Care Quality Commission

Orchard Care Homes.Com Limited

Clipstone Hall and Lodge

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 21 and 22 January 2015 and was unannounced. Clipstone Hall and Lodge provides accommodation and personal care for up to 90 people some people were living with dementia and some had physical health conditions. On the day of our inspection 79 people were using the service, which is split into five areas. Two units catered for people requiring residential care and three units supported people living with dementia. We found there was a variation in the quality of care provided across each of the units.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The registered manager was not present during this inspection.

Summary of findings

When we last visited the service 19 June 2013 we found the provider was meeting all standards in the areas we looked at.

During this inspection we found that people did not always receive their medicines when they needed them and they were not always stored and recorded appropriately. Risks to people's safety were not appropriately managed because staff did not have access to information and guidance about how to minimise risks. There were sufficient numbers of suitable staff to meet people's needs.

We have made a recommendation about how people whose behaviour may challenge others are supported.

People were cared for by staff who did not feel fully supported to carry out their role. Whilst sufficient quantities of food and drink were provided, we received mixed feedback about the quality of the food. People were not always supported to eat and drink sufficient amounts. Support for people to access healthcare services was inconsistent and staff did not always apply the guidance received.

We found the Mental Capacity Act (2005) (MCA) was being used correctly to protect people who were not able to make their own decisions about the care they received. We also found staff were aware of the principles within the MCA and had not deprived people of their liberty without applying for the required authorisation.

People's dignity was not always respected and staff did not always speak with people in a polite and respectful manner. People were able to be involved in planning their care and making decisions and had their privacy respected by staff.

People did not always receive support in line with their care plan and staff were not always aware of what support people required. Whilst the complaints received had been appropriately investigated, not everybody felt comfortable in making a complaint.

People were aware of different ways they could provide feedback about the service. However, the systems in place to monitor the quality of the service were inconsistent and risks to people were not always managed. Records about the care people received and staff were not always accurate and up to date. We had received the required notifications in a timely way. Providers are required by law to notify us of certain events in the service.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

People did not always receive their medicines as prescribed. The risks to people's safety were not always well managed, however there were sufficient staff to meet people's needs.

Requires Improvement

Is the service effective?
The service was not always effective.

People were cared for by staff who did not feel fully supported but people had the opportunity to provide consent to their care. There was appropriate use of the Mental Capacity Act (2005).

People did not always receive the support required to eat and drink sufficient amounts and felt the quality of food was not always acceptable. Access to healthcare services was inconsistent.

Requires Improvement

Is the service caring?
The service was not always caring.

People were not always cared for a kind and considerate manner. Efforts were made to involve people in their care planning and making decisions about their care.

Requires Improvement

Is the service responsive?
The service was not always responsive.

People did not always receive the care and support they required and changes to care plans were not always made when they were needed. Complaints were investigated and responded to in a timely manner however not everybody felt comfortable making a complaint.

Requires Improvement

Is the service well-led?
The service was not always well led.

People did not always receive a quality service because the systems to manage risks to people were not effective. The records about people's care and staff were not always accurate and up to date. There were meetings and surveys for people and staff to provide feedback about the quality of the service.

Requires Improvement

Clipstone Hall and Lodge

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.

This inspection took place on 21 and 22 January 2015 and was unannounced. The inspection team consisted of one inspector and a specialist advisor with experience in dementia care and nursing.

Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We also contacted commissioners (who fund the care for some people) of the service and asked them for their views.

During our inspection we spoke with eight people who were using the service, four visitors, five members of care staff, the manager and the provider's operations manager. We also observed the way staff cared for people in the communal areas of the building. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We looked at the care plans of six people and any associated daily records. We looked at five staff files as well as a range of records relating to the running of the service such as audits and six medication administration records.

Requires Improvement

Is the service safe?

Our findings

People gave positive feedback about the management of their medicines. One relative said, "I don't have any concerns about medication." However, people did not always receive their medicines as prescribed. For example, staff had left a pot of liquid medication with one person during the morning. We saw that, after lunch time, this person had forgotten to take the medication and staff had not followed the correct procedure to check this person had taken their medication.

Staff had not always ensured people had access to the medicines they required, including pain relieving medicines, or that they were administered safely. We saw three examples of a person being without their medicine as it was not in stock, for example one person did not have access to their pain relieving medicines. Several people received some of their medicines covertly, this is when medicines are hidden in food or drink. Staff had not taken advice from the pharmacy about the best way in which to administer these medicines to ensure they remained effective. Therefore, there was a risk that people's medicines may not be acting effectively. When a tablet had not been administered to a person, the reason for this was not always clearly recorded. This meant that staff did not have an accurate picture of the reasons why a person may not be taking their medicines and had not taken action to rectify this.

People's medicines were not always stored or disposed of correctly. A bottle of pain relieving medication was two months past its recommended disposal date, but it was still in use. Medicines require storage within a particular temperature range to ensure they remain effective. Staff were not always recording the temperature of the room that people's medicines were stored in or the fridges some medicines were kept in. This meant people may be receiving medicines that are not as effective as they should be.

We found that the registered person had not protected people against the risks associated with medicines. This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People felt safe at the care home. One person said, "I have always felt safe here." Another person said, "I am happy here, I like all the staff and feel safe." Relatives told us they felt their loved ones were safe living at the home. There was information available to people and staff about who they could contact should they suspect any abuse had occurred. Staff knew what action to take if they needed to report an incident and we saw that information had been shared with the local safeguarding authority when required.

However, staff did not always have information about the support people needed to reduce the risk of harm to themselves and others. People's care plans contained limited information about what may put them and others at risk of harm and how staff should respond. For example, one person's care plan stated they could become physically and verbally aggressive. However it did not state why this might occur or how staff should respond. The staff we spoke with told us how they tried to manage such situations. The information provided by staff showed that a consistent approach was being applied to support people to remain safe.

Action was not always taken after an incident to review the support offered to people to keep them safe. Records were completed following an incident to show what had happened before, during and after it. Despite this information being available, it was not being used to review the type of support offered to people to keep them safe.

Staff told us they had not received any specific training in understanding people's behavioural needs. We saw that member of staff had suffered an injury whilst supporting a person. We checked this person's care plan and saw that it did not offer staff any guidance in how to manage situations when they may become distressed. The manager acknowledged that the care plan guidance could be improved upon. Training records confirmed that less than half of the staff had received training in understanding behaviour that may challenge others and this had not been refreshed for almost two years.

People we spoke with did not raise any concerns when asked about how any risks to their safety were managed. One person said, "I am a bit wobbly on my feet, staff make sure I move about safely." The relatives we spoke with did not raise any concerns about how risks were managed.

However, people did not always receive the support they required to reduce risks to their safety. For example, one

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Is the service safe?

person was at risk of falling and their care plan stated staff should ensure they wore glasses and have appropriate footwear on. Despite staff being aware of this guidance it was not applied in practice and left the person at risk of falling. Another person was at risk of sustaining pressure damage to their skin and required encouragement to reposition themselves every 15 minutes. We observed staff instruct this person to, "Sit down" because they were concerned that they may fall and they did not receive the support required to reduce the risk of pressure damage.

Risk assessments had not always been completed correctly to inform the appropriate level of care and support required. We saw three examples where a risk assessment score had been incorrectly competed and this resulted in the wrong level of risk being recorded. This left people at risk of not receiving the support they may require.

There were risks to people's safety because building maintenance tasks had not always been completed in a timely manner. For example, a dishwasher in one kitchen dining area had broken down and the front panel was missing from the dishwasher door. This exposed the metal interior of the dishwasher door and was a risk to people living in this area of the home. The manager told us they had ordered a replacement dishwasher. Also, a sluice room which contained hazardous chemicals had been left open which left people at risk of accessing items which may be harmful to them.

The people we spoke with told us they thought there were sufficient staff to care for them. One person said, "Staff check on me regularly and always come quickly when I need them." Another person told us, "Staff are busy, but they always respond quickly when I need them."

We received mixed feedback from staff about whether there were sufficient staff to meet people's needs. However, we observed there were sufficient numbers of staff to provide people with the support they required. The manager told us they assessed people's needs and used this information to determine the required staffing levels. The provider had taken steps to protect people from staff who may not be fit and safe to support them. Before staff were employed the provider requested criminal records checks, through the Disclosure and Barring Service (DBS) as part of the recruitment process. These checks are to assist employers in maker safer recruitment decisions.

We recommend that the provider refers to the current guidance regarding supporting people whose behaviour may challenge others.

Requires Improvement

Is the service effective?

Our findings

People told us they felt well cared for by staff who were competent. One person said, "I think the staff are very good at what they do." A relative told us, "The staff seem to do a lot of training, I think generally they know what they are doing."

People were cared for by staff who did not feel fully supported to carry out their duties effectively. Staff told us that, whilst they received supervision, they did not feel fully supported because concerns they had raised were not always acknowledged or responded to. The manager told us staff received regular supervision with their line manager and records confirmed this was the case. We checked the supervision records for five staff and saw that supervision records were not always in place. The records we saw were often generic and did not show what support was being offered to staff.

People were supported by staff who received training on a regular basis, such as infection control and safeguarding. Some of the staff we spoke with told us they would like some more training relating to the needs of people living with dementia. Whilst staff were provided with dementia awareness training, not all staff had received training in how to understand any behaviour which may be challenging to others. Staff told us they sometimes struggled to support people who were living with dementia because they did not have a full understanding of their needs. We also observed that staff did not always support people living with dementia in a way that met their individual needs.

People were supported to make decisions about their care and to provide consent. The people we spoke with told us they had been asked to provide consent to their care which was described in their care plans. One person said, "I was involved in discussions about that when I moved here." A relative we spoke with said, "I was involved with all the paperwork when [my relative] came here and signed the care plan."

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. The DoLS is part of the MCA, which is in place to protect people who lack capacity to make certain decisions because of illness or disability.

DoLS protects the rights of such people by ensuring that if there are restrictions on their freedom these are assessed by professionals who are trained to decide if the restriction is needed.

People's rights to make decisions about their care were supported in accordance with the MCA. Where staff had doubts about a person's capacity to make a particular decision, an assessment of their capacity was carried out. A best interests decision was then made relevant to the area of care being assessed. Staff had received training regarding the MCA and showed they had an understanding of how to support people to make decisions.

Any restrictions to people's freedom had been assessed and were being appropriately managed.

The manager was aware of Deprivation of Liberty Safeguards (DoLS) and had appropriate procedures in place to ensure people's freedom was not restricted unlawfully. The manager had made applications to the local authority and was awaiting an outcome to these.

We received mixed feedback from people about the quality of food, although people said they were given plenty to eat and drink. One person said, "I like the food and there is always plenty of it." Another person said, "I don't really like the food, it is bland and tasteless." Another person told us, "I like my food to be presented in a certain way. However it is not presented how I like it so I don't eat as much as I might." One relative we spoke with said, "[My relative] seems to enjoy the food." However another relative said, ""I don't think the food is very good, it always seems to be overcooked." We spoke with the manager about this feedback and they acknowledged the quality of food needed to be improved. A chef had recently been employed with a view to improving the quality of food being provided.

We saw that people had a choice of food and drinks offered to them at mealtimes and we observed people's requests for specific drinks were responded to by staff. People who were able to eat independently appeared to enjoy their meal. However, where people required support to eat their meals this was not always provided. For example, one person struggled to use cutlery to eat their meal and spilt a large amount of food. Staff cleared the spillage away however did not offer the person any more food or support to eat their meal.

Requires Improvement

Is the service effective?

People did not always get the support they required to drink sufficient amounts to maintain a good level of hydration. We observed that staff did not always support or prompt people to drink enough. Fluid intake records were not fully completed so we could not ascertain whether people received sufficient fluid intake. Specialised diets were catered for, such as soft foods and low sugar alternatives.

People told us that they had access to the relevant healthcare professionals when required. One person said, "The staff will call the doctor for me if necessary." However, two of the relatives we spoke with raised concerns that action had not been taken quickly enough when their loved one was unwell. We saw that people were not consistently supported to access healthcare services.

For example, one person's care plan stated they were to be encouraged to see the chiropodist 'every six to eight weeks.' We checked their records with the manager which confirmed this person had not seen a chiropodist for a period of nearly 11 weeks. A member of staff commented that the person's nails were, "Quite long." Another person refused support to have their teeth and gums cleaned due to having pain in this area. Staff had not requested the support of a dentist to promote this person's health and well-being. However, we saw that other people were supported to access services such as their GP and district nurse in a timely manner.

People's day to day health needs were not consistently met because staff did not always follow guidance that had been received from healthcare professionals. For example, one person had received a visit from the falls prevention team who had provided staff with some guidance. However, staff were not following this guidance in practice. The person's care plan was different to the guidance that had been provided. Whilst the person had not fallen, there was a risk that they may not received the required support because staff were not aware of the advice that had been provided.

Requires Improvement

Is the service caring?

Our findings

The majority of the people told us they were happy living in the home and felt that staff were caring and compassionate. One person said, "I am very happy here, I feel well cared for." Another person told us, "I think the staff are lovely, I have no complaints about staff." However one relative commented that they felt some staff were not caring in their approach, saying, "Some staff are lovely, others don't really show that they care."

Staff did not always speak with people in a kind and caring manner. We observed occasions where staff did not show respect and understanding of people's needs. For example we heard staff make comments such as, "No. Stop it. That's not nice. " and, "Put your hand over your mouth darling," when a person coughed. Another person was instructed to, "Sit still." and to, "Sit down and stay there."

However, we also observed positive interaction between people living in the home and staff. For example, a member of staff noticed that one person did not have an item with them that they normally carried everywhere. They arranged for this to be fetched and the person was very grateful. Also, a member of staff responded quickly when a person began to cough repeatedly, to alleviate their discomfort. The staff we spoke with told us they valued the relationships they had with people. We saw that staff showed empathy when trying to relieve a person's distress. For example, one person regularly became distressed and staff responded in a kind and understanding way.

People told us that they were able to make decisions and be involved in planning their own care. One person said, "I was asked what I wanted when I first came here and staff respect my wishes." A relative said, "I have seen the care plan and was involved in providing information to go in it."

The staff we spoke with told us they were aware of decisions people had made regarding their preferences about their care. Staff told us they supported people to make decisions about their care on a day to day basis. We observed that people were supported to make decisions such as where they wished to sit and whether they wished to join in activities.

People told us they were treated with dignity and respect by staff. One person said, "The staff are very mindful of my privacy and dignity." Another person told us, "The staff are very polite and considerate. They help me to use the facilities, but leave me to do what I can for myself." However, we observed that people's dignity was not always promoted by staff. A relative we spoke with told us they felt staff did not always ensure their loved one was dressed in a manner which preserved their dignity, we observed this to be the case during our inspection. They also told us their relative's clothing often went missing in the laundry. We saw that there was a large amount of clothing in a store which had not been returned to its owner.

We observed that the layout of the building allowed people to have privacy in their own bedroom or in smaller, quiet lounges. Equipment was provided to support people to maintain their independence such as grab rails, raised toilet seats and assisted bathing. People could receive visitors at any time of the day and privacy was respected by staff.

Requires Improvement

Is the service responsive?

Our findings

We received mixed feedback from people about whether their changing needs were met. One person said, "I am very well cared for, I am happy to stay here." Another person told us, "I don't feel that staff are always aware of what I need because I have to tell them each day." Two of the relatives we spoke with expressed concern that their loved one did not receive responsive care, for example one relative told us their loved one wasn't always seated on their pressure cushion. However, another relative said, "I think [my relative] receives good care, they seem happy here."

People did not always receive care that was responsive to their needs. For example, one person had received advice from the falls team who had recommended that two staff should assist them to mobilise. This information was in the person's care plan however staff were not aware of it and we saw this person was being assisted by only one member of staff. This meant the person was at greater risk of falling because they were not receiving the support they required. This person's mobility assessment stated their skin was intact however we saw other records which demonstrated the person suffered regular skin tears and bruising.

Information about how best to care for people living with dementia was not consistently available. For example, one person's care plan stated they could become verbally or physically aggressive and that if this happened staff should record it. However the care plan did not offer staff any guidance as to what might cause this situation to occur or how it should be managed. We saw that there had been occasions when this person had been aggressive and no amendments had been made to the support provided. Their care plan also stated they were at risk of self-harming, however there was no further information about this. The staff and manager were unaware of this information and were unsure as to what support they should offer if the person were to self-harm.

Staff did not always assess whether people's care plans remained suitable following an incident or a change in their needs. For example, one person suffered a high number of injuries such as skin tears and bruising. However this had not been taken into account during the reviews of their care plan, which remained unchanged.

We found that the registered person had not protected people against the risk of receiving care that was not responsive to their needs. This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Reasonable adjustments were not always made to support communication with people with different needs. One person's first language was not English and they had limited speech. The staff had not considered alternative ways of communicating such as using picture cards or attempting to learn key words from the person's first language. Despite this, the person had been assessed as being at low risk of social isolation. Their care plan did not show how this person could be supported to communicate with others. We observed that this person spent long periods of time without any interaction.

People told us they were provided with choices about how they wished to spend their time. One person said, "There are some activities going on and I join in sometimes." Another person said, "The activities are not really for me but I am not pressured to join in." Activities were provided in a variety of ways to support people to develop relationships and prevent isolation. Attempts had been made to provide activities that were linked to people's interests and hobbies. There were communal activities such as visiting entertainers and bingo and special occasions were celebrated. An activities coordinator also spent time with people who preferred to stay in their own rooms.

We received mixed feedback about how comfortable people felt making complaints. The majority of people we spoke with told us they would be happy to make a complaint and knew how to do so. However, one person said, "I have raised things in the past but nothing seems to get done so I don't bother anymore." A relative told us they did not feel able to raise concerns about their experience at the home because they felt uncomfortable speaking with the manager.

People were provided with information about how to make a complaint when they moved into the home. Any complaints received had been investigated in a timely manner and an outcome provided to the person who made the complaint. Where possible complaints were resolved to

Requires Improvement

Is the service responsive?

the satisfaction of the complainant. The complaints procedure was displayed in various parts of the home and people who attended meetings in the home also had the opportunity to raise concerns if they wished to.

Requires Improvement

Is the service well-led?

Our findings

People told us they were aware of different ways they could provide feedback about the quality of the service. One person said, "I have had a survey and I filled that in." Another person said, "I have been to some of the resident's meetings." The relatives we spoke with were also aware of the different feedback methods that were available to them. There were regular meetings for people who used the service and their family to provide feedback and make suggestions.

However, the quality systems in place did not ensure that action was taken to manage risks that had been identified to people. A range of auditing tools were available but these did not always result in improvements to people's care. For example, we looked at care plan audits and medicines audits which had identified areas where improvements were needed. Action plans had been implemented, however these were not monitored to ensure improvements had been made. A medicines audit from August 2014 had identified issues with medicines ordering, storage and recording. An action plan was put in place which was due to completed by the end of September 2014. However, there was no confirmation of the monitoring and completion of the actions and we found issues with medicines and care planning during this inspection.

We found that the registered person had not protected people against the risks which had been identified. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records about the care people required and had received were not always accurate and up to date. For example, scores within three of the risk assessments we looked at had been incorrectly calculated and this affected the assessed level of risk to those people. This meant that the care provided to people did not accurately reflect the level of risk. Daily records about the care provided to people were not always accurately completed. For example, where people required regular changes to their position to prevent damage to their skin, staff had not always recorded this so we could not be sure people had received care to protect their skin integrity. Records about staff were not always available, for example the manager could not locate some of the supervision and induction records we asked to see.

We found that the registered person had not protected people against the risk of receiving inappropriate care because records were not always accurate and up to date. This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We received mixed feedback about the culture of the service. One person said, "I see the manager around and she seems very nice and friendly." Another person said, "I wouldn't know who to raise any problems with or how." Two of the relatives we spoke with told us they did not feel that improvements were made when they had raised matters of concern.

The staff we spoke with acknowledged recent changes in the management structure had had a positive impact. There were deputy managers who provided a channel of communication for care staff to raise issues and staff told us they felt comfortable raising issues this way. However, some of the staff we spoke with told us that when they had raised issues recently they did not feel they had been listened to. For example, two staff told us they had expressed their concerns about staffing levels but felt no action had been taken to address their concerns.

The service had a registered manager and she understood her responsibilities. The manager received regular support visits from the provider. We received mixed feedback from people about how visible the manager was. One person said, "I very rarely see the manager." Another person said, "I often see the manager she seems very busy." A relative said, "The manager's office is on the other side of the home, I don't really see her come over here."

Sufficient resources were available to drive improvements to the service people received. For example, the manager was exploring different way of providing an environment that would be more suitable for people living with dementia. Funding had been made available to enable to

Requires Improvement

Is the service well-led?

purchase of various items to support this approach. However, despite these resources being available, improvements to the service were not always made when required.

Records we looked at showed that CQC had received all the required notifications in a timely way. Providers are required by law to notify us of certain events in the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care 9. (1) The care of service users did not meet their needs because the registered person did not take proper steps to ensure each service user received care that was appropriate and safe, by means of: (b) designing care or treatment with a view to achieving service users' preferences and ensuring their needs are met.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance 17. (1) & (2) (a) Systems were not effectively operated to ensure compliance because the provider had not assessed, monitored and improved the quality and safety of the services provided in the carrying on of the regulated activity. 17. (2) (c) & (d) The registered person did not maintain an accurate, complete and contemporaneous record in respect of each service user and persons employed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment 12. (2) (f) and (g) Service users were not protected against the risks associated with the unsafe use and management of medicines.