Clarendon House Care Limited

Clarendon House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Clarendon House is registered to provide accommodation and personal care for up to 23 older people, including people living with dementia. There were 21 people living at the home on the day of our inspection visit.

At the last inspection of the service in November 2014 we rated the service as Good. Since the last inspection the provider had changed their provider name to Clarendon House Limited. This meant the service was required to be re-inspected and rated. We inspected Clarendon House on 28 April 2017. The inspection was unannounced.

There was a registered manager for the service. 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.

The provider had policies and procedures to make sure people remained safe at Clarendon House. These included a safeguarding procedure and a process to manage risks associated with people's care. Staff understood their responsibilities for keeping people safe and for reporting concerns about abuse or poor practice within the home. Staff were properly checked before they could work in the home and there was an effective procedure for managing people's medicines.

The registered manager understood their responsibilities in relation to the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Where people had their liberty restricted in their best interests, applications had been submitted to, or authorised by the Supervisory Body. Staff understood how to support people to make decisions about their daily lives.

There were enough suitably trained staff available to keep people safe and to respond to people's needs. Staff received the training and support they needed to meet people's needs effectively.

Staff had good knowledge of people's needs, preferences and abilities and provided safe and effective care to people. Staff had a handover meeting when they came on shift to keep them up to date about people's care needs. Care records contained individualised information about how people liked to receive their care.

The provider used a computerised care planning system that provided up to date information about people's care needs to staff.

People told us staff were kind and caring. Throughout our visit staff showed people kindness and treated people with respect. People were treated as individuals and were encouraged to make choices about their care. Staff protected people's privacy and dignity when providing care.

There were processes to ensure people's nutritional needs were met and people had enough to eat and drink during the day. People's health needs were monitored and people were referred to healthcare professionals when a need was identified.

People were supported to pursue individual hobbies and some activities were available to people. The registered manager was looking at ways to develop the activities programme so people would be better occupied and stimulated during the day.

Relatives and friends could visit people at any time. People's feedback was sought by provider surveys and meetings held in the home. People knew how to raise concerns or complaints and information about making complaints was displayed in the home. The registered manager had an 'open door' procedure for anyone who needed to see them.

The provider and registered manager had systems to monitor and improve the quality of the service. This was through feedback from people and staff, and a programme of regular checks and audits on care records and the environment.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was Safe.

Staff knew how to keep people safe and what action to take if they had any concerns about people's safety or wellbeing. Staff understood how to manage identified risks to people's care and there were enough staff to keep people safe. The provider had safe procedures for recruitment of staff and managing and administering medicines.

Is the service effective?

Good

The service was Effective.

People were supported by staff who had completed an induction and training to provide effective care and meet their needs. Where people lacked capacity, the registered manager understood the principles of the Mental Capacity Act 2005 so people's rights were protected. People's nutritional and health needs were monitored to maintain people's health and wellbeing.

Is the service caring?

Good

The service was Caring.

Staff were friendly and had formed good relationships with people. Staff understood how to provide emotional support for people who became anxious or upset. People were supported by staff who were considerate and maintained their privacy and dignity.

Is the service responsive?

Good

The service was Responsive.

Staff had good knowledge of people's individual preferences and how they liked to spend their time. Staff provided the care and support people required, and were kept up to date about people's care needs through care records and a handover meeting at the start of each shift. People knew how to complain

if they needed to.

Is the service well-led?

Good

The service was Well Led.

The registered manager understood their responsibilities and provided good leadership. Care staff felt supported to carry out their roles and said the registered manager was always available and approachable. The provider and registered manager regularly monitored the quality of service people received through a series of audits and checks.

Clarendon 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.

The inspection took place on 28 April 2017 and was unannounced. The inspection was undertaken by two inspectors and an expert by experience. The expert by experience was a person who had personal experience of caring for someone who had similar care needs to people living at the home.

Before our visit we asked the provider to complete a Provider Information Return (PIR). The PIR 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 found the information in the PIR reflected how the service operated.

We reviewed the information we held about the service. We looked at information received from relatives, from the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

During our inspection visit we spoke with five people who lived at the home, and two relatives. We spoke with the registered manager, a senior care staff, three care staff, an agency care staff and the cook. We also spoke with a health professional who visited the home while we were there.

We observed people's care and support during the day. Some people at Clarendon House were unable to tell us, in detail, about how they were cared for and supported because they were living with dementia. To help us understand people's experience of the service 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 to us.

We walked around the home to view the environment. We reviewed five people's care records to see how their support was planned and delivered. We checked whether staff were recruited safely and trained to deliver care and support appropriate to each person's needs. We looked at other records related to people's care including the service's quality assurance audits, records of complaints and incident and accidents at the home.

Good

Our findings

Most people at Clarendon House were living with dementia, so it was difficult to ask some people specific questions about feeling safe. We observed how people and staff interacted with each other. We saw people were relaxed with staff and there were positive relationships between staff and people living in the home. People were confident to approach staff with requests for support or to have a conversation, which indicated they felt safe. People we spoke with told us they felt safe at the home, one person said, "I'm quite comfortable and safe really." Staff we spoke with said people were safe. They told us this was because, the environment was secure for people who were unable to go out unsupported, and "There are enough staff to support and observe people," so they remained safe.

Staff told us there was enough staff to keep people safe and respond to their needs. One staff member told us, "Today we have a cook, four staff, one senior and the manager. I do think there is enough staff, we pull together and work as a team so we can get things done." Since the last inspection in 2014 the registered manager had increased the staffing in the home. They told us there was now a senior and three care staff on duty during the day and two care staff at night. They had appointed additional kitchen, domestic and laundry staff so care staff could concentrate on providing care and support to people, without having to complete kitchen or cleaning duties. The registered manager told us the increase in staff had provided additional supervision of people within the home as there were 'more eyes on the floor.' During our visit there was enough staff to meet people's need and keep people safe.

We looked at the staffing rotas for the past three weeks; these confirmed what the registered manager had told us. To ensure people remained safe the registered manager said they made sure there was a trained first aider and a person trained to administer medicines on each shift.

The registered manager told us they had one full time vacancy that was being recruited to, which was being covered by agency staff until the post was filled. They told us the same agency staff were used to provide continuity of care for people and to make sure they got to know people and how the home was run. Care staff we spoke with confirmed the same agency staff were used. One staff member said, "We normally have the same agency staff so they know the residents and their routines."

The provider's recruitment processes for employing staff ensured risks to people's safety were minimised. A staff member told us, "I had an interview, my DBS check, I had to show my certificates, for moving and handling and dementia. I had to have two references and a character reference before I could start." We checked three staff recruitment files. Records showed the provider obtained references from previous

employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS provides information about a person's criminal record and whether they are barred from working with people who use services. Staff told us they had to wait for checks and references to be returned before they started working with people. These checks ensured, as far as possible, staff were of suitable character to support people living in the home. When using agency staff the provider obtained confirmation from the agency that the staff member had been properly checked to provide care to people.

People were protected from the risk of abuse or poor practice. Staff had completed training in safeguarding adults and understood their responsibilities for keeping people safe. Staff demonstrated their awareness of what constituted abuse and knew what they should do if they had concerns about people's safety or if they suspected abuse. One staff member said, "Abuse could be physical, financial or unexplained bruising. Another told us, "Safeguarding is learning to recognise signs of potential abuse, you might see bruises on a client, you can take a picture with the devices we have so you have immediate evidence." Our discussions with staff confirmed they understood the importance of reporting concerns to a senior member of staff. Comments included, "I would let [registered manager] know if I had any concerns." And, "I would speak with [registered manager] and I could report it to her manager or CQC if I wanted to go above her head." The registered manager understood their responsibility to report safeguarding concerns, and had referred concerns to the local safeguarding team and submitted notifications to us as required.

The provider had a whistle blowing policy (this policy supports staff to raise concerns, in confidence, about staff practice, or wrong doing in their workplace). Staff confirmed they were confident to raise concerns with the registered manager or the provider if they witnessed poor practice.

Risks associated with people's care were assessed prior to admission to the home so the provider could be certain they were able meet people's care and support needs. Staff we spoke with understood risks associated to people's care and knew how to manage those risks safely. Staff told us they could access people's risk assessments with information about how to support people, on their IPOD. Each staff member was allocated an IPOD, an electronic hand held device which they used to access people's care records.

Staff had a good understanding of people's mobility skills and who required equipment to help them move. Where people required assistance to move around we saw staff supported people safely. For example, one person used a walking frame; staff walked alongside the person and gave guidance about how to use the frame safely. We also observed staff using equipment such as a hoist to move people. Staff were competent and confident using the equipment and people were transferred safely. People's care records contained mobility care plans and risk assessments that instructed staff about the individual support people required to move around.

People who had restricted ability to move around had plans completed to reduce the risk of damage to their skin. Staff understood how to reduce the risks of skin damage to people. For example, people had pressure relieving mattresses on their beds and cushions on the chairs. We saw staff move people's pressure relieving cushions onto lounge chairs when they transferred people from wheelchairs. One person wore padded boots to reduce the risk of skin damage to their heels. The registered manager told us if staff noticed any changes to people's skin they reported this to her or the seniors so they could contact the district nurse or GP.

The registered manager told us most people were unable to use the call alarms in their rooms to call for assistance due to their dementia. They told us hourly checks were completed at night to ensure people remained safe and well. We saw there were 'bar codes' on bedroom doors that could be scanned to evidence staff completed regular checks.

Accidents and incidents in the home were recorded. The records were checked and monitored by the registered manager to identify any trends or patterns. They told us since staffing in the home had been increased the amount of falls to people had reduced. Staff were aware which people were at risk of falling due to poor mobility and their dementia, and there were procedures to reduce these risks. These included beds that could be lowered and floor sensors to alert staff when the person was out of bed.

We checked to see whether medicines were managed safely. Medicines were stored safely and securely and kept in accordance with manufacturer's recommendations to ensure they remained effective. We observed a senior staff member administer medicines to people. They understood the provider's medication policy and procedure and were confident giving medicines. They took their time to speak with people whilst administering their medicines, offered people drinks and explained what they wanted them to do. For example, "Time for your eye drops (name)", in a friendly pleasant way, and chatted whilst administering the drops. They asked the person if they required any pain relief tablets. When they responded, "Yes, two please", the senior went to get them and then observed the person took the tablets before leaving them. We looked at a sample of medicine administration records. These had been signed by staff to confirm medicines had been given as prescribed or a reason had been recorded why they had not been given.

Medicines that required additional safety checks had been stored, recorded and signed for as required. Two people were prescribed patches for pain relief. There was no written guidance from the pharmacist about where to place the patches. The staff member administering medicines told us they alternated where the patches were placed on the person's chest. However, the guidance with the medicine advised not to use the same area for three to four weeks. The registered manager took action to provide written instructions for staff to follow, that included a body map for additional guidance while we were there.

Where people were prescribed medicines "when required" for example, pain relief, there was instructions in place to ensure staff gave them safely and consistently. The registered manager said only a 'responsible person' administered medicines. A responsible person was a staff member that had completed training and been assessed as competent to give medicines safely.

The provider had effective systems that kept people safe in an emergency. These included regular fire alarm testing and fire equipment checks. Each person had a personal evacuation plan that provided the emergency services with important information about their mobility and any equipment needed to evacuate them safely.

There were procedures to ensure the premises and equipment in the home remained safe. The provider employed a maintenance person who completed routine checks around the building and carried out repairs. During our inspection we noted the cleaning trolley, with cleaning solutions, had been left unattended in a corridor. We were concerned as people could have mistaken the cleaning solutions for drinks. We discussed the risks to people with dementia with the registered manager and with the domestic, who told us they usually took the trolley into the rooms with them. The registered manager moved the trolley and instructed the domestic not to leave this unattended in future.

Good

Our findings

We looked at how the provider was meeting the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The 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. Where people lack mental capacity to take particular decisions, any decisions made must be in their best interest and in the least restrictive way 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 registered manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). They explained, "Where I have been concerned about a person's capacity, I have arranged for a mental capacity assessment and a best interest meeting." Records showed where people did not have capacity; decisions were made in their best interests in consultation with family and others involved in the person's care. For example, where people refused medicines that were important for them to take, it had been agreed for this to be given covertly (disguised in food or drink).

Staff had received training in the MCA and understood the need to support people to make their own decisions. One staff member told us about MCA, "It was put in place to help people who are not able to make a decision. They have to have assessments. For example [Person's name] is not always compliant with care, and can get agitated sometimes." They went on to explain how staff intervened to make sure the person received personal care. Another staff member said, "MCA, I have done this [training]. It is about decision making, you don't make the decisions for them [people].

Several people at Clarendon House were living with dementia and had restrictions on how they lived their lives. People were under constant supervision and were unsafe to leave the home on their own. There were coded locks on the external doors to keep people safe. Applications for DoLS had been authorised or applied for and documents to confirm this were available on people's care files. The registered manager had sent the required notifications to CQC when a DoLS had been authorised. Staff knew which people had authorised restrictions on their lives. A member of staff told us, "DoLS are in place to protect people from leaving and keep them safe. [Person] would not know where they were going. It is needed to protect them."

Staff had the skills and experience to carry out their role effectively. Newly recruited staff completed an induction which involved working alongside experienced staff before they provided care on their own. A

member of care staff said, "I am still on my induction, [staff name] is my buddy. I was coming in for training before I started, I have had moving and handling, fire safety, and food safety training." The registered manager told us the induction programme for new staff was based on the Care Certificate. The Care Certificate sets the standard for the fundamental skills, knowledge, and behaviours expected from staff working in a care environment.

We asked staff about their training. Staff said the level of training was good, and that they received regular training to keep their skills up to date. For example, "The raining is good. I have done a moving and handling refresher, control of hazardous substances, and the Mental Capacity Act. Yesterday I did fire marshal training, it was a refresher. It reminded me of my responsibilities, as I could be legally held responsible." All staff said they completed training to meet the needs of people living at the home. This included moving and handling training, safeguarding, and dementia awareness. A new staff member told us they had completed dementia training with a previous employer, "I went on a course for people with dementia, it was over six weeks. It lets you know why the person is more vulnerable, some people vary in their capacity, you need to be patient and put yourself in their shoes." The training records showed all staff, including non-care staff completed dementia awareness so they could interact effectively with people. We observed staff put their training into practice during our visit. Staff used equipment to move people safely, communicated effectively with people living with dementia, and safely administered medicines. Where people showed signs of agitation staff knew how to interact with people to calm them and reduce their anxiety.

Staff said they were supported by the provider to complete a qualification in social care, such as a national vocational qualification (NVQ). One staff member told us, "I am doing a foundation degree in health and social care." Another said, "I have completed my NVQ level 2." Training records showed staff training was updated regularly.

Staff told us, and records confirmed they had regular supervision meetings with the registered manager to monitor their knowledge and learning. They said during supervision they discussed their personal development and training requirements.

We spoke with the cook about people's dietary needs, they told us, one person had softened food which was able to be mashed with a fork and another person had a pureed diet due to their risk of choking. They went on to say "We have no vegetarian diets and no one with cultural needs." A menu for the day was available on a chalk board in the dining room. This showed the evening meal was fish, chips and peas, or fishcake, chips and peas or poached fish and mashed potatoes. The cook told us, "It is poached fish today for soft diets and some other people ask for this too. People can have snacks in between meals. I make sandwiches and these are kept in the fridge. The night staff can come in here and get food for people. I don't order the food, but I make the list." The registered manager told us they were not restricted on the food they ordered and told us, "I often overspend on food as I like to get people what they want."

The registered manager told us they had changed mealtimes recently and had moved the main meal to the evening and served a snack meal at lunchtime. They told us they had suggested this change to see if eating the main meal nearer to bedtime improved people's sleep patterns, which they said it had. People had been consulted about this, and had agreed to change the meal times.

We observed the lunchtime meal. People were able to choose where they ate their meal. Most people sat in the dining areas, others sat in the lounge while some preferred to eat lunch in their rooms. The lunchtime meal was a selection of sandwiches, or tomatoes on toast. We saw one person was provided with an alternative choice, as the cook knew this person did not like sandwiches. People were offered a drink with

their meal, some people had a cold drink and others were offered a cup of tea. There were enough staff available to serve people their food and to offer people encouragement or assistance to eat if needed.

Where people required assistance to eat and drink, staff sat at the table alongside people. People were not hurried to eat, and when people said they were finished staff prompted some people to eat a little more before they took their plates away.

During the day we noted one person who required thickened fluids had three different thickened drinks on a table in front of them. The person had not drunk much from any of the drinks. A member of staff bought the person another thickened drink, and told us the person preferred their drink warm. We looked at the fluid records for this person; this showed an accurate account of what had been offered and the amounts of fluids taken had been recorded.

People's health and welfare was monitored and referrals made to health professionals when needed. For example, records showed people had assessments of their nutritional needs completed. Where people were at risk of dehydration or malnutrition their food and drink intake was monitored to ensure they received sufficient. People were weighed regularly, if their weight fluctuated this was monitored more frequently and referrals made to their GP or the dietician. People had other health conditions regular monitored, such as skin integrity, to make sure their wellbeing was maintained. People received regular visits from their GP or the district nurse to monitor health conditions. A health professional who visited while we were at the home told us, "I don't have any concerns with this service. There is a good manager and I have no concerns with the carers. They call me out appropriately." The registered manager told us the local GP will hold a surgery at the home if requested. They told us the GP surgery was "100% approachable and responsive to requests. There is never a problem referring people to the falls clinic, dietician of speech therapist."

People had a hospital transfer record completed, which the service referred to as a 'grab sheet'. These included a summary of people's physical and emotional needs. Should they need to be admitted to hospital this would support hospital staff to understand people's existing health conditions, their mobility and capacity to make decisions.

Good

Our findings

During the day we observed interactions between staff and people who lived in the home. Staff were observed to be caring and attentive with people and there were mutual friendships between staff and people. Staff told us, "I love working in the home, I look forward to being here." And, "[Name] loves hugs and kisses." Another said, "I think people see us [staff] as a family."

We asked the registered manager how they made sure staff had the right attitudes towards their work and were kind and caring. They told us, "I think I'm a good judge of character, making sure I have the right staff with the right attitude starts at the interview process. I ask them questions about 'caring' and 'privacy'. I give them scenarios about situations they will come across and ask what they will do. I am compassionate and I expect this from my staff. I usually only employ staff with previous care experience, as it reassures me as the manager that they understand what working in care means."

We asked staff about being caring, and what 'caring' meant to them. One staff said "I definitely do feel staff are caring, we go that extra mile. With [name] she can sometimes shout, we always answer her because we know she needs reassurance and to feel safe, to know that she is not on her own." Another said, "It is about taking time to sit with people and talk to them. People can get emotional and not understand why they are here. We always take time out for people."

We saw staff had time to sit and talk with people. We observed one staff sat chatting to a person looking through a book of photographs. They were having a friendly animated conversation, clearly enjoyed by both.

Staff supported people to feel valued. Staff knew people's preferred names and spoke to people in a positive and respectful way. All staff we spoke with and observed clearly knew people well and were able to tell us about people's backgrounds. For example, "With [name] he built motorised engines, he has written a book about it." And, [name] was a pharmacist, I had a sore throat and he told me I should gargle with TCP."

Staff were attentive of people, patient, and asked for consent before they supported people. For example when assisting people at lunchtime staff were heard to say, "Not long to wait now, give me your hand darling." And when assisting a person use the hoist, "Okay [name] sit still for a moment while we move you to the chair, are you alright." Staff were responsive to people's requests and people did not have to wait very long when they asked for assistance.

Visitors we spoke with said their relative was looked after well, "The staff are quite good yes, very hands on and they meet her needs, she seems happy." They went on to tell us when their relative first arrived they spent a lot of time in the small quiet lounge and became withdrawn and how staff had encouraged them to use the larger lounge (with other people) and they had "improved a great deal".

Staff maintained people's privacy and dignity. During our observations staff spoke discreetly to people when they asked about personal care and escorted people to bathrooms or their bedrooms to deliver this in private. Staff told us how they supported people's privacy. Comments included, "With people's privacy personally, I do the top half, I use towels to cover them and then do the bottom half." At lunchtime some people wore clothes protectors or used paper napkins to protect their clothes. A visitor told us their relative looked "clean and tidy when I arrive, I've never noticed anything untoward so I assume she has a shower, and her laundry seems to come back ok." However we did observe one person had their eye drops administered while sitting at the table waiting for lunch which was not very dignified. We discussed this with the registered manager, who said they would make sure this did not happen again.

We saw staff knew what to do to support people if they were distressed. At lunchtime, one person became very vocal to another person. We observed a member of care staff bend down to talk to the person and asked what was wrong. They stayed talking to the person until the person became calm.

We saw people were treated as individuals and were encouraged to make choices about their care. This included how people wanted to spend their day, what clothes to wear, where they would like to sit, and their choice of food. One person enjoyed smoking cigarettes, as they were unsafe to have a lighter themselves they asked staff each time they wanted a light. We saw when this was requested staff offered the person a light. One staff member told us, "[Name] likes to smoke; we try not to ration him. He can smoke four or five in 15 minutes. We try to explain and encourage him to cut down."

Where possible, people were supported to do things for themselves and to remain as independent as they could be. Staff told us how they promoted people's independence, "With [name] at bedtime I say to her, you get yourself changed, I encourage her I don't do it for her. Also with [name] I encourage her to use the spoon when she is eating and do this herself." At lunchtime some people used adapted cutlery so they could eat their meals independently.

Staff supported people to maintain relationships with family and those closest to them. Relatives and visitors were welcome to visit at any time. However, staff told us they did not have a lot of visitors to the home.

Good

Our findings

Staff we spoke with had a good understanding of people's needs and preferences and how they liked to spend their day. Staff told us care plans contained information about people's preferences and background history so they got to know about the person. One staff told us, "We always read the care plans; you have to know about the person before you can do personal care. For example, I learned [name] is mobile and he can do lots of things himself."

The PIR completed by the registered manager told us, "In order to ensure staff understand clients as people, we research their background, hopes and lifestyle and present this to staff by way of a door sign. This "getting to know you" information helps staff identify with the person who lives in that room, enabling them to more fully meet their aspirations as well as needs." We saw people had their photographs and information about their backgrounds on their bedroom doors. The registered manager told us, people or their family had agreed for the information about them to be displayed, and had provided the information for staff. They told us about a person who used to be a chemist and that they had found a book about chemistry in the 1950s that the person would look through and talk to staff about. Staff said knowing a little about people's past lives helped them to hold conversations with people.

Staff told us they had a handover meeting at the start of their shift which updated them with people's care needs and any incidents since they were last on shift. Staff said this kept them updated about people's care. One staff member said, "We always have a handover, it is verbal and written. On the devices if you swipe to the left, anything you need to know is there. We talk about everyone so we know the reasons why there are any changes." We observed the handover of shift in the afternoon. Staff were given an update about each person, and a record of what had been discussed was recorded so staff could refer back to this if they needed to.

There were enough staff to respond to people's requests and needs. Staff told us there were enough staff to carry out all the care and support people required and to sit and talk with people. One staff told us, "If there is any spare time I enjoy talking to people, we speak about relatives and people's families." The registered manager told us they had developed task sheets for staff so they knew what their responsibilities were during the shift and at meal times. They told us about lunchtime, "How I tackle this is I implemented a task sheet, staff know their roles, two staff concentrate solely on one area. They sit either end of the table to help people to eat." We saw staff carried out these tasks during the meal.

We asked staff about people's equality and diversity needs and how they would support this, for example if

someone was gay. Staff said people's diversity would make no difference to how people received their care. One staff member said, "We would have no problems with anyone here, we would treat everyone equally."

People's care plans were being transferred into electronic versions that staff accessed by IPODS, [hand held devices]. The PIR told us, "The computerised care planning system informs all staff about likes, dislikes, life history, needs, risks, family and other things important to each client. This highly personalised system is available to all care staff and really enhances the care they can give." Staff told us about using the new system, "We are getting better, it is very new, but it is starting to click. It has been very hard, remembering to input what you have done, when you might get called away." Another said, "I am using the new system, it is good. It is easier to do it and I think it takes less time."

We looked at four care plans two electronic plans and two care folders, these reflected how people would like to receive their care, and included personal information, health needs, preferences, and daily living tasks. Plans were person centred and provided staff with information about the person's background, as well as their preferred lifestyle and support needs. Plans instructed staff if people were likely to become anxious or agitated and what to do to support the person. We saw staff put these plans into action while we were there. Staff knew how to respond if people became agitated or anxious, "We talk calmly and not too much, we are patient, we try to find out what is the matter. [Name] gets agitated if he needs the toilet, but he can't say."

Care plans were reviewed monthly to make sure they continued to be accurate and meet people's needs. For example one person had recently been discharged from hospital; we were told the person's needs had changed significantly (during their stay in hospital). For example changes to their capacity to make decisions, their mobility and loss of weight. The person's care needs had been reviewed and the care plan revised and updated to incorporate the changes. This included a best interest meeting with family and a review of their DoLS authorisation, equipment was put in place to help the person move and minimise risk of falls, they had been visited by the GP and food supplements prescribed and a referral made to the dietician. The registered manager told us, "I am very proactive; from my care experience I know what measures are needed to protect people."

People's communication needs were assessed and plans in place to inform staff how people with restricted verbal skills communicated their likes, preferences and choices. One plan clearly identified how the person communicated when they may be in pain, so staff knew when to offer pain relief medicines. For example, changes in their facial expressions and body language. During our visit we observed staff communicated appropriately with people, where people took time to respond to questions staff did not hurry people. The registered manager told us, "I try to increase staff awareness of communication with people, particularly people who have difficulty talking. I have purchased communication cards with pictures to support people's communication and choices. [Name] sometimes uses these; it helps them to let us know things like happy, sad, drink, and toilet. Simple words that, visually are easy to understand, it has helped them communicate." Communication cards were available for people to use if they wished, although we did not see these being used while we were there.

Care plans included people's hobbies and interests. A few people were engaged in individual activities during our visit. One person was colouring in, one person was playing with toys, and another person was looking at a book. One person's care plan told us they liked to listen to music and read, which we saw the person engaged with during the day. We saw another person enjoying a book of pictures about Australia, they told us they had visited there several times and recognised some of the places in the photographs where they had visited. During the afternoon a member of staff, played a game of soft darts with one person. There were different communal areas where people could choose to spend their time, a main lounge, a

conservatory a small quiet lounge and the garden. During the day although some people were engaged in individual activities other people in the main lounge were asleep or staring into space.

We asked a visitor if their relative was kept occupied during the day, they told us "There isn't a lot going on really." When we asked if their relative went out with care staff, they responded, "Not as far as I'm aware." A staff member told us, "I would love to be able to do some more activities. We don't have them planned, we improvise. We do a lot of games, colouring and painting. I think there are wheelchair exercises each week and a hairdresser comes one day a week." The registered manager told us "We have tried to introduce group activities like bingo but it doesn't work here. People do like listening to music, and watching music DVD's. We buy newspapers and magazines and have a range of books. People do like to watch the television in the evenings, and several enjoy watching the news."

Staff knew how to support people if they wanted to complain and complaints information was displayed in the home and available in people's rooms. One staff member told us, "If someone had a complaint I would ask them about it and ask if they were happy to speak to me about it or if they wanted to speak to the manager. Either way I would let the manager know the person had a complaint." There had been no formal complaints in the last 12 months. Records showed the registered manager recorded and looked into minor concerns people raised.

Good

Our findings

There was good management and leadership within the home. Staff told us they enjoyed working in the home and that the home was well managed. Comments from staff included, "It is well run, there are lovely people here and lovely staff." And, "[Registered manager] is a good manager." An agency worker told us, "I feel supported, it is friendly, easy to work with people, and communication is good. I would like to work here permanently and I have applied." Another said, "What is good is I feel the home is kept very clean. Cleaners are here every day and there is plenty of staff around."

The home had a registered manager who understood their roles and responsibilities and what was expected of them. The ratings from the last inspection were displayed in the entrance hall and a copy of our last report was available for visitors to read. Statutory notifications had been sent to us as required and the Provider Information Return (PIR) which they were required to send to us; had been completed and returned. We found the information in the PIR was an accurate assessment of how the service operated.

The registered manager was knowledgeable about the care and support needs of all the people living at the home. The registered manager said they walked around the home several times a day and told us, "I know people's needs exceptionally well" and, "I am reassured when I am not here because staff know people very well. They know they can contact me at any time when I'm not here." They went on to say, "I am very much aware of how this homes runs. I know when I leave at 6pm people are safe and staff are happy."

Staff said communication in the home worked well. Staff had a handover at the start of each shift and IPODs provided current information about people's needs. The registered manger told us they had formal and informal meetings with staff. And, "We also use [internet application] to communicate with staff when not on site. We use this for general feedback or if anything had happened on shift. It's good as we can have a group chat in the evenings."

Staff told us they received supervision (individual meetings) and observations of their practice. Seniors carried out formal observations of staff practice. They also worked alongside staff on shifts so they could monitor practice regularly to make sure staff work to the providers policy and procedures. Records showed observations of staff practice included, observations of personal care, moving and handling practice and 'time wasting'. The registered manager told us they used the information from observations to hold discussions with staff in supervision meetings. Staff said they had opportunities to share their views and opinions in supervision meetings and at the monthly staff meeting.

The provider and registered manager used a range of quality checks to make sure the service was meeting people's needs. These included checks to ensure staff reviewed care plans and kept up-to-date records of care. Medication records were audited to make sure people had received their prescribed medicines. Accidents and incidents were recorded and monitored for trends or patterns.

The registered manager told us they had implemented several improvements since our last inspection in 2014. For example, they had recently changed the mealtimes for people. They told us this had been implemented as research had shown people living with dementia were more relaxed in the evenings and slept better if they ate their main meal in the evening. They said this had a positive effect on people as they now slept better and the levels of agitation people experienced in the evenings had significantly reduced.

The registered manager had increased staffing levels in the home. This meant there were now four care staff on each shift during the day and there was now additional kitchen, domestic and laundry staff so care staff could concentrate on providing care and support to people. The registered manager told us this had eased pressure of staff, and as there were more staff around, had reduced the amount of incidents and accidents in the home.

The registered manager said another reason they had increased staffing was so staff had time to incorporate activities with people and had more time to spend with people outside providing personal care. We noted minutes from the staff meeting in January 2017 included a discussion with staff about activities with people which stated, 'the registered manager had observed activities within the home had become extremely lapse' and noted that 'staff go to the same people to do the same activities'. Staff were reminded that the fourth member of staff had been implemented on each shift to ensure people were stimulated throughout the day. The registered manager advised staff to involve people in everyday tasks like clearing the table after meals or making a drink. This showed the registered manager routinely monitored staff engagement and activities for people.

The registered manager told us as the provider was not willing to employ an activity organiser they were looking at other ways to provide activities for people. The had spoken with the local authority monitoring officer about this who had arranged for an occupational therapist to visit the home to work with individuals to provide person centred activities for people. The registered manager had also contacted Age UK about providing a volunteer to focus on activities with people.

We asked the registered manager about the challenges to the service. They said the biggest challenge had been implementing the provider's new electronic care planning system. They said it was taking time for them to become competent with the new IT system and to have confidence that everything in peoples care plans had been transferred on to the new system. They said they were given four hours training and a workbook to refer to. They told us, "The new electronic system has had a major impact on how I work as it's taking such a long time to put all the information in the system. It has increased my workload 100%." However, they told us they could see the benefits of using the system when it was fully implemented. The registered manager told us "I have good care staff here and we provide good care, I want this to continue." They told us to make sure staff understood the system they had arranged a supervision meeting with each staff member to discuss this, they told us, "I don't only have a duty of care to people who live here but also to my staff." Staff we spoke with gave positive feedback about the new care system and using the IPOD.

The registered manager told us another challenge had been the recruitment and retention of staff, and that they had experienced a high turnover of staff. They thought this was due to the location of the home as there was a lack of public transport, and competition with other larger care homes that had opened in the area. To improve staff retention the provider had recently increased the hourly rate care staff were paid.

People who lived at Clarendon House were sent a survey by the registered manager to find out their views of the service. The last survey was sent to people in January 2017, this had not yet been collated as only five surveys had been returned. Returned surveys showed people were satisfied with the care and that any minor concerns had been acted on. The registered manager told us, "I have tried to implement relatives meetings but they were so poorly attended it wasn't worth it. I even tried arranging 'open door' sessions on a Saturday to see if this encouraged family to come, but I came in three Saturdays and no one turned up, even though it was well publicised within the home."

The registered manager told us they received good support from the provider who visited the home at least once a week and carried out checks on records for example MARS to make sure they were being checked correctly.

The registered manager told us the provider had used an electronic system for managing people's medicines for about six months. They said this had benefited the home as the system checked the medicines delivered were accurate. They told us, "The CCG (Clinical Commissioning Group - health commissioners) medicine management team have visited the home to look at medicines and were happy with everything."

At the start of our inspection we made a tour of the home to view the environment and introduce ourselves to people. We saw some doors in the corridors were covered with large pictures of trees. The registered manager told us they had camouflaged the laundry and domestic stores to look like woodland as dementia research had shown this deterred people living with dementia from going into these areas, as they did not look like doors. They said people living in the home did not attempt to open these doors. In the domestic store we noted the COSHH cupboard (Control of substances hazardous to health) had been left open and unattended. The registered manager took action to secure this.

The last infection control audit for the service was completed in 2014. The registered manager had discussed this with the local authority contracts monitoring officer as they wanted to assure themselves the home continued to meet a good standard. The registered manager told us the infection control officer had been arranged to carry out a review on 24 May 2017.

The registered manager had a plan of improvement for the home that included renewals and redecoration. They told us bedrooms were redecorated regularly but the communal areas were showing signs of wear, particularly carpets in the main lounge. The registered manager told us, "I want to ensure we don't only provide good care but that the environment also has the wow factor. I have spoken to my line manager [the provider] and asked them to consider this." They said, "We can't change the structure of the home but the environment could be improved. Everything costs money but I would like new carpets in the lounges, it would improve the overall appearance."

The registered manager told us, "I am confident I have managed to maintain a good service. I have had excellent support from the local authority monitoring officer who has been brilliant. Activities for people are a continued issue, trying to find personalised activities. I try my best to make sure peoples are safe and well looked after."

To keep up to date with current good dementia care practice the registered manager had completed a 'Dementia Leadership' course. They told us, "It opened up my eyes particularly around the environment and mealtimes, that's why I changed mealtimes and it has had a huge impact on people. It's reduced people being agitated in the evenings and roaming around the home. People sleep better, and because they are full up they are more relaxed in the evening so we can now put on a film for everyone to enjoy."

Staff told us they enjoyed working at Clarendon House their comments included "I have really enjoyed it here so far, it is a lovely care home, small and intimate. There is time to sit and have a chat with people. It's lovely with their pictures on the doors and it helps having pictures next to names on the devices. "Another said, "I love my job, and all the people here, and the staff are great."