Ms Alison Curtis

Clarondene Residential Home

Inspection report

View Road
Lyme Regis
Dorset DT7 3AA
Tel:
01297 442876
Website: www.clarondene.co.uk

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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?	Requires Improvement

Overall summary

The inspection took place on 16 January 2015 and was unannounced. At the last inspection on 16 May 2014, we found the provider was not meeting standards relating to cleanliness and infection control, the management of medicines and in assessing and monitoring the quality of the service. We asked the provider to take action to address these areas and send us a plan telling us how and by when they would do this. At this inspection we found that this action had been taken and completed.

Clarondene Residential Home provides personal care and accommodation for up to 12 older people. At the time of inspection, seven people were living in the home. The home is based on the ground floor of the building. The building is situated on a residential street served by a front car park and gardens to the side, with office and residential accommodation upstairs.

Summary of findings

There was a registered manager who was also the registered provider. 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.

At this inspection we found there had been improvements across a number of areas and we did not have concerns that the service was in breach of any regulations. However we found that some areas required improvement to ensure a consistent service was provided. Although there were some very stable elements of staffing, including the registered manager who was also the owner, there had been a relatively high staff turnover. This meant people had to get to know new faces regularly and family members commented that they thought this had affected their relative at times. One person told us they did not know the names of all staff. This was mitigated to some degree by the staff working closely together in a small home and being able to quickly get to know people and develop relationships with them. Although some staff felt they could influence decisions in the service, not all staff felt they could raise questions and this affected their confidence in approaching the registered manager.

People benefitted from living in a small home where people and staff quickly got to know each other. One person told us they would recommend the home to a friend. Two relatives told us they felt the home did much to keep them up to date with any changes in their loved one's care needs and they felt involved. Most people had lived at the home for some time and their needs were well understood by the registered manager and senior staff. Care was responsive and changes in people's needs were noticed and acted upon. Risky conditions were monitored and reviews were held with families and external professionals. The service sought and followed advice from experts where needed.

Within the home we observed warm interactions between staff and people who were encouraged to express themselves. Not all people could express themselves verbally; however staff adapted their communication to be able to connect with people. For example, getting down to their level if they were sitting down, using visual devices for communication and observing people's facial expressions.

Staff demonstrated they understood people's right to autonomy and respected people's right to be consulted at all times about their care. Where people presented risks to themselves or others and were not fully aware due to their mental capacity, this had been formally considered. The registered manager and deputy manager demonstrated knowledge and understanding of the formal framework for protecting the rights of people who live in care homes. They consulted with families and relevant professionals to help to protect people's rights.

Staff were trained either through induction or ongoing training which helped them to develop their knowledge. They had opportunities to shadow experienced staff if they were new. The leadership within the home had been boosted by a temporary additional management, brought in by the registered manager. This additional management support had helped to achieve improvements in the health, safety and cleanliness of the premises and in the systems and routines of care. This meant people benefited from a clean and safe environment where their needs were met effectively.

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 safe. Risk assessments were used in a proportionate and balanced way to ensure people were safe whilst ensuring their autonomy.

Staffing was sufficient to maintain a safe service.

People's medicines were handled safely.

People lived in a safe and hygienic environment.

Good

Is the service effective?
Staff were trained and helped to develop their knowledge of people to meet their needs effectively.

People were supported to maintain a balanced diet.

The service made sure people had access to healthcare services when needed.

Good

Is the service caring?
People were treated with kindness and respect and staff showed concern for their wellbeing.

People's dignity and privacy was respected.

People were listened to and given time and encouragement to express their preferences.

Good

Is the service responsive?
People received care that met their individual needs and staff showed understanding of individual needs.

People responded positively to staff and social isolation was minimised.

Changes were monitored and specialist advice sought as necessary.

The views of staff, people and relatives were sought informally; however it was not clear how they influenced learning or improvements in the service.

Good

Is the service well-led?
Resources and support were available in the service to drive improvement.

Staff were led within a caring and compassionate culture, however did not always feel empowered or that the registered manager was approachable.

Systems of checking quality and safety were sufficient and risks were known and understood.

Requires Improvement

Clarondene Residential Home

Detailed findings

Background to this inspection

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

The inspection took place on 16 January 2015 and was unannounced. The inspection was carried out by an inspector and a specialist advisor in dementia and mental capacity. Before the inspection we reviewed information received from the local authority contracts team and information we held about the provider from statutory notifications about notifiable incidents and events.

We spoke with three of seven people who used the service and two relatives. Some people were unable to speak with us so we used observation to help us understand the experiences of those people. We spoke with four members of care staff, one support staff and a member of staff working on administrative systems. We also spoke with the deputy manager, registered manager and a temporary assistant manager. We reviewed the care plans for people living in the home and associated records. We looked at management records including audits, staff duty rosters, information about the premises and safety, training records, medicines records and four staff recruitment files.

We spoke with three community healthcare professionals and two representatives from the local authority social services.

Good

Is the service safe?

Our findings

The care staff had an understanding of safeguarding and how to escalate a concern should they not be satisfied with the response from the manager. For example, care staff mentioned the Whistle-blowing policy in the context of safeguarding people living in the home. Staff confirmed that their induction training including a component about safeguarding or that they had completed refresher training, which we confirmed from staff files.

Although the majority of people were reliant on care staff to meet all their essential personal care needs, people's freedom was respected. Staff showed understanding of how to keep people safe whilst respecting their autonomy. We looked at the care of two people who presented complex needs that challenged from time to time. One person placed themselves at risk from complex needs and the registered manager and staff worked positively with them, family members and community healthcare specialists to help manage the risk whilst respecting the person's right to make choices. We observed another person who sometimes became restless, who was offered positive distraction to help them keep safe as part of their care plan. This was backed up by the use of door sensors which alerted staff if external doors were opened. This helped to ensure a balance of people's safety and freedom.

Risk assessments were based on a combination of understanding and knowledge of each person and external professional advice from a specialist such as a community nurse. Written and verbal guidance was given to staff about risks affecting people and what to do to manage and reduce any harm such as skin breakdown. One person who needed close monitoring of their skin condition was observed appropriately by staff who recorded regular updates and care given. This information was used to monitor their condition and adjust care which ensured the person received the care they needed. This had resulted in the reduction of harm and successful treatment of the person's skin which was confirmed by a healthcare professional.

People were helped to move and transfer safely. Staff demonstrated safe moving and handling procedures. We observed two members of staff assisting someone to transfer from a wheelchair to a lounge chair using a hoist, and how they worked together to ensure a smooth and confident transfer experience for the person. People were offered verbal reassurance while they were being assisted. From a review of the accident and incident records we found there had been a low number of falls or accidents affecting people at the home.

Staffing levels were adequate to meet people's needs safely at the time of inspection. The registered manager had been carrying out domestic and care duties, including night care, over most of 2014 to cover for vacancies at that time. We received information of concern in July 2014 that the service might become unstable as a result of staff leaving. By the time of inspection new staff had been recruited and in place for two months. Eleven permanent staff were employed in total and some continuity was provided by the registered manager, the deputy and two other members of staff who had been employed for over a year. The registered manager told us this staffing level was sufficient to meet the needs of all people at the home, including three people who were cared for in their rooms, either due to their choice or their level of infirmity. Staff told us they felt staffing ratios were adequate, however that there were times when people had to wait if two staff were occupied assisting someone with their personal care. Some staff had been given designated duties such as catering, night care and cleaning. The registered manager provided contingency cover and the deputy manager worked three days of the week to provide guidance and support for less experienced members of staff. This helped to ensure staffing levels were sufficient to meet the diverse range of needs being catered for by the service and that overall staffing and premises were maintained safely.

Since the last inspection, the home had experienced a relatively high staff turnover. The registered manager and deputy manager told us that the home had been through a period of instability in staffing which had an impact on the quality of the service. One person told us, "Some staff are better than others. I don't know their names. At night I have to wait but I can't expect immediate service." Two relatives told us that while the care had been maintained safely, they thought their relatives had found it difficult at times to get to know staff. However they told us they felt things had stabilised again.

From our review of the recruitment records we found that staff had been recruited safely. For example in one staff file we found identity had been verified by their passport and birth certificate. A record of a check by the Disclosure and Barring Service (DBS) was on file. Where there was a gap

Good

Is the service safe?

between a previous check and the new check from the DBS, there was a document signed by the staff agreeing to work under supervision until the new clearance was received. We looked at the recruitment files of two staff who came from overseas. Each file contained references, DBS clearance, and identity documentation. In one file there was a 'right to work in the UK document'. These checks helped to ensure that people were protected from unsafe recruitment.

People had benefitted from improvements made to the safety and condition of the premises since the last inspection. Improvements had been made to the external driveway, previously potentially hazardous for people walking outside, making it level and therefore more accessible. We were shown a report of a health and safety assessment carried out by an external contractor in January 2015 which stated that the overall standard of health and safety management was satisfactory, based on actions which had taken place since their last assessment in February 2014.. A thermometer had been fitted to the lounge to help monitor the ambient temperature. an additional heater had been supplied for this area to improve the comfort of people. Some bedroom flooring had been replaced since the last inspection to enable more effective cleaning to take place.

People were cared for in a hygienic environment. At the last inspection we found that action was needed to improve infection control and maintain cleanliness. At this inspection we found these actions had been carried out and the home and equipment looked visibly clean and there were no unpleasant odours. Daily and deep cleaning had been made a higher priority; and a specified staff member had been given responsibility for cleaning and housekeeping. A detailed schedule was in place to guide staff about each task to be carried out in each area of the home. The kitchen and laundry had been tidied of unnecessary clutter, helping to ensure more effective cleaning could take place.

A pleasant and safe atmosphere for people and staff was provided because actions were taken to prevent infection and maintain standards of hygiene. Staff were observed regularly washing hands in between tasks. Clean aprons were worn for food preparation. Staff were heard in the handover to discuss infection control in relation to laundry and remind each other of the requirement to keep laundry in the designated area when drying. We observed that the two dogs that lived on the premises did not have the free run of the home as had been previously observed. Since the previous visit the kitchen door had been fitted with a stair gate to prevent the two dogs from entering during food preparation. Staff told us that the dogs did not have the free run of the premises and were kept from the ground floor residential area for most of the day. This helped to ensure that appropriate standards of hygiene were maintained at the home.

People's medicines were managed safely. At the last inspection we had a concern about errors in relation to the administration of medicines for one person. We also received information of concern in October 2014 about pain relief not being given when needed. In the incident which was observed by the local authority, the GP subsequently advised that they were satisfied the registered manager had acted in the best interest of the person. The GP acknowledged some ambiguity in how the medicine was prescribed and that they would take responsibility for addressing this. At this inspection we found there were safe systems in place for the handling and storage of medicines. The medicines trolley and cupboard were organised to contain all relevant stock, which was listed and checked once a week by a senior member of staff. Checks of each person's medicine administration record (MAR) were carried out daily and monthly audits were carried out of all stock, including creams, prescribing and administration. Each person had an individual medicine plan, including a photo for identification, details of any allergies, guidance for 'as and when' medicines and relevant medical contact details. A recent check by the pharmacy had found the provider's arrangements for the management of medicines to be satisfactory.

Good

Is the service effective?

Our findings

Staff expressed mixed views of the support they received to do their some staff felt supported and others who did not always feel supported by the registered manager. Supervision and appraisals did take place; one staff had not had formal supervision. However, one member of staff told us there was a 'good atmosphere in the home and staff are friendly'. There was a consensus amongst staff that the care being offered to people was good. We observed staff communicating well at handover which helped to provide continuity of care and to deliver an effective service. There was a visible presence of senior staff where care was provided which helped to support less experienced members of staff.

People benefitted from staff who were supported and trained to deliver a safe service. In addition the registered manager and deputy told us that staffing roles and responsibilities had been reviewed to ensure that care staff could concentrate on providing care. A system was in place to train staff, develop their skills and keep their knowledge up to date. Staff were a mix of established, experienced and new staff. Training was given at induction and included sessions on fire safety, infection control, food hygiene, dementia awareness, first aid, equality and diversity and moving and handling. We looked at three staff training records which contained the relevant certificates for the training. Staff told us they were given the opportunity to shadow more experienced staff for a week at the beginning of their employment. It was communicated to staff that home study would also be required in view of the amount of subject matter and the two day training period. Records showed that training took place and we looked at a system recently developed to enable more regular checking of any gaps in training and supervision. This helped to staff acquire the knowledge they needed to meet people's needs effectively.

People were offered choices in their day to day care and staff sought their consent before helping them. Where people were thought to be at risk if they left the home alone, appropriate consideration had been given to any restrictions to their liberty. Accordingly applications had been submitted by the registered manager in respect of three people to ensure Deprivation of Liberty safeguards were considered by the appropriate body. CQC monitors the operation of the Mental Capacity Act 2005 (MCA) as it applies to people living in care homes, and checks there is a process which is followed and understood by staff. The Deprivation of Liberty Safeguards (DoLS) is a part of the MCA, and applies to a care homes and hospitals. The DoLs applications had been acknowledged by the local authority and were awaiting authorisation. This helped to ensure that where people's freedom was being restricted, this was done lawfully.

Where people had been assessed as unable to make decisions about their care and treatment, their mental capacity had been assessed and formally recorded as part of their care plan. A process of best interest decision making was evident. This meant that the service understood how to ensure that where someone was unable to make an informed decision because they could not understand or weigh up relevant information, this was recorded in their care plan. For example, where two people needed lap belts as a form of safety restraint in their wheelchair, a best interest decision process had been followed and recorded. The deputy manager and registered manager showed understanding and knowledge about best interest decisions. Staff we spoke with told us they had training in consent and mental capacity.

People were provided with a balanced diet and individual nutritional needs were known by staff. Where people needed a specialised diet this was catered for and that senior staff had obtained external specialist dietary or swallowing advice as needed. This was recorded as part of people's care plans and incorporated into menu preparation. We observed a choice of home cooked food on the menu and fresh vegetables and fruit being prepared for this. Food preferences were last recorded in August 2014. A record of people's diet and consumption was made in the form of a daily food and drink diary completed by staff. The deputy manager told us this had been recently reintroduced as it helped staff to see what people ate and drank and indicated what they enjoyed if they were unable to express this verbally. One person told us, "the food is very good here." We observed people eating well, either independently or having one to one support to eat. We observed drinks and snacks were offered throughout the day.

People had access to healthcare services for assessment and monitoring of their health. This included eye care, appropriate health screening and dental care. Staff worked with people's families or their representatives to ensure

Good

Is the service effective?

people could attend appointments at local clinics for example or staff accompanied people. Where people had complex healthcare needs staff followed advice from local community healthcare professionals. We observed people being informed about what was happening to them and given information about their condition. One nurse told us, “they [staff] always comply with our advice.” Another nurse told us that, “staff do contact us when needed and carry out our instructions adequately. Lately they have been more effective and gone the extra mile.”

We looked at a system recently developed to enable staff to maintain effective and accurate records of daily care delivered to each person. This was drawn up from each element of the care plan for each person and provided prompts to staff to systematically record care and observations for each person. Staff told us this helped to promote continuity of care by providing them with a picture of the person and anything they need to be aware of when they took over their care at the start of their shift.

Good

Is the service caring?

Our findings

We observed that people were treated with respect We observed each person in the home had developed positive and caring relationships with a number of staff. Staff described the ethos of the home as caring, for example, "person centred care in a homely atmosphere." We observed people responding to the care staff with warmth, reflected in facial expression and verbal interaction. People were well presented and there were displays of affection between people and staff. One person told us, "I like it here, the care is very good. I would recommend it to a friend". Staff had been encouraged to find ways to engage with people, sitting and chatting, reading or going for a walk. The home remained calm and welcoming throughout the inspection and visitors were welcomed into the home to spend time with their relative or friend. The dedicated activities person was no longer working at the home, however staff were tasked to provide opportunities for people to socialise and take part in activities which promoted their well-being. We saw this taking place. We observed three people having the opportunity to take part in an informal religious service held by a member of the local church. We saw evidence that arts and craft activities had taken place recently.

Staff showed their concern when people expressed discomfort or were observed to be uncomfortable. We observed people being offered drinks, snacks or an extra blanket for example. Staff recorded their observations about people's mood on a daily basis, which helped them be aware of people's emotional and psychological needs. Staff carried out 'Wellbeing' assessments with people, which encouraged either the person or staff on their behalf to consider specific questions about their wellbeing. These included whether someone's privacy was respected, if they were happy with the food and if their personal care was carried out to their liking. These questions had been answered either by people, their family or staff, and helped to describe their experience.

People's privacy and dignity was respected and people exercised a degree of choice about how to spend their day and about important things that mattered to them. One person told us about regular meetings with their advocate, so that their wishes could be known and followed. When staff assisted people, they took time to explain what they were doing or reassure them. Staff were discreet in how they helped people with their personal care or mobility in communal areas, treating them with dignity. Appropriate explanations of care being given were heard from behind a closed door, with clear instructions and encouragement given to ensure the person was actively involved in the process of their care. Care had been taken to provide care which took account of people's gender, where a specific need for this had been identified.

Family involvement in decisions was sought in the care of another person who had become ill. The registered manager and staff told us about how they involved the family members. Through regular discussions during visits and telephone calls people and relative's views were shared with staff and information and about the person's condition. This helped them to be an active part of the decision making about the care and treatment of their relative. We observed that the person's religious and spiritual needs were considered appropriately as part of helping to provide a positive experience. One relative told us, "the care here is fantastic and my relative could not have a better place to stay."

People were supported at the end of their life to have a comfortable and pain free death. We found examples where staff worked closely with family to ensure people's wishes were respected. The service worked in partnership with specialist staff to ensure pain relief was managed and their instructions were put into practice.

Good

Is the service responsive?

Our findings

People's needs had been assessed and were understood by staff. Each person had a written care plan based on their assessed needs. The care plan gave details about care and support needed including people's preferences and relevant personal history which helped to make the care planning and reviews focused on the whole person, including their skills and abilities. This had been set out in a daily care notes system to prompt staff understanding of each element of care needed for each individual. Staff were encouraged to read care plans and be familiar with people's care and social needs. We observed that some staff knew people very well and because the home was small. Staff worked closely together which helped less experienced staff develop good caring relationships with people living at the home. A relatively new member of staff was able to explain why some people were known by alternative names and the history behind such decisions.

People's care plans were reviewed to ensure they remained relevant and where their condition changed this had prompted a review or a referral for a specialist assessment. Where people's care and support needs changed, the service held a review with family members and relevant external professionals to consider how to adapt the care plan. We found two recent examples where the service had adapted their approach to take account of people's wishes following a review.

We observed staff adapted their communication for different people, for example taking account of verbal and cognitive ability, or any hearing or visual impairment. We observed one person assisted to communicate effectively through the use of a handheld device and a small simple whiteboard. We saw staff varying their speech for people's understanding, for example, getting down to their level if they were sitting, and speaking clearly. One person consistently had their verbal and facial expression responded to by staff and we saw they were reassured and comforted by this. Effective communication helped to ensure people did not become socially isolated either through their memory loss or sensory impairment.

The registered and deputy managers demonstrated awareness of people's choices and took this into account in the staff rota and in the planning of the day to day delivery of the service. For example, they demonstrated awareness of people's chosen activities and supported staff to spend time with people on a one to one basis where possible. We observed the managers and staff regularly checking with people how they were. When someone said their drink had gone cold they were immediately offered another cup. People's views and decisions were recorded in their care notes. We observed one person was supported to go out when they asked.

There was no recent evidence of a formal survey of people, families and or staff or visiting professionals. This meant there was a risk that the service's managers could not be sure they understood the experience of all people using the service and that they were learning from any feedback either formal or informal. However we saw that there were a number of improvements which came from the action plan drawn up following the last inspection, following contract monitoring visits by the local authority over 2014 and from two external assessments of health and safety.

Requires Improvement

Is the service well-led?

Our findings

The feedback from staff and external professionals reflected a mixed picture. Some members of staff, whilst recognising the caring culture within the home, did not always feel appreciated in their role. For example staff told us they did not always feel empowered to take responsibility for their duties or have a say in how the service was delivered. The registered manager although demonstrated they were passionate about the home and the well-being of people in their care did not always effectively communicate their overall vision to staff or others. This resulted in uncertainty in the service. Three members of staff told us they did not feel the registered manager was approachable and did not have the confidence to question practice, although two members of staff told us they had made suggestions which were listened to. Community health and social care professionals told us they felt their feedback was sometimes not seen objectively and was personalised. There was some concern that specialist mental health advice was not sought. Professionals stated that the service recently followed advice more effectively.

Improvement in the quality of the service was acknowledged by the registered manager to be very recent. People and their relatives told us there had been an impact on their experience of the service due to the changing staff. We saw that there had been a regular turnover of care staff over the last two years which affected the stability of the service and meant the quality of the service was not embedded. This was also reflected in comments by two members of staff who expressed the wish for a stable team so they could work effectively. The registered manager, who was also the owner of the service, since the last inspection appointed three additional staff to strengthen the management and administrative arrangements. There was evidence this built up the capability for improvement. This was demonstrated in the service's administration, which was significantly improved since the last inspection. This included improvements in care documentation, which helped to support a safe service and that people received care in line with their needs. The additional management support had provided mentoring and support for staff and enabled the registered manager to focus on overall improvements to premises, health and safety.

Health and safety and infection control were areas noticeably improved with a benefit to people and staff. Improvements in staffing were very recent and so although there was stability in the senior staff; it was not possible to make a judgement about consistency in all aspects of staffing at the time of inspection. Checking of quality and control of risks had improved since the last inspection. For example, we found medicine audits were detailed and up to date and the service continued to seek relevant GP and pharmacy advice about their processes. Staff competency in medicine was kept up to date through training and regular spot checks. Checking of cleanliness in the home had improved with regular spot checks, which included the kitchen. Records were kept up to date as part of an overall housekeeping programme for the home. The registered manager had developed a more systematic approach to the overall management of the service which helped to reduce the risk of important safety checks or maintenance issues being overlooked.

Information about all the improvements was readily shared with us by the registered manager and other members of staff. They knew the needs of people well and were observed responding appropriately to people. There was evidence of a caring and compassionate culture within the service, with care being delivered in a kind and sensitive manner. Individual needs and preferences were brought into the planning and delivery of the service.