken responsibility for the medicines for many years and had wanted to maintain their independence. Although staff were able to tell us how they ensured medicines were administered safely by the person a risk assessment had not been completed. We discussed this with the registered manager and on the second day of our inspection a risk assessment had been completed and a check added to the monthly medicine audit.

Where topical creams had been prescribed for peoples skin conditions a body map showed staff were it needed to be applied and detailed how often. We checked medicine administration records and people had received their creams as prescribed. One person needed medicine administering several times a day and told us "Staff keep to my medicine times much more than I would".

Staff had been recruited safely including checks with the disclosure and barring service to ensure they were suitable to work with vulnerable adults. People told us there were enough staff to meet their needs. One person said "When a use my call bell they come straight away". A member of staff told us "There is normally enough staff and things run smoothly". Staffing levels were regularly reviewed to reflect the needs of people. The registered manager told us "We introduced a twilight shift as we found people's needs required more staff in the lounge area. It now means people are supervised whilst others are being helped to bed".

People were protected from avoidable risks from infection as staff had completed infection control and food hygiene training. We observed staff wearing gloves and aprons appropriately and hand cleansing facilities were available around the building. All areas of the home were clean and odour free.

Lessons had been learnt when things went wrong. Incidents, accidents and safeguardings were seen as a way to improve practice and action had been taken in a timely way when improvements had been identified.

Good

Is the service effective?

Our findings

People and their families had been involved in a pre-admission assessment which had been used to gather information about their care needs and lifestyle choices. The assessment gathered information about a person's medical history and how they needed to be supported whilst reflecting their level of independence. The information had been used to create person centred care plans which had been developed in line with current legislative standards and good practice guidance. Where assessments had included equipment such as a pressure relieving mattress' these had been in place prior to admission ensuring effective care. A member of staff told us "We have time to read care plans and get to know people's choices; what they like".

Staff had completed an induction and on-going training that enabled them to carry out their roles effectively. Inductions included, for, for staff new to care the Care Certificate. The care certificate sets out common induction standards for social care staff. It has been introduced to help new care workers develop and demonstrate key skills, knowledge, values and behaviours which should enable them to provide people with safe, effective, compassionate and high quality care.

We spoke with a care worker who explained about a Stress Management course they had completed. "It opened my eyes at what causes stress to people. Not getting enough sleep or enough drinks. It has really helped me in my job and personal life". Another told us about a dementia course they had completed. "It has helped me recognise symptoms; it helps you understand a person's body language. Some residents can't explain but their body language helps let you know what they need".

Staff received regular supervision and told us they felt supported in their roles. Opportunities for professional development had included staff undertaking national diplomas in health and social care.

People had their eating and drinking needs understood by both catering and care staff. We observed people being offered choices at mealtimes. One person told us "Food not bad at all. Plenty of choice. Anything I want they would get for me". Another told us "You can have whatever you like for breakfast from full English to a slice of toast". Information about people likes, dislikes and any special dietary requirements had been shared with the catering staff including any cultural requirements. We saw that people had access to drinks throughout the day, both in the lounge and their own rooms. Modified crockery had been provided such as plate guards and beakers with two handles to support people's independence. When people needed the assistance of staff with eating and drinking this was carried out sensitively, at the persons own pace, ensuring their dignity.

The service worked with other organisations to ensure people had effective care. This included community district nurses when people needed support with diabetes or wounds, community mental health teams when people needed support with their dementia and palliative care nurses when people were receiving care at the end of their life. Each person had a 'grab sheet' which provided essential care information which would accompany them if they needed to move to another service such as a hospital admission.

People had been supported to access healthcare both in planned and emergency situations. A relative told

us "If (relative) needs a GP (name) has a GP". Records showed us people had access to a range of health professionals including chiropodists, opticians and audiologists.

The design of the building enabled people to have independent access around the home and gardens. Signage directing people to various areas of the home, including the lounge, toilets and bathrooms, enabled people with sensory problems to orientate themselves more independently around the building. A communal lounge and dining room provided an area for people to socialise and meet others. People were able to have private time in their rooms or seating in the foyer. People had been involved in decisions about their environment including the introduction of a small bar and new garden furniture.

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.

We found that the service was working within the principles of the MCA. Mental capacity assessments had been completed for people and DoLs applications had been submitted to the local authority. When people had been assessed as not having capacity, decisions had been made in the persons best interest and included families and health professionals. Records were not specific to one decision but combined a number of aspects of a person's care needs. This was not in line with best practice guidance. The registered manager told us that they would review any best interest decisions in line with the MCA guidance. Following our inspection we received four best interest decisions completed correctly.

We observed staff seeking consent from people and offering choices before providing any interventions. We observed a staff member saying to people "Any preference on music; calm and quiet or loud and rowdy". When people declined we saw this was respected. Care records showed consent had been obtained appropriately for photographs, use of bed rails and administration of medicines. Files contained copies of power of attorney legal arrangements for people and staff understood the scope of decisions they could make on a persons' behalf. This meant people were having their rights upheld.

Good

Is the service caring?

Our findings

People and their families spoke positively about the caring nature of the staff team. One person told us "They (staff) are good fun. We have a good giggle". Another told us "If I mention something they do something about it; nothing is too much trouble". A relative told us "The care is fabulous. They care so much. There's a real family feel. We have noticed things like the summer fete; even staff off duty come in to be part of it".

We observed a relaxed but professional relationship between people and the staff team. We observed staff showing kindness, patience and understanding when helping people. One lady was dozing in an armchair at lunchtime. We observed a member of staff gently rubbing the persons arm and quietly saying "Hello sleepy head". They patiently encouraged the person to eat a little bit of their lunch explaining the time of day, that it was lunchtime. Throughout the interaction the member of staff stroked the person's hand, using calming, gentle body language to help the person understand, feel safe and orientate themselves.

Staff demonstrated a good understanding of people's past lives and family and friends important to them. A staff member told us "(Name) has a lot of photos and loves talking about them. They tell you all about their past; one lady lived on a farm and I love hearing all about it". We observed conversations taking place between people and the staff team about a favourite singer, places people lived or had travelled to in their younger years. This meant people were able to have conversations that were meaningful to them.

People had their communication needs understood and met. A care worker explained "One person can't hear and so we have done signs; the night staff made them by hand. They drew a sun for good morning and a moon for goodnight. (Name) is disorientated in time and now sleeping much better".

People were involved in decisions about their care and how they spent their day. One person told us "If you ask for anything they deal with it; I'm pleased with everything". A relative explained "We can visit when we want and take (relative) out whenever we want". We observed people making decisions about where and how they spent their time and staff respecting people's choices.

People had their privacy, dignity and independence respected. One person needed to be cared for in bed. Their relative told us "(Name) always looks comfortable and the bedding is nice and fresh". Another relative told us "When staff speak to (relative) it's with dignity" they went on to say ""They always ask (name) nicely and explain it to (relative). They do a good job". We observed staff knocking on doors and waiting to be invited in to people's rooms. We observed people walking slowly with their walking aids and staff walking with them at the persons pace, demonstrating patience and encouragement enabling independence.

Information about people and staff was stored securely to ensure their right to confidentiality.

Good

Is the service responsive?

Our findings

People had care plans which reflected their personal care needs and choices and were reviewed at least monthly. Staff were able to demonstrate a good knowledge of the actions needed to meet people's care needs and choices. One relative told us "They (staff) are really attuned to what (relative) needs". Another told us "The systems seem organised; it's all down in writing what the staff are doing".

Staff were aware and respected people's individual lifestyle choices. Care plans described people's religious and cultural needs and these were understood and respected by the staff team. Links had been made with local churches that were able to provide religious support when needed.

Staff were kept up to date with changes in peoples care needs through daily handover meetings at the start of each shift. A care worker explained "At handover you get told what has been happening and you know what you are facing in the day; you then know what to expect".

The service met the requirements of the Accessible information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. A communication sheet had been completed specific to each person's communication preferences.

People had opportunities to join in group activities, spend one to one time with staff and access the local community. We observed people sitting together whilst news stories were shared from the daily newspaper. The activities co-ordinator had chosen stories linked to people's experiences and interests which promoted a lively discussion. People enjoyed a game of bingo and one person told us "I really enjoyed that even if I didn't win". An activity planner on a noticeboard had details of a range of activities each day. Some activities linked to popular events and occasions such as a royal wedding and Wimbledon.

People who were unable or chose not to join in group social events had opportunities for one to one time with staff. One person loved soft toys and staff told us they were a good point of conversation. The activities co-ordinator told us how one person had enjoyed gardening. They had sourced flower scents to provide sensory memories. One person told us "(Activities Co-ordinator) came to talk to me and asked if there was anything they could do that I would like. Instantly said I would like to go for a walk in my wheelchair. (Staff name) took me out and I could hear the birds singing; there's nothing like it".

A complaints procedure was in place and people and their families were aware of it and felt able to use it if needed. The procedure included details of how to appeal against the outcome of a complaint and provided details of external organisations such as the local government and social care ombudsman. No complaints had been received since our last inspection. A suggestion box was in reception for people, their families, visiting professionals and staff to use to share feedback and ideas.

People had an opportunity to develop care and support plans detailing their end of life wishes which included any cultural requirements and decisions on whether they would or would not want resuscitation to

be attempted.

Good

Is the service well-led?

Our findings

When we last inspected the service in May 2017 we found breaches in regulation in relation to good governance. Systems and processes had not been effective in monitoring and reducing risks to people related to their health and welfare. We asked the provider to take action to make improvements and this action has been completed.

The registered manager carried out a weekly evaluation of risks to people which included monitoring of actions put in place to reduce avoidable harm to people. Changes in senior roles had enabled more time for the registered manager to monitor the effectiveness of the service. Auditing and monitoring tools had been reviewed and were more effective in identifying areas of improvement. When improvements had been identified, actions had been taken promptly. We looked at an infection control audit which highlighted new clinical waste bins were needed and saw these had been replaced.

Quality assurance surveys had been completed and had captured feedback from people and their families. One person had requested more vegetarian meal options and the cook had met with them and discussed menu options. A relative suggested a clock at the signing in book and this had been purchased.

People, their families and the staff team all spoke positively about the management of the home describing it as an open, friendly and fun place. One person told us "I see (registered manager) most days; quite approachable. We're going to have a few (staff) changes; more senior staff. We had a meeting yesterday and they told us". Another told us "The organisation is excellent and the staff seem happy with (registered manager). They always knows my name and talk to me. They all (staff) speak highly of (registered manager)". A relative said "(registered manager) really cares about getting it right. Totally approachable".

The registered manager provided visible leadership and had also taken opportunities for professional development. They were in the process of starting a level five diploma in management and leadership in health and social care. They had also identified they needed a refresher course on the Mental Capacity Act 2005 and had booked on to a course for managers.

Staff were clear about their roles and responsibilities and were focused on the importance of teamwork. A member of staff told us "We know where we are; what's expected of us. We are a team. If I have time I might go and help with the laundry". Another told us "Really feel appreciated; feels like my second home, my second family". Staff had their religious and cultural diversity respected. This had included providing flexibility with working hours to support religious practices.

The registered manager had a good understanding of their responsibilities for sharing information with CQC and our records told us this was done in a timely manner. Engagement with people, their families and staff was achieved through a range of methods. These included both group and individual meetings, social gatherings and a quarterly newsletter. A care worker explained "We have staff meetings which keep us up to date with things we need to know about. It's also a good way to welcome new staff". We read a newsletter

which had photographs of events that had taken place and details of decisions about how fundraising money had been spent.

Links with the community included supporting national fund raising events. The home were raising funds for an Alzheimer's charity with a cake baking event. The registered manager explained that the local church also helped provide links between the home and local community. Links with community health professionals had enabled the home to provide urgent respite care in a crisis.

The staff team worked with other organisations and professionals to ensure people received good care. These included 'Skills for Care' to keep up to date with best practice guidance. Information had been shared appropriately with other agencies such as the safeguarding teams and social care commissioners.