Clifford House (Homes) Limited

Clifford House

Inspection report

Lucy Street
Blaydon On Tyne
Tyne and Wear
NE21 5PU

Tel: 01914148178

Date of inspection visit:
08 February 2017
13 February 2017

Date of publication:
18 April 2017

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 8 and 13 February 2017 and was unannounced. We had last inspected Clifford House in February 2016 and found breaches of legal requirements in relation to safe care and treatment, staffing, need for consent and good governance. At this inspection we judged the necessary improvements to meet legal requirements had been implemented and have changed our rating of the service.

Clifford House provides care and support for up to ten people who have learning and/or physical disabilities. Nursing care is not provided. At the time of our inspection there were eight people living at the home.

The service 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.

We found safety in the home had been improved by the completion of works advised by the fire authority, including a certified test of the electrical installation. There were now plans for dealing with emergencies and an identified place of safety for people should the home need to be evacuated.

Risks to personal safety were appropriately managed and steps were taken to safeguard people from harm and abuse. Relatives confirmed they felt their family members were safely cared for.

New staff had been properly vetted before they started working at the home. Sufficient numbers of support staff were employed and people were given continuity of care. The staff received training that equipped them to meet people's needs effectively. Improvements had been made to supervision and appraisal arrangements to support the staff in their roles and development.

Medicines were managed safely. People were well supported with their healthcare needs and there were close working relationships with NHS professionals, including specialist learning disability nurses. A varied diet with choices of food and drinks was offered and people's nutritional needs were assessed and monitored.

Formal processes were followed under mental capacity law to uphold the rights of people who were unable to give consent or make important decisions about their care. Staff understood people's diverse needs and the ways they communicated and preferred to be supported.

Staff were caring in their approach and knew people well. Good relationships had been formed and people were treated as individuals. People's privacy, dignity and independent living skills were promoted.

Personalised care plans were in place which guided staff on meeting people's needs. A range of social activities was undertaken and people had good links with their local community. People and their relatives

were made aware of how to make a complaint if they were ever unhappy with their care. No complaints had been received over the past year.

The management provided leadership and support to the staff team. An inclusive culture encouraged people and their relatives to influence how the service was run. There was now improved governance, with further methods of obtaining feedback and checking the quality of the service.

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 now safe.

Necessary works to make the home safe and plan for emergencies had been carried out.

There were appropriate systems for safeguarding people against the risks of harm and abuse.

Enough staff were employed to make sure people received safe and consistent care.

The management of people's prescribed medicines was safe.

Is the service effective?

Good

The service was now effective.

Improvements had been made to ensure staff were suitably supervised and had their performance appraised.

Mental capacity assessments were now routinely carried out for specific decisions about people's care and treatment.

People were given good support in meeting their health care and nutritional needs to maintain their well-being.

Is the service caring?

Good

The service remains caring.

Staff were kind, caring and had developed good relationships with people living at the home.

People were well supported in making choices and decisions about the care they received.

The staff treated people respectfully and protected their privacy and dignity.

Is the service responsive?

Good

The service remains responsive.

Individualised care plans were focused on each person's needs and preferences.

People were given a good level of support to meet their social needs and regularly accessed activities within the community.

People and their representatives were listened to and no complaints had been raised.

Is the service well-led?

Good

The service was now well-led.

Governance of the service had improved, with more effective monitoring of standards and additional means of obtaining feedback.

The views of people and their relatives showed they rated the service highly.

The management team promoted an open culture and worked inclusively.

Clifford 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. We checked if improvements to meet legal requirements had been made following our last inspection in February 2016.

The inspection took place on 8 and 13 February 2017 and the first day was unannounced. The inspection team consisted of an adult social care inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We contacted the local authority that commissions the service.

During our inspection we met and talked with six of the people living at the home, two relatives, the registered manager, deputy manager, and four support staff. We telephoned a further two relatives to get their views and spent time observing how staff interacted with and supported people. We looked at three people's care records, two staff files and a range of other records related to the management of the service.

Good

Is the service safe?

Our findings

We checked the action taken in response to the breaches in legal requirements that we had found at our last inspection. These had related to no up-to-date testing of the building's electrical installation and a business contingency plan for emergencies was not in place.

The registered manager showed us the certificate dated April 2016 that confirmed testing of the electrical installation system had been undertaken by an external contractor and was safe. Other works, as previously advised by the fire authority, were also confirmed as completed. Plans to manage emergencies had been drawn up, including an identified place of safety in the event of people needing to be evacuated from the home. We concluded that the provider was no longer in breach of the relevant regulation.

People's relatives said they had no concerns about their family member's safety. They told us, "No issues; everything is absolutely fine" and "No concerns at all." Safeguarding advice posters were displayed around the home to raise awareness. Safeguarding and whistle-blowing (exposing poor practice) policies were given to staff, guiding them on how to recognise and report any abuse or unsafe care. Staff undertook safeguarding training annually and their understanding was discussed during staff meetings and individual supervision. The staff we talked with understood their roles in protecting people from harm and abuse and were confident about reporting any concerns.

Appropriate action had been taken in response to the one safeguarding alert that had been raised since the last inspection. A 'duty of candour' policy had been devised and was being disseminated to the staff team. This duty requires providers to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong.

A thorough recruitment process was followed to check the suitability of new staff. The registered manager assured us a process would be implemented to assess and authorise employment of anyone with a criminal conviction. Staffing levels continued to be four to five support staff during the day and two to three at night. Levels during the night were under review, looking at people's dependency and routines. Continuity of care was provided, with existing staff covering absence and no use of agency staff. The registered manager, deputy and senior staff shared an on-call system, enabling staff to get advice and support outside of office hours. We observed there was enough staff to safely provide people's care and this was confirmed by the staff we talked with.

Care records demonstrated people's personal safety had been assessed and steps were taken to reduce identified risks. Risk management addressed a range of issues associated with each person's care delivery, support outside of the home and their individual vulnerabilities. Cash held for safekeeping was properly accounted for and audited weekly to ensure people's monies were safely managed. Accidents or incidents were reported and documented. Risk assessments were conducted for potential hazards in the environment and the security of the home. Regular checks were carried out of the premises, facilities, equipment, fire safety and infection control to make sure safety was maintained. We observed the home was clean, fresh-smelling and comfortable. A maintenance person was employed and repairs were dealt with promptly.

Safe arrangements were made for the secure storage and management of medicines. Senior staff, who were trained and had their competency assessed, administered medicines following care plans which specified people's requirements. Records supported that medicines were given safely and at the times people needed them. Separate records for topical medicines (applied to the skin) and protocols for 'as required' medicines had been introduced. Weekly stock checks and monthly audits took place to monitor that people's medicines were safely handled.

Good

Is the service effective?

Our findings

We checked the action taken in response to the breaches in legal requirements that we had found at our last inspection. These had related to a lack of supervisions and appraisals for staff and mental capacity assessments not being carried out for all people living at the home.

The registered manager told us the supervision policy had been changed and was more flexible in terms of the frequency and extent of support that individual staff members needed. A minimum of three supervision sessions and an appraisal each year was now being provided. This was confirmed by the schedule records and the staff we spoke with. One staff member said, "I had my supervision two weeks ago and I'm due my appraisal in two months."

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).

The majority of people living at the home had DoLS authorised to enable them to receive the care and treatment they required. We saw mental capacity assessments had been carried out, leading to decisions being made about specific areas of care in people's best interests. These included decisions in relation to managing finances and support with health conditions and medicines. Such decisions had often involved healthcare professionals and Independent Mental Capacity Advocates. We concluded that the provider was no longer in breach of the relevant regulations.

The service did not advocate the use of excessive control or restraint. Staff told us people rarely displayed distressed or challenging behaviours. They gave us clear accounts of the ways they worked with individuals, using consistent approaches and monitoring behaviours to identify causes or triggers. The staff knew people well, enabling them to quickly spot the signs of changes in their moods and communication. One staff member said, "Some residents have bad days, like we all do."

Relatives felt the care provided at the home was effective. One relative explained their family member had previously lived at another care home and said, "Based on how [name] is as an individual, I feel they're happy here and things could hardly be better." Another relative told us staff had arranged for a walking aid to be provided that had dramatically improved their family member's mobility.

New staff were given induction training when they started working at the home to prepare them for their roles. This included inexperienced staff undertaking the 'Care Certificate', a standardised approach to training for new staff working in health and social care. Ongoing training was provided for staff in mandatory safe working practices and topics relating to people's needs such as epilepsy and dementia. Over the past

year training courses had included food hygiene, medicines, health and safety and mental capacity law. Most staff had either achieved or were studying for nationally recognised care qualifications. The staff we talked with were positive about the training and support they received. A newer staff member said, "Everything is great here. I get to see different aspects of how the residents are looked after."

Staff supported people in meeting their dietary needs and, where necessary, gave assistance with eating and drinking. Nutritional screening was now carried out and people were weighed regularly. Food and fluid intake was monitored where risks were identified and advice had been sought from dietitians and speech and language therapists. People were involved in menu planning and supported to take a balanced diet and drink sufficient amounts. Good support was provided with weight management and provision of special diets, including following dietetic guidance. Staff were also trained in enteral feeding techniques (where food and supplements are provided through a tube in the abdominal wall into the stomach). We found that mealtimes were a relaxed and pleasant experience and people appeared to enjoy their meals. A relative told us, "[Name] loves her food."

Staff had close working relationships with learning disability community nurses and worked well with healthcare professionals in co-ordinating people's care. Examples included being trained by a physiotherapist to carry out exercises and by a podiatrist to deliver essential foot care. A NHS dentist had also provided training and given the home an award in oral health quality.

People had the necessary aids and equipment for their comfort and safety, for instance mobility and bathing aids, overhead tracking and profiling beds. Detailed records were kept about people's health needs and all contact with healthcare professionals, including annual learning disability health reviews. We observed and were told about the care provided to people with complex needs. For example, a multi-disciplinary approach was taken in supporting a person with multiple health conditions, including working with their relatives to achieve the best outcomes. Another person had returned to the home following a move during which their health and well-being had significantly declined. The deputy manager told us, "[Name] is now thriving."

Good

Is the service caring?

Our findings

Many of the people living at the home were unable to tell us about their care experiences. We observed people were comfortable in the company of staff and responded well when engaging with them. There was a calm, relaxed atmosphere and we saw the staff were kind, friendly and respectful. It was evident there were good relationships. For example, a person put their arm around the deputy manager and said, "It's my mate" and we heard another person say to a support worker, "You're my keyworker." Staff told us they were designated as keyworkers for people, with particular responsibilities towards the planning and provision of their care. They explained keyworker roles were changed annually, which involved looking at relationships and identifying the best match for each person.

Relatives told us they were satisfied with the care and support provided and that staff had caring attitudes. One relative said, "When [family member] is unhappy it's obvious and there are just no issues here. [Name] is extremely happy and wanted to come here. It's gone extremely well." Another relative explained that when a member of the family was too ill to visit, "Staff arranged for [name] to visit them instead."

All staff were trained in the values of person-centred care, with an emphasis on the caring for people as unique individuals with diverse needs. The registered manager said this training encompassed care planning, promoting privacy, dignity and independence and adhering to the person's preferences. They told us standards of care practices were made clear to staff and were checked to ensure they were consistently applied. Expectations included staff being discreet and sensitive in their approaches and when giving personal care, to use tactile communication when this was appropriate, and to always explain what they were doing. Staff were also informed about the conduct expected of them in the staff handbook they received and in key policies, such as maintaining confidentiality.

During our visits we observed the staff were caring in the ways they treated people. They spoke politely, adjusting how they communicated with each person, and listened to what they had to say. There were high levels of interaction balanced with giving people space to spend their time as they wished. In congratulatory moments we saw that staff gave 'high fives' to people.

We saw and were told about the methods used to support people in expressing their views and making decisions about their care. Easy read information was displayed, such as the day's menu and posters about how to report complaints or safeguarding concerns. Working with other professionals, the service had made information available to some individuals in formats they could understand. For instance, photo boards designed to display the staff on duty, family visits and help in making choices of activities and food. Guides with pictures, had been used to support people's understanding of medical issues, including helping a person to decide whether to take part in different types of health screening. Staff told us about how they had supported a person with a specific preference around their religion, helping them to talk about their feelings. Another person was being referred to access grief counselling, to support their emotional well-being.

We observed staff worked inclusively with people, offering choices and encouraging them to be involved in

everyday life in the home and to go out into the community. For example, they ensured a person, who did not take food orally, joined others in the dining room at mealtimes and had small 'tasters' twice daily. A staff member told us, "Residents are involved with everything we do" and explained that some people helped tidy their bedrooms.

We saw staff supported people's self-esteem by assisting them to maintain good standards of personal grooming. People wore clean, co-ordinated clothing and were given support with hairdressing, shaving, manicures and to wear jewellery and accessories. Attention to detail was also reflected in people's care plans. For example, one person's plan for personal care '[Name] likes to have hair blow dried and styled after showering' and to add 'some sparkly jewellery as a finishing touch to her outfit'.

We observed that staff were mindful of people's privacy, always knocked on doors and waited for answer before entering the room. Staff described their ways of ensuring privacy and providing dignified care. One staff member told us, "Always ask their permission in relation to personal care and treat the residents as adults." Other staff said they approached people as they, or their parents, would wish to be treated.

The management and support staff had good understanding of people's communication needs and the ways in which individuals expressed themselves. Care plans addressed the level of support each person needed with decision-making. Where people were unable to make important decisions about their care, advocates represented their views. Care was also taken to consult people and their relatives through meetings and surveys to get their feedback about the service.

Good

Is the service responsive?

Our findings

We observed that people were supported to lead active lives and take part in a variety of social activities, within the home and in the local and wider community. A good level of information had been gathered about people's backgrounds, lifestyles and interests. This was incorporated into profiles and daily routines which showed what was important to the person and what they liked to do at different times of the day. Weekly plans with activities timetables were also in place and were used to record what people done. For example, one person's plan indicated they enjoyed listening to music, watching DVDs, pampering sessions and visits from family. They also went out shopping, to a local church and on various day trips.

During our visits, some people were attending day centres whilst others went out shopping or did indoor activities. Most activities were undertaken either individually or in small groups. Activities materials, such as jigsaws, colouring books and building blocks were made available and people used the garden in good weather. People regularly visited nearby amenities including a drop-in centre, a lunch club and facilities in the local shopping centre. Most people had also had short breaks or holidays in the past year.

Staff we spoke with clearly understood people's interests, pointing out to us what individuals preferred to do and how they worked flexibly to accommodate their routines. The deputy manager said staff adapted their approaches and the care they gave when, for example, people were poorly or there were changes in their mental health.

We saw a range of assessments were completed to identify each person's needs and risks and plan their care. The care plans were tailored to the individual, the ways they preferred to be supported and their independent abilities. They provided good guidance for staff to follow about the extent of support to be provided across the day and at night to meet people's needs. The care plans were currently evaluated weekly, though this frequency was being reconsidered to ensure people's care and progress was reviewed in a more meaningful way. Bi-monthly meetings between people and their keyworkers to review and forward plan support were also held.

Support staff reported on each person's welfare daily and, where applicable, completed additional records to monitor particular aspects of their care. Verbal and written handovers took place between shifts to make sure all staff were updated about significant information or any changes which had occurred.

The complaints procedure was advertised around the home and explained to people. The registered manager told us there had been no complaints about the service over the past year. None of the people or relatives we talked with had any complaints about the care or the service in general. One relative did however feel a little unclear about an issue they had raised in 2016, which the management agreed to take forward and resolve.

Good

Is the service well-led?

Our findings

We checked the action taken in response to the breach in legal requirements about good governance that we had found at our last inspection. This had related to a lack of effective quality monitoring of the service.

We found that a more structured approach was now taken to conducting checks and audits of the standards of the service. Checks of the premises and equipment were carried out, in more detail, and with management oversight to ensure any remedial action needed was completed. The management and senior staff kept a communication book to pass on directions to one another about any staffing or household matters which needed to be dealt with. A comprehensive audit of infection control measures had been introduced and care documentation, medicines management and finances were audited. The registered manager and deputy manager had also undertaken a review of the home's policies and procedures. They told us a great deal of effort had been made to bring these up to date in line with current legislation and linked to the Care Quality Commission (CQC) standards of quality and safety.

The registered manager told us the provider visited the home regularly and often called in unannounced. The deputy manager felt the provider was supportive. They said he could be contacted when out of the country and ensured the management had the necessary resources for running the home.

The provider was now making records of their visits, had done some audits of the quality of the service and arranged a meeting with relatives in October 2016. This meeting had taken place on a Saturday, with refreshments provided, and was well attended. There had been informal discussion, a question and answer session with the provider and no suggestions for improving the service had been received. Copies of the new home's brochure were provided and relatives had been asked how often they wanted to be given satisfaction surveys. Some relatives we talked with felt this meeting had been a positive step. They told us they could not think of anything they would change about the home or the way it was run and said, "It seems to be everything it needs to be."

Annual surveys for people living at the home had recently been completed, with support where needed. Minutes of 'residents meetings' showed people's views were sought about activities and holidays, staff, decoration in the home, menus and checking if there were any complaints. The meetings had however lapsed and the deputy manager assured us they would schedule a date for the next one.

Surveys with relatives had been introduced and the latest findings were very positive, with all rating different areas of the service as either excellent or good. Relatives had also made a number of comments about the staff and management, such as "Staff are amazing", "The staff and manager keep the family updated on [name's] welfare at all times" and "All staff are excellent with the residents." We concluded that the provider was no longer in breach of the relevant regulation.

The home had an experienced registered manager who understood the requirements of their registration and had notified the CQC of events affecting the service. The registered manager's hours and a proportion of the deputy manager's hours were in addition to the staffing levels, to support the smooth running of the

home. The management held separate meetings with day, night and senior staff to discuss employment and care practice issues and ensure all were made aware of their responsibilities.

Relatives told us they felt the home was well-managed. Staff agreed, telling us they could approach the management with ease and that messages from them were clear and consistent. Other comments from staff included, "The manager's door is always open" and "They speak with everyone and ask questions about your day." Staff told us they enjoyed working at the home and that morale and teamwork was good. They stressed the importance of working in an inclusive way saying, "Everybody is in this together and we're all there to help each other" and that they "Loved to make people happy and see them smile." Another staff member, who had a relative living in a care home, explained they did not feel the staff were there for people and in comparison that, "The staff at Clifford House are brilliant and it is all about the residents."