Springbank House Limited

# Cliff House Care Home

## Inspection report

Cliff Hill
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Tel: 01246810246

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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

Cliff House is registered to provide personal care for up to 40 people and was last inspected in April 2014. This inspection was unannounced and took place on the 17 and 23 August 2016. At the time of our inspection there were 31 people using the service.

The service did not have a registered manager and are required to do so. 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.

There was not enough sufficient trained staff to meet people's needs and wishes. People were left unattended in communal areas for periods throughout the day. They had no means of calling for assistance.

During our inspection visit we observed that staff were friendly and approachable. When staff delivered care it was done in a respectful and appropriate way. Staff were caring and communicated well with people when they had the opportunity. However, they focused on tasks they were performing rather than on the people they were caring for.

Staff did speak in a positive manner about the people they cared for and they said they wished they had more time to spend with people. Staff had a good understanding of people's health care needs however no account was taken of emotional or personal needs. People were offered healthy food and drinks though they did not have free access to drinks. Staff were not always available to assist people to eat their meals in a timely manner.

Mostly people were left un-stimulated and had nothing to occupy them other than a TV which most people could not see or hear properly.

There were no effective training and processes in place for staff to follow to keep people safe. People's physical health was promoted. However, staff were unaware of how to ensure people's rights under the Mental Capacity Act were promoted. Medicines were stored appropriately but were not always administered and recorded as prescribed.

Most people were escorted or taken to the communal sitting area when they were dressed. They stayed there for the duration of the inspection visits. Meals were served as a task and no effort was made to make lunch a social occasion. Most people were given their lunch where they had been sitting all morning and were not given the opportunity to socialise and use lunch time as a social activity.

People were supported to maintain relationships with family and friends. Visitors were welcomed at any time.

Records we looked at were not personalised and did not include decisions people had made about their care including their likes, dislikes and personal preferences. However, there was a good hand over sheet in use that was personalised. There was little or no activity to stimulate and occupy people. There was one person dedicated to activities. However, due to lack of care staff they were called upon to assist people with everyday living tasks.

The service was not managed in an inclusive manner. People were not facilitated to have their wishes made known, therefore they were not recorded as part of care planning. There was no system in place to capture staffs' knowledge of people's needs and wishes.

The provider did not have a quality assurance process in place. There they had no means of identifying and addressing the failings in the service.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 at this inspection visit. You can see what action we 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 safe.

The provider did not have thorough process in place to ensure staff were aware of their duty of care to keep people safe and to report any concerns. Sufficient staff were not deployed to meet people's needs and staff were unaware of what to do should they suspect a person was at risk. There were systems in place for the storage and administration of medicines. However these were not always followed appropriately.

### Is the service effective?

**Requires Improvement**

The service was not effective.

Staff did not receive training to meet the varied and specialised needs of people using the service. People and their individual care needs were not always identified and addressed. Staff were not aware of people's rights under the Mental Capacity Act 2005.

People's nutritional needs were understood and met.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

Staff did not always know what was important to people. Staff were caring and compassionate but did not spend quality time with people. There was no system in place to prevent people from becoming isolated.

People's independence was not promoted and people were left alone and un-stimulated. People were moved about without staff getting their consent. The privacy and dignity of people using the service was not always promoted

### Is the service responsive?

**Requires Improvement**

The service was not responsive.

People were not included in ensuring their care plan represented their needs and wishes. People were not offered the opportunity

to participate in their interests. They were not offered stimulation and the provider had not ensured people had the opportunity to pursue their hobbies and interests.

## Is the service well-led?

**Requires Improvement**

The service was not well led. There was not a registered manager in post.

The provider had no quality assurance in place. Staff concentrated on care tasks rather than interacting with people.. There was no recognised system in place to assess staffing levels. The provider had no effective management structure in place.

People and their needs were not put at the centre of the service. Staffs' opinions were not listened to.

The provider had no system in place to capture people's opinions of the service and how it fitted their needs and wishes.

# Cliff House 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.

The inspection took place on the 17 and 23 August 2016 and was unannounced. It was carried out by one inspector on the 17 August and on the 23 August by one inspector and a specialist professional nursing advisor.

Before the inspection we reviewed the information available to us about the home, such as the notifications that they had sent us. A notification is information about important events which the provider is required to send us by law.

We spoke with four people who used the service and 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 spoke with four relatives of people who used the service.

During the inspection we spoke with four people, four staff members and the acting manager. We observed how care was delivered and reviewed the care records and risk assessments. We checked medicines administration records and reviewed how complaints were managed. We looked at four staff recruitment records and staff training records. We also reviewed information on how the quality of the service was monitored and managed.

Requires Improvement

# Is the service safe?

## Our findings

People mainly felt safe. One person said, "Yes it's safe here." Another said, "I don't worry about anything here." However, the provider did not ensure people who lived at Cliff House were protected from harm because there were not enough staff to keep them safe. They did not have a recognised tool to establish how many staff were needed to care for people and to keep them safe. The staffing levels had been reduced. There was no longer a deputy manager and the night staff had been reduced by one carer. We were told this was despite an increase in the numbers of people being cared for. We noted the acting manager also had to complete a nursing shift further taking them away from the task of managing the service. The acting manager could not provide any rationale for this staff reduction. The provider was not available for us to consult with on these issues.

People were frequently left unattended in the large lounge dining area. We saw people were left without means of calling for assistance other than verbally. For example, we saw nine periods where people were left unattended. The absence of staff varied from two minutes to six minutes. During this time we saw people were unsettled and at risk as at least three people were trying to get attention. We saw people trying to get staffs' attention without success until we asked for them to be attended to.

When we asked staff about this we were told they were assisting people to get up and dressed. We saw this was accurate. People who needed assistance had to wait their turn. If someone needed care urgently there was no easy way of knowing this. To respond to urgent need staff had to interrupt the care they were giving to one person and go and assist another person. We were told most of the people needed two staff to assist them for personal care and help to mobilise.

At the time of our visits there were four care staff on duty and one nurse to care for 31 people; most of whom needed two staff to assist them in their personal care. This lack of staffing meant people not only had to wait for staff to assist them, people only had their basic needs met in a task oriented manner.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A review of records showed people's medicines were not always safely administered as prescribed by their GP. We found some medicines had not been administered. There was no explanation in the records to explain the gaps. There was no process in place to capture medicine errors and to address them in a timely manner. Staff who administered medicines were trained to do so and plans were in place to update training for all staff completing administration of medicines.

Medicines were stored appropriately within a locked cabinet. There was a system to return unused medicines to the pharmacy. Protocols (medicine plans) were in place for people to receive medicines that had been prescribed on an 'as when needed' basis (PRN). Routine reviews by psychiatrist, community nurses, annual reviews by the GP and diabetic clinics were also evidenced where required.

The acting manager told us some senior carers had been assessed by the home manager on their skills and training in this field, however no evidence of the assessment process and staffs' competencies were available. The last recorded audit of medicines was carried out by an external company and was carried out in December 2015.

Staff were not always trained effectively to keep people safe and how to recognise and respond to signs of abuse. Staff told us they understood abuse and the different types of abuse and all the staff we spoke with said they had received training on keeping people safe. However, they were not always able to demonstrate that they had a good understanding of how to do this. Some did not know the procedures to follow if they suspected abuse had occurred. All staff assured us that they would follow up on concerns until they were sure the issues had been dealt with. However they did not know how to do this.

People had individualised risk assessments which looked at risks to their health and well-being. Each assessment identified the risk to the person, however the steps to minimise the risks were not always clear and the directions to staff on how to keep people safe were not clear.

For example one person needed two or three staff to keep them safe due to their behaviour. It was not clear how the staff were to give care or why it needed additional staff to care for them. Also there were no procedures in place to ensure this person was not restrained inadvertently by the use of up to three staff to give them personal care.

There were risk assessments for assisting people to move safely and to prevent pressure areas. Evidence showed that these risk assessments were reviewed and where necessary people's weight was monitored on a monthly basis. We saw that staff understood the risk to people and followed written risk reduction actions in the care plans. We saw staff move people safely using equipment. However people did not have individual slings which would ensure their safety as they would take into account people's individual size, weight and why they needed the assistance of a sling. These reasons could include upper or lower body weakness. Staff did not have guidance on which sling to use to keep people safe. We saw them attempt to use one and then to change it as it was not suited to who they were caring for.

People were protected from risks posed by the environment because the provider had carried out assessments to identify and address any risks. These included checks of window restrictors, hot water and fire systems. The provider had contingency plans for staff to follow in the event of an emergency such as a gas or water leak. Staff were mostly aware of these plans and what they needed to do. This enabled staff to know how to keep people safe should an emergency occur.

We found thorough recruitment procedures in place. These ensured the staff had the right skills and attitude, and were suitable to support people who lived at the home. The provider checked whether the Disclosure and Barring Service (DBS) had any information which might mean a person was not suitable to work in the home; and checked staff references. The DBS is a national agency that keeps records of criminal convictions. We saw from staff records that they did not commence employment until all the necessary checks were completed.

Requires Improvement

# Is the service effective?

## Our findings

People did not have their rights promoted because staff did not fully understood the requirements of the Mental Capacity Act 2005 (MCA) and the importance of acting in people's best interests. The acting manager told us how they put the principles of the MCA into practice when providing care for people. However, we found some people's records showed they lacked capacity. There was no record on how this was established and how the person's rights were protected. Where people lacked capacity and decisions about their care or support had been taken, mental capacity assessments and best interest's decision making processes had not been completed.

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. 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.

The provider did not ensure the acting manager and staff fully understood the circumstances which may require them to make an application to deprive a person of their liberty. They were not familiar with the processes involved. People can only be deprived of their liberty so as to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

We saw that the process of applying for DoLS had started. However, staff were not aware of who was required a DoLS to be in place. They knew some people might be. All staff we spoke with gave us different names of people they felt may require a DoLS. This meant some people who were not to subjected to a DoLS may have had their liberty unlawfully restricted. Although one person who was subjected to a DoLS and had the process conducted appropriately had details of their DoLS kept in a separate folder and noted on handover sheets, this was not noted in their care plan. This meant there was a risk staff would be unaware of any conditions in the persons DoLS authorisation and how the DoLS informed their care and support.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who have capacity were not free to come and go in the service. For example, people could not leave the home without staff assistance to operate the front door release in the lounge area. While it is understood this was to keep all people safe it deprived people of their rights to free passage. This meant that people's rights to freedom of movement were not protected.

People without family or representatives did not have access to advocates who gave independent advice and acted in their best interest. This meant people's rights were at risk of not being lawfully upheld.

Forms in relation to 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) were included in four

people's care plans. These had been completed by the visiting GP in conjunction with people or their representatives. There were systems in place to easily recognise who had chosen not to be resuscitated. People who did not have a DNACPR in place were denoted by having a green dot on the spine of their care plan. Staff were unaware of the meaning of the green dot. This lack of knowledge meant that there could be a delay in implementing resuscitation.

The provider had not ensured staff were given training and guidance on how to meet the needs of people. New staff completed induction training. However most of this was done away from the service using an online method of training. There were no systems in place validate this training or to ensure the training was competed by staff.

None of the staff had started The Care Certificate. This identifies a set of care standards and introductory skills that non-regulated health and social care workers should consistently adhere to. Some, but not all staff told us they had access to a variety of training. This included assisting people to move safely, food hygiene and first aid. Staff were not consistently trained to care for people living with dementia. This resulted in staff not always been able to recognise people's needs and to respond effectively to ensure personalised care.

Supervisions, appraisal, and team meetings were sporadic and not conducted on a regular basis. This meant that staff had not always been supported to deliver effective care that met people's needs.

People were offered a good choice of food and drinks during our inspection visit. We saw food was freshly prepared, nutritious and reflected people's needs. We heard staff supporting people to make a choice of food and drink. Staff catered for people with specialist dietary requirements. For example, suitable choices and consistency of foods were provided for people who required soft diets. People who had difficulty swallowing were referred to appropriate health care professionals. Some people who had difficulty using cutlery were offered finger foods.

There were systems in place to ensure people's health and well-being were monitored and reviewed. We saw staff documented any changes to people's health conditions and contacted the relevant professionals for advice. These were easily identified within their care plans.  A visiting professional we spoke with said they were called to the service appropriately and their directions were followed. However, we saw repositioning charts that had no required repositioning frequency identified so as to reduce the risks to areas vulnerable to pressure area development. Some people had regular three hourly repositioning recorded. Repositioning charts should the risk to people's skin and how these risks should be mitigated. They should show the frequency of re-positioning and the timings of these.

Requires Improvement

# Is the service caring?

## Our findings

Staff were seen to be kind and caring in their interactions with people. However they were not always able to respond to requests from people as they were busy meeting people's immediate needs. One person said, "The girls are kind. They are much nicer now than they used to be." Another said, "Lovely girls always smiling."

The provider did not always promote people's choice and independence because people did not have a choice over where they ate lunch. At the time of our visits the dining room had dining space for 16 people. There were 31 people using the service. Most people ate their meals at their easy chairs. We were told this was their choice. We did not see evidence to support this. This meant people were not given the opportunity to enjoy lunch time together or to socialise as they could only talk to those next to them.

Lunch was served in a haphazard manner. We saw some people at the same table were not served at the same time. Some had finished their main course before others were served their first course. This meant that the opportunity to promote a social occasion was lost. Lunch was a solitary experience for most people.

The provider did not ensure people who needed assistance with eating were offered this assistance in a timely manner and in a manner that promoted their dignity and independence. One person who was eating their lunch in bed was seen to be partially sitting up in with a bed table in front of them. This contained both main course and pudding. They said they were unable to eat it as they were sitting awkwardly and by now, "Their dinner was cold." They were unable to use cutlery (due to their position in bed) and were attempting to take food from the plate using their hands. They said they had raised issues before, "I'm always too far down the bed," and we saw staff had not responded to their need or request.

We saw a person was brought in to the lounge on a commode chair. This was pulled backwards and the person was asked to keep legs up as there are no foot plates on the commode chair as it is not meant to be used to assist people to move

The provider did not have procedures in place to promote people's dignity. People were frequently moved without staff getting their permission or telling them what was happening. Staff spoke over people and did not include them in decision making. For example, a person was taken into the lounge area. A senior staff member told the carer in an easily audible voice, "[Person] has been to the toilet," therefore they did not need any more assistance. They did not check if this was accurate with the person.

Choice and inclusion was not promoted. One person who wanted to have a cigarette had to wait as staff were attending to other people. One staff member said they, "They always want a cigarette, they will have to wait until we have finished the lunches."

People's chairs were placed around the walls in the sitting room making it possible for people to only speak to those who were on either side of them. This restricted people's ability to make friends and to have a more social occasion.

Requires Improvement

# Is the service responsive?

## Our findings

The provider had ensured people had their needs assessed and a plan of care drawn up to assist staff to look after them. However, care plans were not always fit for purpose and did not give staff the information and direction they needed to care for people in a personalised manner. For example, the care plan of one person who had complex needs did not give clear directions to staff on how to recognise and to meet their needs in a safe and effective manner. The directions in the care plan stated, 'staff are to carry out personal care in the person's best interests as they are at risk of self- neglect.' There was no direction on how to do this, what the self-neglect entailed or when to recognise when giving care in their best interests may become restraint.

Care plans focused on meeting people's basic care needs. People's interests and hobbies had not been explored. There were no personal histories to ensure staff knew the people they cared for and assist them to understand people's personal needs and wishes. The care plans were not easy to follow as they had numerous format changes. This made them difficult to follow and therefore they were not a useful working document. The manager was aware of this and had plans to review them. Care plans were not personalised and therefore people were at risk from not receiving personalised or responsive care and treatment.

Most of the staff we spoke with were unaware of the detail in people's care plans as they had not read them. One staff member said, "We don't have time to read care plans." This meant the staff relied on handover meetings for details about how to care for people. Handover sheets contained good information on basic needs of people. However, they did not always contain the level of detail and information needed to ensure people's needs were met. The lack of up to date information in care plans meant there was a risk that information being passed on was inconsistent.

Plans were reviewed, however we found people and families or representatives were not invited to contribute to care planning. By excluding people who know people best the provider cannot be sure they are providing personalised care.

People were not assisted to pursue hobbies or interests. None of the staff we spoke with were aware of people's interests. Details of people's hobbies and interest were not recorded in care plans. There was a staff member whose role was to organise activities. We noted they were absorbed into caring for people when the lounge area was left unattended. This meant people did not get the opportunity to be stimulated or entertained. There were two TVs on in the lounge area. Both were very loud on different channels making it impossible for people to focus on either. No care had been taken to ensure those who wanted to, could see their programme of choice. Most people did not have a clear view of the TVs. We saw there was a variety of books and magazines in the lounge. People were not offered these. Our observations showed most people were not stimulated and spent their time dozing and disconnected from their surroundings.

Relatives said before the present manager it was pointless complaining. They said the new acting manager was, "Really good at listening to us. They have made a big difference." There was a complaints process in place. However, the provider had not always proactive in receiving feedback and open to listening and

making changes, before they became a problem. Details on how to make a complaint were freely available. At the time of the inspection there were no outstanding complaints. However the provider had not provided people with an easy way of offering their opinions on the service such as a questionnaire. This meant the provider could not assure us they were actively seeking feedback with the view to improve and develop the service.

Requires Improvement

# Is the service well-led?

## Our findings

The provider is required to have a registered manager at Cliff House and one was not in place at the time of our inspection visits. A new acting manager had been appointed and was at the service on the second day of our inspection visits. They had not applied for registration.

The provider did not have an effective communication system in place. For example there was no system in place to provide cover when the manager was off duty. There was no designated person whose responsibilities covered this area. This meant that when the manager was off duty the provider had no effective system in place to ensure the safety and welfare of people was promoted in a timely manner. Staff felt they were not listened to and the provider had no effective ways of ensuring their knowledge of people was captured and used to improve their care.

The provider did not have a quality assurance process in place. Therefore they had no identifiable way of knowing how the service was meeting people's needs and wishes. For example, medicines had not been audited. A system had recently identified the need for this but had not yet started.

The provider did not have an effective system in place to ensure risk was monitored and to ensure clear directions were given to staff to provide care in a manner that reduced risk to people.

The provider did not ensure staff were trained in the MCA and DoLS. We found the provider was depriving people of their liberty without due reference to their responsibilities under the law. For example risk assessments did not identify how care should be given in the least restrictive manner. Also the door release to allow people to leave the home was in the sitting room some distance from the front door. This meant a staff member had to open the door and if a staff member was not available people had to wait.

The provider failed to maintain an accurate, complete and contemporaneous record in respect of providing care to people This included personalised care plans. The provider did not ensure people had the opportunity to contribute to planning their care. People's views were not sought therefore preferences wishes and aspirations were not identified and met. Because of this care plans did not show people's needs and wishes. They did not provide staff with information to ensure people had personalised, safe effective care.

The provider did not have an effective system in place to ensure there was enough staff on duty to meet people's needs and wishes in a personalised manner. This left people receiving basic personal care and resulted in people been left unattended for periods of time and left without stimulation and the opportunity to follow interests and hobbies.

Systems and processes designed to assess, monitor and improve the service were ineffective as no audits were in place to identify shortfalls in the quality and safety of services. For example, the provider had not identified staff lacked the relevant skills and knowledge to care for people effectively.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had yet to fill the post of deputy manager which had been vacant for several months. We did not see evidence that the provider had made attempts to fill this post. In addition to covering the post of manager and deputy manager the manager was expected to cover the duty nurse one day a week. On the second day of our inspection visit we noted the acting manager was also performing the role of nurse. This meant that the service was not managed in a proactive manner. The manager had identified areas that needed to be updated such as training and care planning but had not had the time or the resources to address them. For example, the acting manager was aware the staff needed training on caring for people who lived with dementia or had behaviours that challenged. However they had been unable to make improvements in this area due to a lack of resources and time.

The provider did not ensure the environment was dementia friendly. There was no signage to assist people to orientate and it was difficult for people to distinguish the doors from the walls as they were all the same colour. This meant people's independence and safety was not promoted.

The provider did not ensure people had a choice of where people ate. The provider is registered to provide a service for 40 people yet there was dining space for only 16 people. There were 31 people using the service at the time of our visit. We were told this was people's choice. We did not see evidence to support this. This meant people were not involved in making decisions about where they ate their lunch.

However people, visitors and staff told us that the service was, "Fifty times" better with the new manager in post. Staff said the acting manager was easy to talk to and was very supportive. One person said "She's always there and will do all she can to help."

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<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 11 HSCA RA Regulations 2014 Need for consent<br>People who use services did not always have their rights protected as the provider had not ensured the staff were aware of people's legal rights under the MCA. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br>People who use services were not protected as the provider had not ensured there were thorough systems in place to review and improve the service. |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br>Diagnostic and screening procedures<br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br>People who use services were not protected from unsafe care as they provider did not ensure there was sufficient staff to meet their needs in a timely and safe manner. |