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Clarendon Care Home

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**

Summary of findings

Overall summary

The inspection took place on 30 November and 2 December 2016. This was an unannounced inspection.

Clarendon Care Home is registered to provide accommodation and care for up to 20 older people, some of whom live with dementia. It is situated in a residential area of Southsea, Hampshire. At the time of this inspection, there were 17 people living at the service. The home is purpose built and accommodation is provided over two floors in single and double occupancy rooms. A stair lift provides access between the floors. There are two communal lounges and a dining room.

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 that people were at risk of harm because guidance on how to minimise risks was not sufficient and monitoring of risks was not always effective.

We identified issues with the handling of topical creams and found some gaps in the administration records of medicines.

Some people required aids to support continence. People were prescribed continence aids, which met their individual needs. However, we found packs of pads throughout the service, which were not named for the individual and were being shared communally.

People told us they enjoyed the food and were involved in planning the menus. Staff monitored people's weight to ensure they were receiving enough to eat. However, where concerns were identified, action had not always been taken to ensure people had adequate fluids.

Although staff were routinely recording accidents and incidents these were not effectively analysed and investigated to identify any trends or patterns.

Staff were kind and compassionate when they spoke with people. However, social interaction between staff and people mostly occurred when staff completed tasks for people. Care practices did not always respect people's dignity, promote their independence or enhance people's well-being.

The atmosphere in the main part of the service was warm; however, we found, that people lacked social stimulation and that few opportunities to engage in activities offered. The range of activities available to people was inadequate and not always meaningful, specifically where people had dementia care needs.

Systems and processes to ensure good governance were not being effectively operated. Records relating to

managing the health and care needs for people were not always being updated or completed by staff. People's fluid intake was not being recorded as instructed in the care plan. Wound care records were not accurate according to the care required in the care plans.

The service had a system of induction but it was not in line with current best practice. This is completion of a nationally recognised induction training programme. We discussed this with the manager who told us staff were being enrolled onto a diploma level programme and an assessor visited on the day of our inspection.

We saw that some staff had only received one or two supervision's in the last 12 months. However, the staff told us they felt they supported each other well and found the registered manager and provider approachable and supportive.

The Care Quality Commission monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The staff had a good understanding of their responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS). Staff sought people's consent about arrangements for their care.

People told us they felt safe at the service and that staff treated them respectfully. Staff understood local safeguarding procedures. They were able to speak about the action they would take if they were concerned someone was at risk of abuse.

People had access to healthcare professionals when required. This included GPs, dentists, district nurses and opticians.

Pre-employment checks were completed before new staff began work. All of the staff that we spoke with told us they enjoyed their work.

The views of people, relatives, health and social care professionals were sought as part of the quality assurance process.

Everyone told us that the registered manager was approachable and that she responded promptly to any issues they had raised.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We found one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we have told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People were at risk of harm because guidance on how to minimise risks was not sufficient and monitoring of risks was not always effective.

We identified issues with the management of topical creams. Other medicines were stored, administered and disposed of safely.

People said they felt safe. Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

There were sufficient numbers of staff to make sure that people were safe and their needs were met.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People told us they enjoyed the food and were involved in planning the menus. Staff monitored people's weight to ensure they were receiving enough to eat. However, where concerns were identified, action had not always been taken to ensure people had adequate fluids.

Staff received training in the Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) which, they followed to ensure people's consent was lawfully obtained and their rights protected.

People had access to healthcare professionals to maintain good health.

Staff were knowledgeable about people's care needs. They had received training to carry out their roles and received annual appraisal. Staff told us they felt supported by the registered manager and provider

Is the service caring?

Requires Improvement

The service was not consistently caring.

Staff were kind and compassionate when they spoke with people. However, social interaction between staff and people mostly occurred when staff completed tasks for people.

Care practices did not always respect people's dignity, promote their independence or enhance people's well-being.

People were supported to express their views and to be involved in all aspects of their care. Relatives attended review meetings.

Is the service responsive?

Requires Improvement

The service was not responsive.

People's care had been planned but did not always include detail for staff on how to engage effectively with people living with dementia.

There were gaps in some care records, which meant staff, did not always have the information to respond to people's needs.

The range of activities available to people was inadequate and not always meaningful, specifically where people had dementia care needs.

Complaints were managed in line with the provider's policy.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The service lacked appropriate governance and risk management frameworks, which resulted in poor outcomes for people who used the service.

The registered manager did not have a quality assurance system to ensure there was effective monitoring of the service and for driving improvement.

The registered manager had failed to notify the Commission of incidents in accordance with the law.

The registered manager was well respected and approachable.

Systems were in place to seek the views of people who used the service and those acting on their behalf.

People and their relatives felt able to approach the registered manager and there was open communication within the staff team.

Clarendon Care 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.

This inspection took place on 30 November and 2 December 2016 and was unannounced. One inspector undertook this inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed notifications received from the registered manager before the inspection. A notification is information about important events, which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We observed care and spoke with people, their relatives and staff. 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 care records for four people, medication administration records (MAR), monitoring records for people's food and fluid intake and weight, six staff files, staff training and supervision records, staff rotas, quality feedback surveys, accident and incident records, staff handover records, activity records, complaints, audits and minutes of meetings.

During our inspection, we spoke with eight people using the service, one relative, the registered manager, the deputy manager, two care staff, the chef, one housekeeper and the provider who was visiting.

The service was last inspected on 18 August 2014 when no concerns were identified.

Requires Improvement

Is the service safe?

Our findings

Identified and assessed risks to people's wellbeing and safety had not always been effectively mitigated. People who had been identified as at risk of skin breakdown had equipment such as pressure relieving mattresses. We found, however, that the pressure relieving mattresses for one person was not set correctly, according to the person's weight. Having the mattress set too firm or too soft could result in pressure damage occurring. There was no guidance in the person's care plan as to the correct setting. Staff we spoke with were not aware of the correct settings for the mattress. We observed the setting was at 75 kg. We reported our concerns to the deputy manager who told us the setting should be on 60 kg. However, on our second day of inspection, the registered manager told us that the setting should have been on 40 kg. By the end of our second day, the registered manager had reviewed the mattress checking system, linking weight to pressure relieving mattress settings as described in the guidance for the different manufacturers. By the end of the inspection all people with pressure, relieving equipment had a chart reflecting their weight, the mattress being used and set correctly. However, had this not been identified by the inspector people would have continued to use equipment that was not set correctly for its intended purpose to protect people from the risk of pressure sores.

We looked at records in relation to wound care for four people in relation to acute injuries from accidents. Records for these people did not consistently evidence that the wound was checked and dressings changed. The records were limited in detail, in that an adequate description of the wound had not been completed on a regular basis. We did not find any evidence of a negative impact on these people, the wound was described as improving. We did observe that one person was under the care of a visiting district nurse. However, records were not completed on how frequent the dressings required changing or how frequent the district nurse needed to visit, to treat the wound. The care plans for these people did not also document how the wounds occurred and whether or not the wounds were healing. The body maps were completed ad-hoc and were not monitored. The lack of a consistent record meant we could not be certain this care had been provided.

Two people had bedrails in place. However, staff were not clear why they were in place and there was no clear rationale within people's care plans to identify why bedrails were required. There were no risk assessments in place for the use of bedrails, which would identify any further risks such as entrapment. There was no additional evidence that the risks associated with these had been fully explored. The documentation for people who had bedrails did not show that the least restrictive options had been considered or discounted before bedrails were put in place.

Some medicines were not managed safely. We identified issues with the management of topical creams, such as barrier creams, which had been prescribed to support good skin integrity. These were administered by the care staff and were not regularly recorded. This could mean that creams had not been administered in line with the instructions of the prescribing GP. We checked the prescribed creams in two people's bedrooms. We found their prescribed cream but there was the name of another person on the tube. Creams were not dated when opened to ensure that they remained effective and were not stored in line with the manufacturer's recommendations. There was a lack of clarity around the management of topical creams,

which meant there was a risk that people's pressure areas may not have been adequately cared for.

The registered manager had not done all that was reasonably practicable to mitigate risks to people's safety because care records lacked detail and monitoring was not always effective. The registered person had not protected people against the risks associated with the unsafe handling and recording of medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager told us they audited the medicines weekly, but did not evidence this. We looked at the previous month's Medication Administration Records (MAR) and found two gaps. We showed this to the deputy manager. The member of staff responsible for the gaps in the MAR had been identified and this was being followed up. By the end of the second day of inspection, the registered manager had ensured the topical creams were correctly labelled and distributed into people's bedrooms. The registered manager also ensured topical creams were clearly labelled with the person's name and were dated on opening. With the exception of the above issues, medicines were administered by staff safely and correctly. Where people had been prescribed medicine on an 'as required' (PRN) basis there were clear instructions for staff. This helped to ensure that PRN medication was administered consistently and not used as a long term treatment. People told us that they received their medicines regularly and that they were offered pain relief when needed. Medicines were securely stored in a locked cabinet. Only the staff on duty had access to the keys. There was a clear system in place for the ordering of medication with two staff counting and countersigning for incoming medicines. Medicines were stored safely and accurately recorded. Records for the disposal of medicines were up-to-date.

Risks to people's safety had been assessed. Mobility assessments included details of specific tasks such as 'sit up in bed', 'turn/roll in bed', 'sit/stand', 'walking', 'toilet', 'dressing' including where people could manage independently and when staff were required to support them. Mobility aids that people required to promote independence were clearly recorded in risk assessments. We observed staff supporting one person to transfer from their wheelchair to an armchair using a stand aid. This was carried out safely, with guidance and reassurance provided to the person. One person told us, "I have a walking frame which makes me feel safe".

People told us that they felt safe. They said that they felt happy and comfortable to speak to any of the staff and that their possessions were secure. The service had policies and procedures regarding the safeguarding of people, which included definitions of what constituted abuse, how to recognise abuse and how to report any suspected abuse. There was a copy of the local authority safeguarding procedures on a notice board in the office so staff had details of how to report any safeguarding concerns. Staff had received training in safeguarding procedures. They had a good knowledge of what abuse was and knew what action to take. Staff were able to identify a range of types of abuse including physical, institutional, sexual, discriminatory, financial and verbal. Without exception staff told us that if abuse was suspected, they would keep the person safe, observe the person, give them 1:1 if needed, talk to their manager and if needed report their concerns to the Care Quality Commission and/or the local authority safeguarding team.

Staff had undergone pre- employment checks as part of their recruitment, which were documented in their records. These included the provision of suitable references in order to obtain satisfactory evidence of the applicant's conduct in their previous employment and a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Prospective staff underwent a practical assessment and role related interview before being appointed. People were safe as they were supported by sufficient staff whose suitability for their role had been assessed by the provider.

Staffing numbers were adequate to meet the needs of people living at the home. The registered manager used a dependency tool to determine staff allocation. This ensured there were always sufficient numbers of staff with the necessary experience and skills to support people safely. Staff told us there were always enough staff to respond immediately when people required support, which we observed in practice. There were two care staff and the deputy manager on duty from 8am to 8pm. In addition to this, between Mondays to Friday, the registered manager worked from 9am to 5 pm, offering support and guidance when needed. At night, there were two waking members of staff from 8pm to 8am. The service had a 24 hour on call system in case additional staff were needed. Rotas we reviewed confirmed there were sufficient staff to meet people's needs safely. The rota included details of staff on annual leave or training. Shifts had been arranged to ensure that known absences were covered. In addition to the care staff, there was a housekeeper who worked, 8am to 1pm Monday to Friday and a chef who worked, 8am to 1pm Monday to Friday.

Risks arising from the premises or equipment were monitored and checks were carried out to promote safety. For example, for the gas heating, electrical wiring, fire safety equipment and alarms, Legionella testing and electrical appliances to ensure they were operating effectively and safely. The service had a fire risk assessment, which included guidance for staff in how to support people to evacuate the premises in an emergency.

Requires Improvement

Is the service effective?

Our findings

Records did not demonstrate that risks associated with nutrition and hydration had been monitored to ensure people's safety. Fluid charts were completed for people who had been identified as being at risk from dehydration; however, we saw that these were not completed in a timely manner, which increased the risk of error and inaccuracies.

Fluid monitoring charts did not include the volume of output and intake had not been totalled to demonstrate that the person had enough to drink. There was no information in the care plans of people who were at high risk of dehydration in relation to ensuring people drank sufficient quantities to minimise dehydration risks. Fluids at night were given out just after 8.00pm. The registered manager said they promoted fluids throughout the night. However, records showed fluid intake between 8.00pm and 8.00am with many gaps, with no record as to why.

We monitored two people's fluid intake during our two-day visit. We documented on the first day of our visit what fluid staff had recorded as being given. On the second day of our visit, we checked the records from our first day and staff had recorded fluid had been given at regular intervals; however, our observations were that this was not accurate. For example, we observed for one person they had their fluid chart completed on five occasions to say the person had been given fluid. At the end of the day there were a further 24 entries. We had visited the person at the times stated as them being offered fluid, and found the entries documented did not reflect our observations. For another person we measured their fluid in their jug and cup, staff recorded that fluid had been given, when it had not. We informed the registered manager of what we suspected was happening at the start of our inspection on day two. The registered manager agreed to monitor the same two people with us during day two. This enabled the registered manager to identify why the documents were not accurate and immediately address these serious issues.

We observed these two people as appearing thirsty, both people had dry lips, one person who was unable to ask for a drink, stuck their tongue out. The registered manager offered both individuals a drink, which was accepted by the persons. Both of which, gulped the drink, demonstrating they had been thirsty. This meant the systems in place to ensure people had sufficient fluids to help keep them well were not robust.

The registered manager was unable to demonstrate that the hydration needs of people were being met. This is a breach of Regulation 14 of the Health and Social Care Act (Regulated Activities) Regulation 2014.

Following our identification of these concerns, the registered manager implemented new monitoring forms, which included what volume of fluid, should be consumed, a section for the fluid to be totalled and analysed. They had also been updated to include, all entries to be signed by staff, therefore taking accountability for the entry and enabling more transparency. The registered manager arranged 1:1 meetings and a team meeting to address these serious concerns.

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 services and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We found that appropriate DoLS applications had been made, and staff were acting in accordance with DoLS authorisations. Where Deprivation of Liberty Safeguards decisions had been approved, we found that the necessary consideration and consultation had taken place. This had included the involvement of relatives and multi-disciplinary teams.

We checked people's files in relation to decision making for people who are unable to give consent. Documentation in people's care records showed that when decisions had been made about a person's care, where they lacked capacity, these had been made in the person's best interests. Records showed that staff had received training in the MCA and DoLS. When we spoke with staff, they were able to tell us their understanding of the MCA and DoLS. Staff were knowledgeable and were able to apply the requirements of the acts in practice ensuring peoples day-to-day care and support was appropriate, and that their needs were met.

Not all staff had received supervision sessions in line with the provider's policy, which stated staff should receive supervision four to six times per year. Six staff files showed that the staff had only received one to two supervisions in the last year. However, staff told us they felt very supported by the team and the registered manager. They told us the management had an open door policy and could approach the deputy manager or registered manager any time if required. We spoke with the registered manager about their plans for supervisions. They told us that part of their plan was to review the provider's policy and update it to reflect staff should receive at least three supervisions per year. By the end of our second day, the registered manager had arranged supervision with each member of staff for December.

The service had a system of induction; however, it was not in line with a nationally recognised induction training programme. This is designed to provide staff new to the care sector with the necessary skills and knowledge to carry out their role safely. We discussed this with the registered manager who told us the organisation had chosen the option to enrol staff onto a diploma level programme. Staff were supported through the programme by assessors. To achieve the diploma candidates must prove that they have the ability to carry out their job to the required standard. Each new employee spent one week shadowing experienced staff on a supernumerary basis. This allowed them time to get to know the people they would be supporting and to understand their role and responsibilities.

The registered manager maintained a spreadsheet record of staff training in courses considered mandatory to provide effective care and recorded when staff had completed these. This allowed the registered manager to monitor this training and to check when it needed to be updated. These courses included infection control, moving and handling, fire safety, first aid, health and safety, food hygiene, safeguarding and the MCA. Staff told us the training they received was of a good standard.

Each person either had their own bedroom or shared with one other. Rooms were personalised Staff had helped people to personalise their rooms and make them more homely.

Food was produced using fresh ingredients, to a good standard and offered good choice to people. People could choose to eat in the dining room or other areas of the home. A main meal was cooked at lunchtime taking into account people's preferences, but people had the choice of an alternative. A good variety of food

and healthy snacks was available including fruit. People enjoyed the food at the service. During lunch we heard comments including, "That looks nice", and "It was delicious". The mealtime experience in the main dining area was positive and enjoyable with plenty of conversation between staff and people. The chef explained that they used a four-week menu, which consisted of two main meal choices and changed with the seasons. People had the opportunity to make suggestions about the catering at residents' meetings or directly to the chef.

We looked at people's care plans in relation to their dietary needs and they included detailed information about people's dietary needs and the level of support they needed to ensure that they received a balanced diet. People's weight was monitored where they were assessed as at risk of not receiving adequate nutrition. This was monitored and professional advice obtained if required. Annual reviews that took place with local authorities demonstrated staff always sought advice and guidance when needed.

People's care records showed that their day to day health needs were being met. People had good access to healthcare services such as dentist, optician and GPs. People's care plans provided evidence of effective joint working with community healthcare professionals.

Requires Improvement

Is the service caring?

Our findings

We saw some good examples of kind and caring interactions between people and staff. People and a relative spoke well of staff commenting, "Staff are caring", "The girls are kind to me" and "Staff help me." However, despite the quality of staff interactions being good, these interactions were brief and infrequent.

Over our two-day inspection, we spent a total of three hours observing people's care in the lounge. During this period, there were between 12 to 14 people in the lounge at any one time. These people were sat in the same place throughout the duration of our observation. People were clearly happy when staff spoke with them. We saw their faces light up and they smiled broadly when care staff had a brief conversation with them. However, these interactions did not occur very often and in between these very fleeting interactions with care staff, people were not engaged. During this observation, one person was visibly distressed and crying for 45 minutes. We saw one staff member make eye contact with the person but did not offer assistance or comfort.

We found the approach of some staff to be largely task-based and not person-centred. Some staff actions were based on the convenience for staff rather than the person's preferences. People's individual views and wishes were not always taken into account and there was little support to help people develop and maintain their independence. Staff did not encourage people to take some risk by doing things for themselves. For example, we observed that if people tried to get up, staff would intervene and encourage them to sit down in case they fell. The registered manager told us she had made the decision to put in place motion sensors to monitor the movement of 12 people in their rooms. We asked the registered manager the reason for using sensors. The registered manager told us, that once the person moves from their position, for example, from the bed to walk or from a chair, the sensor is triggered and this alerts a member of staff in the building. We were told by the registered manager that the member of staff then supports the person back to where they were, for example, back into bed or their chair. This practice appeared to be 'normal' for staff and showed that rather than helping people to get up and walk around, with whatever assistance was appropriate, people were expected to stay sitting or lying down. This did not promote people's independence or seek to respect their wishes for wanting to move elsewhere.

When we asked staff how they assisted people to maintain their dignity, they were able to give us examples of the steps they took to promote this. During our inspection, we saw that people received assistance with their personal care in private. However, on one occasion during the morning of our inspection we observed that a person's commode had been used and the lid was removed. On entering the bedroom at lunchtime, we found the person eating their lunch next to the commode, which had not been cleaned. We brought this to the registered manager's attention, who confirmed staff must have been into the room to give the person their lunch. However, no action had been taken by staff to empty the commode and clean it. This did not promote this person's dignity.

The service did not always respect people's dignity, promote their independence or enhance people's well-being. This contributed to a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

On other occasions, we saw that staff members reacted kindly to people's needs and wishes. For example, we saw one staff member warmly explain to a person their lunch was ready. We saw that the staff member had made eye contact with the person, smiled and held their hand. The tone of their voice was upbeat and kind. We saw that the person reacted positively to the staff member's approach by returning a smile.

Most people were supported to express their views and to be actively involved in making decisions about their care, treatment and support. The majority of people were able to be fully involved; however, there were a small number of people who lacked understanding in day-to-day decisions about their care and treatment. The registered manager asked relatives whether they wished to be involved in decisions about their family, member's care and how often they would like review meetings to take place.

Visitors told us they were always made welcome and were able to visit at any time. People were able to see their visitors in communal areas or in their own room. The home had no restrictions on visiting hours and people's friends and relatives could come and go as they pleased.

Requires Improvement

Is the service responsive?

Our findings

The care we saw provided to people during the inspection was often task orientated rather than in response to each person's individual needs. We found there was little social interaction with people from staff, apart from when staff spoke with people while carrying out a task with them.

The registered manager told us that a member of care staff provided activities on Tuesdays and Thursdays between 2pm to 3pm. We were told that the activities consisted of quizzes, discussion around films and playing music. However, the registered manager did not have records to confirm these activities took place and how many people participated. People told us this did not happen. The registered manager told us that on two occasions per month somebody externally came in to play music and offer memory games to support people with dementia. However, records of this happening were also not kept. There was no information board for people to inform them when these activities would occur, leaving people not knowing when activities would happen. The range of available activities was limited and did not appear meaningful or planned specifically for people who had memory issues or dementia conditions.

People told us they were bored, comments included, "There is nothing to do", "All we have is the TV" and "There is nothing to do here, it's boring". Activities were not provided during the two days of the inspection. We observed staff sitting with people talking, but there was no evidence that activities had been personalised to people's individual preferences and choices. There were large parts of the day when people were either in their rooms or sitting in the communal lounge without any meaningful interactions with staff. We observed the television was switched on in the lounge during our visit. However, no one appeared to be watching this and we did not hear staff asking people if they had any preference for a particular channel or programme. This meant some people spent the majority of their time in the lounge or in their room, either sleeping or unoccupied, looking ahead but not engaging. For people who were looking ahead and not engaging, we spent time to speak with and they were happy to engage and chat with us, demonstrating that people were receptive to more opportunities for stimulation and engagement.

We saw people were sitting waiting for their next meal or for something to happen. Some people had a newspaper to read but most were bored and slept for long periods. The lack of activities and interaction showed that staff had not understood people's needs and choices, or were unable to provide support based on their preferences. This placed people at further risk of social isolation, withdrawal and low mood, particularly for people living with dementia where social stimulation is essential to living well with the condition.

People's care and support plans were not centred on individual needs and were not always used by staff to provide consistent care and support. Care plans were task focused and did not contain information about what was important to people or their interests and preferences. Some care plans contained in depth information about the person's life history, where as other care plans did not have information in this area. This meant that staff did not always have access to information in relation to what was important to people. Staff told us they did not rely on the care plans as they felt they knew people well enough. This put people at risk of receiving inconsistent support.

People were prescribed continence aids, which were intended to meet their individual needs. We found packs of pads throughout the service, which were not named for the individual and were being shared communally. This meant people might not get the aid specifically prescribed for their size, which could result in them not being properly supported with their continence needs.

Some people were cared for in bed because they were frail or poorly. We saw staff ensured people who were able to use their call bell were left with it accessible to them, so that they could ring for staff if needed. However, some people were not able to use their call bell due to their health conditions and staff told us these people were checked every two hours. These checks did not involve spending any time with people and we observed the only contact people had with staff was when tasks were completed. We found no assessment had been completed to determine the length of time between checks or how risks of social isolation were minimised for people who were unable to gain staff attention if needed.

The above evidence shows that the registered manager had failed to ensure people received person centred care, which met their needs and reflected their preferences. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We shared our concerns regarding the lack of activities and engagement with the registered manager, who assured us the activity programme would be immediately reviewed and, an activity board purchased by the end of December 2016, to ensure people knew what was going to be offered and when.

Handover records sampled showed entries were completed by staff twice a day between 8 am and 8 pm. Handover records demonstrated that when staffing teams changed shift, people's needs were discussed such as their health and their mood. This helped ensure people's needs were monitored and that all staff were aware of any changing needs. At the handover meeting, a nominated staff member on each shift recorded what each person had done that day. It detailed what else was planned, a reminder for staff to read the house diary for appointments and the name of the carer who was nominated to administer medication. Daily records compiled by staff detailed the support people had received throughout the day and this followed the plan of care.

People were invited to share their views during regular informal residents' meetings. We saw that the menu and activities were regular features on the agenda. People told us that they felt able to speak with the registered manager. Some relatives had attended individual meetings with the registered manager, which were recorded. Suggestions from these meetings, such as for a person wanting their own separate menu with their choice of food had been acted upon.

Complaints were listened to, investigated and managed in line with the provider's policy. One complaint had been recorded within the last year and this had been resolved satisfactorily.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had failed to notify the Commission of specified incidents that are required by law. We found that authorisations of Deprivation of Liberty Safeguards (DoLS) had not been notified to the Commission and that five people suffered serious injury, but these were not reported.

The registered manager had failed to act in line with their legal responsibilities. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The registered manager had failed to ensure that effective management systems were in place to assess, monitor and improve the quality of service people received.

We asked the registered manager to show us what quality monitoring had been undertaken since the last inspection in 2014. The registered manager told us she audited all aspects of the service, for example medication on a weekly basis, health and safety aspects every month, but had not documented or recorded this. Therefore she could not demonstrate any actions taken to ensure the quality and safety of the service.

Although the provider came to the service regularly, he did not provide effective oversight or quality monitoring. As a result, he was not aware of the issues that affected people's safety and quality of care which have been highlighted in this report.

Audits could not be evidenced and there were no effective systems in place to ensure people's needs were properly monitored and reviewed to inform their care planning. There were no systems in place to check monitoring charts, for areas such as food and fluid intake or pressure relief had been completed and any concerns had been acted on. There was evidence that people's care needs were not being met. Service-wide concerns were identified at this inspection, including several breaches of Regulations. However these concerns had not been identified until the inspector brought it to the registered manager's attention.

People could not always be assured that changes were made to improve the service as a result of accidents and incidents. Accidents and incidents were not analysed and learnt from. There were a number of people who had sustained falls but no investigation had been conducted into these and no action had been taken as a result, such as care plans and risk assessments being reviewed and updated.

We found that staff were not actively involved in developing the service. Whilst staff did feel they could make suggestions about the service this was on an ad hoc basis as there were no formal systems in place to support and enable staff involvement.

Appropriate systems were not in place to assess, monitor and improve the quality of the service, resulting in the multiple breaches of regulation identified during this inspection. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each time we informed the registered manager of our findings, she immediately responded by ensuring

shortfalls were addressed. This included informing the safeguarding team of concerns, reviewing and updating monitoring forms to ensure they were more descriptive and arranging staff meetings to offer additional support and guidance. By the end of our second day, the registered manager and provider had also implemented a comprehensive audit tool to ensure that all areas of the service, including the areas of shortfall we identified would be audited on a weekly basis, with immediate effect. Both the registered manager and provider had been receptive to our feedback.

Resident and relative meetings occurred in January, April and July 2016 to gain views about the quality of the service. We read minutes of group meetings with staff, people and their relatives. These recorded that the registered manager invited people to speak with her openly at any time with any concerns or queries. The registered manager told us that she worked flexibly; to give working relatives the opportunity to meet with her face to face and in private, which a relative confirmed.

Surveys had been completed in 2016 to measure the opinions of people, their relatives and staff. Results had not yet been analysed. There were six responses from people and their relatives. Feedback overall were all very positive. Comments included, "We are very grateful for all your efforts" and "The staff are absolutely excellent and we couldn't ask for more from what we have seen on our visits".

Staff said that good teamwork was crucial in moving forward. Staff told us that they felt able to speak frankly with the registered manager with any concerns about the service and understood their responsibility to whistle blow if necessary.

People told us that they felt the culture and atmosphere at Clarendon Care Home was relaxed and open. One person said, "I do get bored, but it is a friendly home." A relative told us "This is a lovely service, the staff try hard". The staff we spoke with also felt that there was an open and honest culture. Staff praised the registered manager's approach saying that the registered manager was happy, supportive and positive.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered manager had failed to notify the Commission without delay the outcome of peoples DoLS applications and five injuries that required hospital treatment as required to do. (1) (2) (a) (ii) (4B) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered manager had failed to ensure people received person centred care, which met their needs and reflected their preferences. (1) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect The service did not always respect people's dignity, promote their independence or enhance people's well-being. (1) (2) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered manager had not done all that

was reasonably practicable to mitigate risks to people's health and safety because care records lacked detail and monitoring was not always effective. People had not been protected against the risks associated with the unsafe handling and recording of medicines.

(1) (2) (a) (b) (e) (g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered manager was unable to demonstrate that the hydration needs of people were being met. (1) (2) (a) (ii) (b) (4) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Appropriate systems were not in place to assess, monitor and improve the quality of the service, and the records were not always complete and accurate, resulting in the multiple breaches of regulation identified during this inspection. (1) (2) (a) (b) (f)