Clarendon Manor Limited

Clarendon Manor

Inspection report

37-41 Golf Lane
Whitnash
Leamington Spa
Warwickshire
CV31 2PZ

Date of inspection visit:
06 February 2018
09 February 2018

Date of publication:
16 March 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Clarendon Manor on 6 and 9 February 2018. The first day of our inspection visit was unannounced.

Clarendon Manor is situated in a residential road in Whitnash. It is a period home which has been extended. The home is three storeys with bedrooms on the ground and first floor. There is lift access to the first floor.

Clarendon Manor provides accommodation and personal care for up to 35 people, some of whom are living with early stage dementia. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. There were 29 people living in the home at the time of our inspection visit.

A requirement of the service's registration is that they have 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 and the associated Regulations about how the service is run. There was a registered manager in post at the time of our inspection visit who was also the provider.

Since our last inspection in January 2017 we have reviewed and refined our assessment framework, which was published in October 2017. Under the new framework certain key areas have moved, such as support for people when behaviour challenges, which has moved from Effective to Safe. Therefore, for this inspection, we have inspected all key questions under the new framework, and also reviewed the previous key questions to make sure all areas were inspected to validate the ratings.

At our previous inspection we found the safety and leadership of the home required improvement. This was because the deployment of staff did not always support people's safety and people were not always given their medicines in accordance with their prescriptions. The provider's monitoring visits were not formally recorded to provide an audit trail of the actions taken to address issues.

At this inspection we found improvements were still needed to ensure people received consistently safe care. This was because risks were not always identified and managed to keep people safe. The provider's checks were still not sufficiently robust to identify the issues we found and learning was not shared within the provider group. As this was the second consecutive inspection visit where we identified a lack of oversight and effective monitoring and the service was rated 'requires improvement', we found this was a breach of the regulations.

Staffing levels were sufficient to meet people's needs and staff understood their responsibilities to safeguard people from potential abuse. Staff had received training to ensure they had the skills, knowledge and confidence to meet people's needs effectively. However, we observed some occasions when staff did not

follow good infection control practice or safe medicines management. People's care plans included risk assessments to ensure staff knew the risks associated with people's care needs, but risks around some equipment and the environment had either not been recognised or managed appropriately.

The registered manager assessed people's physical, emotional and social needs before they moved to the home and people continued to receive support to maintain their health and wellbeing. Care staff were knowledgeable about people's needs and how to address them. People were referred to other healthcare professionals when there was a change in their health or wellbeing. People were assisted to eat and drink enough to keep them as healthy as possible and staff understood people's individual nutritional risks.

There was a calm and homely atmosphere in Clarendon Manor. Staff understood the importance of respecting people's rights as individuals and their diversity. Staff worked within the principles of the Mental Capacity Act 2005 and supported people to make their own choices and respected the decisions they made. People had access to some activities to promote a sense of engagement and wellbeing.

People were supported to remain in the home at the end of their life if this was their wish. Staff worked with other healthcare professionals to ensure end of life care was co-ordinated and the right medicines were available to keep people comfortable.

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 consistently safe.

Staffing levels were sufficient to meet people's needs and staff understood their responsibility to keep people safe from abuse. Management of individual and environmental risks in the home needed to be improved to ensure people's safety at all times. People received their medicines as prescribed, but staff did not always follow safe practice when giving people their medicines.

Is the service effective?

Good

The service was effective.

Staff received training and support to enable them to carry out their role and responsibilities. Staff worked within the principles of the Mental Capacity Act 2005 and gave people choices and respected the decisions they made. The registered manager understood and worked within the principles of the Deprivation of Liberty Safeguards. Staff referred people to healthcare professionals when needed and supported people to eat and drink enough to maintain their health.

Is the service caring?

Good

The service was caring.

Staff respected people's individuality and diversity and treated them with kindness, respect and dignity. Staff enjoyed caring for people and interacted well with them. People were supported to maintain personal relationships.

Is the service responsive?

Good

The service was responsive.

People's care was planned in a way that reflected their individual needs and preferences. Staff were knowledgeable about people's needs so they could respond in a person centred way. People were supported to engage in some occupation and activities that interested them. People felt comfortable to raise any concerns or make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider's checks were not sufficiently robust to identify the issues we found during our visit. Environmental risks were not consistently monitored to ensure people's safety. Learning was not shared to drive improvement. The registered manager was confident staff put people's needs first and staff felt valued and supported by the management team in the home.

Clarendon Manor

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 fully comprehensive inspection visit took place on 6 and 9 February 2018. The first day of the inspection was unannounced and was undertaken by two inspectors and an expert by experience. An expert-by-experience is a person who has personal experience of using, or caring for someone who uses this type of service. We told the provider we would return on the 9 February 2018. The second day of the inspection was undertaken by one inspector.

The provider had completed 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.

Prior to our inspection visit we reviewed the information we held about the service. We looked at information received from relatives, 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. The commissioners did not share any information of which we were not aware.

During our inspection visit we spoke with five people and one relative about what it was like to live at the home. We spoke with the head of care, a team leader, four care staff and three support staff about what it was like to work at the home. We spoke with the registered manager about their management of the service. We observed care and support being delivered in communal areas and we observed how people were supported at lunchtime.

We reviewed two people's care plans and daily records to see how their care and treatment 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 reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection visit we found the safety of the service required improvement because there were not always enough staff available in communal areas to maintain people's safety. People were not always given their medicines in accordance with their prescriptions. At this inspection we found some improvements had been made, but there were still concerns about the management of risks within the home. The rating remains 'requires improvement'.

People's care plans included risk assessments to ensure staff knew the risks associated with people's care needs and the actions needed to minimise these. For example, one person had limited mobility and needed assistance with transfers. The risk assessment identified safe staff levels, the necessary equipment and how to transfer the person safely to minimise risks.

However, risk assessments were not always in place where people had risks around specific health conditions. For example, people with diabetes require regular foot and nail care to maintain their health. We looked at the care records for one person who was diabetic. There were no care plans that referred to this and the risks if regular treatments were not provided. It is also important to maintain good oral health care. This person had dentures although their care plan made no mention of this. The person's dentures had been left on a table top in their room. The dentures had not been cleaned for some time and had dried matter on the plate which increased the risks of infection.

During our discussions with staff they assured us they knew who was at risk of falling and they knew how to manage the risks. One said, "If somebody was at risk of falling and they could mobilise you would have to keep an eye on them. We make sure they are safe, somebody is with them and there are no dangers in sight of them." However, during our inspection visit we saw potential hazards that had not been recognised by managers or staff. For example, the bedroom door of one person's room was propped open by a radio and the wires were trailing on the floor. Another person was sitting in one of the quieter seating areas away from the main part of the home. Whilst staff had ensured the person had a call bell to hand to call for assistance, the wire trailed across the centre of the floor. When we pointed this out to one member of staff they responded, "No it is not safe, it shouldn't be that way", but they did not take any action to put it right. Three hours later the wire was still trailing across the floor. Both these issues presented a slip or trip hazard to people.

During the first morning of our inspection visit we spent time in the conservatory. There was one person in the conservatory, sat in a chair asleep. This person's mobility plan had assessed them as high risk of falls and they needed support from two staff to transfer. There were periods of time throughout the morning this person was left on their own. On one occasion staff came in, realised it was cold, and placed an electric heater next to the person's chair. It was switched on, then staff left and returned to check periodically. By late morning, this heater was too hot to touch which had potential to place this person or others, at risk of burns. When we informed the registered manager, they immediately arranged for the removal of the heater.

Some people at high risk of developing skin damage had pressure relieving mattresses on their beds. We

observed that the settings on pressure relieving mattresses were not regulated dependent on people's weights as guidelines recommend. For example, one person had ulcers on their legs and had been assessed as needing a pressure relieving mattress to reduce any risks to their health and wellbeing. We checked this person's pressure mattress and saw it was set at 200kg when their actual weight was 67kg. Another person's mattress was also set at 200kg and their last recorded weight was 71kg. The registered manager told us the mattresses were checked every three months by the external service that provided them. When we asked how they ensured the mattresses were set to the correct settings in between these checks, they responded, "We don't." On the second day of our visit, the registered manager had ensured the mattresses were on the correct setting and implemented a system to regularly check the correct setting was maintained. Other equipment, such as hoists and bath chairs, had been checked by an external contractor to ensure their safety.

People were not always protected from environmental risks. On the first floor, the boiler and hot water pipes were located behind a lockable door. The door was unlocked and the key had been misplaced. This meant people could access this area and put themselves at risk of unnecessary harm. Later in the day, the maintenance person fitted a new lock.

We found first floor bedroom windows had incorrect or ineffective restrictors limiting how wide the windows opened. One window had a narrow chain screwed to the frame and window which had access to a flat roof. We were concerned that this was not sufficient to prevent someone gaining access outside. Other windows were secured with chains, whilst other windows had appropriate restrictors in place. On the second day of our visit the registered manager confirmed the maintenance person had ordered appropriate restrictors which they would fit as a priority.

We looked at how medicines were managed at the home. Only trained staff administered people's medicines. Staff confirmed they had received training, and a manager observed their practice to make sure they were competent to do so. However, we observed an occasion when a staff member gave a person their medicines, but did not stay to ensure they had taken them. People told us this happened regularly. One person said, "They bring my medicines to me. They missed my eye drops one day, but that was the only time. They know I will take my tablets, they don't wait." Another said, "In my case they leave me to take my medicine because they know I will." Staff should observe people take their medicines before signing the medicines administration record (MAR) to confirm they have been taken. This not only ensures people have taken the medicines they need to maintain their health, but also protects against the risk of other people taking medicines that are not prescribed for them. We shared our observations with the registered manager who confirmed this practice was not in accordance with the provider's policy and procedures. On the second day of our visit, they told us the issue had been addressed with staff, and whilst they were confident staff would now follow safe practice, any further concerns would be addressed through disciplinary procedures.

Some people received their medicines via patches applied directly to their skin. It is important that the site of application of the patch is alternated to reduce the risks of skin irritation and unwanted side effects. Staff did not maintain a record of where the patches had been applied so they could be assured the sites were alternated and the patches applied as directed. When we shared our concerns with the registered manager, they immediately implemented body maps for staff to record where patches had been applied.

This was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Medicines were stored safely and in accordance with manufacturer's instructions. MAR charts confirmed

people received their medicines, including time specific medicines, in accordance with their prescriptions.

Where people took medicines on an 'as required' (PRN) basis, such as mild pain relief, staff used a recognised pain assessment tool to help them identify those people who were unable to tell them they were in pain. Staff maintained a record of why and when these medicines had been given to ensure safe dosages of medicines were not exceeded.

People told us they felt safe at Clarendon Manor. Comments included: "I think I do feel safe, the staff are very reassuring" and, "The carers make me feel safe." Some people told us they felt safe because they could keep valuable items secure in lockable drawers in their bedrooms. One person said, "I have a lockable drawer and a key. I keep my money in there."

Staff confirmed they had completed safeguarding training to obtain the knowledge they needed to keep people safe from abuse. Training included how to raise concerns, and the signs to look for, such as changes in behaviour, which might indicate people were at risk. Staff told us they were confident to report any concerns to their managers, including any poor practice by other members of staff. We asked staff what they would do if action was not taken to investigate their concerns. They told us they would escalate their concerns to the provider or an external organisation such as CQC. One staff member told us abuse was, "Anything that makes people feel unsafe. I would tell my manager and then go to head office. If no action was taken I would call CQC." There had been no incidents of a safeguarding nature since our last inspection.

Staff recruited to the home, went through a series of recruitment checks which included a Disclosure and Barring (DBS) check and reference checks. The DBS is a national agency that keeps records of criminal convictions. Recruitment checks were made before staff started work in the home.

The registered manager assessed people's needs to inform the number of staff required. For example, staffing numbers had recently increased because three new people had moved into the home. The registered manager was recruiting new staff to reduce the use of agency staff due to the increase in staffing levels.

Staff were confident there were enough of them to meet people's needs safely and effectively without rushing. They told us there were enough staff to assist people to get up when they wished and they had time to give people showers if they wanted them. They said the registered manager and deputy manager were on call if they required assistance.

People mostly thought there were enough staff. One person commented, "Occasionally I have waited half an hour for them to come, but they are usually quite prompt otherwise." Another person said, "I think they need more staff at night, as there is too much for two staff to do." We shared this with the registered manager, who immediately reduced the number of 'non-care' tasks allocated to night staff.

We saw staffing levels were sufficient to meet people's needs. Although there was not always a staff presence in communal rooms when staff were busy supporting people with personal care, staff regularly checked people to ensure they were safe.

There were processes to keep people safe in the event of an emergency and equipment that would be needed in an emergency situation was accessible to the staff team. There was regular testing of fire safety and fire alarms so people and staff knew what to do in the event of a fire. People had personal emergency evacuation plans so staff and the emergency services knew people's different mobility needs and what support and equipment they would require to evacuate the building safely.

We spoke with a member of domestic staff who told us they had received training so they understood their responsibilities to ensure the cleanliness of the home and follow infection control procedures. They told us how they followed good practice and used different coloured mops to clean different areas of the home. People expressed no concerns about the hygiene in the home and said their rooms were clean and tidy.

One person in the home had recently been diagnosed with an infection. The registered manager had ensured they followed Department of Health guidance in managing the infection and this information had been shared with all staff. We saw that personal protective equipment (PPE) such as gloves, masks and aprons were outside the person's bedroom so it was readily available to all staff.

However, we observed a spillage in one person's room which had not been wiped up. The source of the spillage was not clear. When we brought it to the attention of staff, two senior staff members began to deal with it without putting on PPE. They then touched personal items belonging to the person without adhering to safe infection control procedures. These actions did not minimise the potential risks of cross contamination.

We discussed with the registered manager and deputy manager how they improved their working practices when issues or concerns had been identified. The registered manager said they reviewed all falls and incidents to ensure the necessary actions had been taken. They were satisfied they were taking appropriate action to keep people safe and told us that recent staff increases had helped. The provider also completed a monthly trend analysis for falls, incidents and accidents which demonstrated that the number of falls, incidents and accidents had reduced in the last 12 months. However, the provider's own analysis did not match the number of falls and incidents recorded by the deputy manager. The registered manager told us the provider wanted them to stop completing their own analysis and to use the provider's, however this was not accurate. The system required better management to ensure the information was correct so any trends or patterns could be managed more effectively to ensure people remained safe. We also discussed with the registered manager that they needed to improve their own systems to monitor health and safety and environmental risks to reduce the potential of further risks to people and staff.

Good

Is the service effective?

Our findings

At this inspection, we found people continued to receive effective care from staff who felt confident in their roles. One relative told us, "I used to work in a care home. Staff are fine, I know good practice when I see it." The rating continues to be Good.

The registered manager assessed people's physical, emotional and social needs before they moved to the home to ensure they could provide effective support and care. The assessment identified any specialist and adaptive equipment people required to keep them safe and maintain their independence.

People received support to maintain their health and wellbeing. People were supported to access health care professionals on an on-going and routine basis, as well as when their needs changed or their health deteriorated. The registered manager said they had a good relationship with the GP surgery and felt able to ask for advice and support. One person told us, "The doctor comes when needed. I have my feet done as well and there is a nurse that comes in." A relative confirmed they were kept advised about any healthcare appointments and said, "Any queries, they are very good and get the doctor in……..I'm always told after they come, the home ring me."

Staff felt the training they received was sufficient to enable them to meet people's needs effectively. Most training was e-learning, and staff completed competency tests to demonstrate their learning had been effective. Staff told us their training was up-to-date and a training matrix was used by the registered manager to ensure training was completed. However, our observations showed not all staff were following safe infection control or medicines management practice. The registered manager acknowledged some further training was required to update staff skills and ensure staff consistently followed good practice. On the second day of our visit, the registered manager told us further training, including infection control, had been arranged.

New staff completed an induction programme when they started working at the home which included working alongside experienced staff. The registered manager told us that previously new staff had completed Care Certificate training as part of their induction. However, they had recognised some staff found the training challenging. They had asked the provider's training manager to provide further support to enable new staff to complete the qualification. The Care Certificate is a nationally agreed set of fifteen standards that health and social care workers follow in their daily working life.

Staff said they received regular supervision meetings with their manager to discuss any concerns or training and development needs. Staff felt they were well supported by the management team and by each other. One staff member commented, "If we had a query we could go to the manager or head of care and they would show us what to do."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

Where restrictions on people's liberty had been identified, the registered manager had made DoLS applications to the relevant local authority so they could be legally authorised. This protected people who could not make all of their own decisions by ensuring restrictions were proportionate and were not in place without the relevant authorisation.

Staff had been trained in The Mental Capacity Act 2005 and understood and acted in accordance with the principles of the Act. We saw staff usually asked people for their consent before giving care. For example, one staff member asked a person "Do you want me to walk with you just in case?" We asked staff what they would do if someone refused care. Staff knew to ask the person again a short time later so that their needs were met.

People told us they made their own decisions. Comments included: "They don't force me to do anything. I can please myself" and, "It's pretty free here, I can wander around all day if I like."

Some people had a lasting power of attorney to allow other people to make decisions on their behalf. At our last visit we found the registered manager had not always seen the relevant documentation to confirm others had the legal right to make these decisions. At this inspection, the registered manager told us they had asked relatives to show them the court documents that gave them the decision-making power. This made sure decisions were made by a person who had the legal right to do so.

People continued to be assisted to eat and drink enough to keep them as healthy as possible. People told us the food was good. They said they liked the meals and always had a choice. Comments included: "The food is very good. They ask me today what I want tomorrow" and, "The food, it's quite good. [Name] always offers me a choice when I am sitting down at the table." A relative told us their family member was unable to make their own meal choices but was reassured because, "Staff know what she likes."

Staff we spoke with, including the chef, demonstrated a good knowledge of people's nutritional needs and their dietary requirements. For example, they knew who had their food pureed and who had their drinks thickened because they were at risk of choking. The service had recently received an award for promoting healthy food choices and maintaining good standards of food hygiene.

Clarendon Manor presented as a homely environment where each person was supported to personalise their bedrooms with pictures and small ornaments that were meaningful to them. The shared facilities included a lounge, dining room, hairdressing salon, small cinema and a large conservatory which was used as a games room. The conservatory accessed the garden area which was secure, well-kept and suitable for people with limited mobility.

The provider had a programme of refurbishment and redecoration in place in the home. Corridors were being freshly painted at the time of our visit and the registered manager explained bedrooms were being redecorated as part of the programme.

Good

Is the service caring?

Our findings

At this inspection, we found people were as happy living at the home as they had been during our previous inspection. People were supported by staff who remained kind and caring. The rating remains 'Good'.

There was a calm and relaxed atmosphere at the home. Comments from people included: "All the staff are very nice, quite respectful to me", "You couldn't wish for anything better than the girls here" and, "The staff are angels, lovely people. They are very kind."

The registered manager told us they were confident they had a caring staff team because the recruitment and probation process ensured staff had the right attitude and values to work in the home. They told us, "I need more care staff but I won't just take anybody. If they are not gelling with other staff and engaging with the residents, then what's the point? I just want my clients to be as happy as they can be and their days fulfilled." They went on to say, "The caring staff I've got, they raise all the money for the residents' fund."

Some of the staff had worked at the home for several years, so they knew the people and their preferred routines. They told us they enjoyed working in the home and providing care to the people who lived there. One staff member told us, "I like it. I like caring for people and I like the reward you get back from it. When they can't do things for themselves, I think it is important to let them know you are there to do it for them." Another staff member told us they were confident people received kind and compassionate care because, "There is a lot of interaction with the residents and we do our hardest to please them. We will go out of our way if they like certain things and we will go shopping for them." This was demonstrated by one person who had recently moved to the home whose relative had phoned to say they liked a particular drink. On the day of our visit the registered manager had bought the drink on their way to work to ensure the person's preferences were met. .

All staff interacted with people as they went about their work. Staff acknowledged people when they walked through rooms or met them in the corridors. There was information in people's care plans about how they liked to be addressed and we heard staff using people's preferred names.

Staff demonstrated their commitment to continually supporting people to maintain and regain their independence wherever this was possible. For example, we saw one person walking slowly with their frame to the dining room for lunch. The person had recently been unwell and staff encouraged the person's mobility with one staff member saying, "Are you feeling better? It does you good to walk around a bit."

Staff understood the importance of respecting people's rights as individuals and their diversity. People were supported to maintain personal relationships. The registered manager described how staff had supported one person to maintain an important relationship based on their understanding of the person's life history and sexual orientation. A Christian chaplain visited the home regularly to carry out services. In addition staff were able to tell us how they met individual needs of people with different religious belief, for example, relating to their dietary requirements. .

People told us staff always treated them with dignity and respect. Comments included: "I am not concerned about anything, they give me respect, always" and, "They are quite respectful to me and have never been otherwise." This was confirmed by a relative who told us, "They are definitely respectful. Nothing is too much trouble and it is all done with kindness." However, we did observe two occasions when staff members entered a person's room without knocking or introducing themselves first.

Visitors were welcomed into the home and could visit whenever they wished. People told us, "There are no restrictions on visiting as far as I know" and, "There are no problems with visitors coming." There were quieter areas of the home where people could see their visitors if they wanted more privacy. A relative told us there was a homely atmosphere at Clarendon Manor and they always felt welcome when they visited.

People's personal details and records were held electronically, and staff accessed these on their handheld IPOD. People's information was held securely as each staff member required a passcode to access it. However, if a device was left unattended, it did not automatically lock to prevent unauthorised people from accessing personal information. The registered manager assured us they would review this to ensure people's personal information remained secure and confidential.

Good

Is the service responsive?

Our findings

At our last visit we found the responsiveness of the service was 'good'. At this inspection staff continued to be responsive to people's needs and their requests for support. The rating remains 'Good'.

Each person had a care plan which explained what support they needed and how they preferred that support to be delivered. This included information which enabled staff to provide person centred care. For example, one person's care plan stated they liked a milky drink before going to bed with their bedroom door left open and their light turned off. One person told us, "They asked me questions about what I like when I first came here."

Overall, care staff were knowledgeable about people's needs and how to address them. For example, some people in the home were diabetic. Staff were able to tell us the signs of high or low blood sugars so they could respond appropriately. Other people had catheters in place. Staff told us what signs they looked for which may indicate a person was developing a urinary tract infection so they could promptly seek medical advice. Staff told us information about any changes in people's health was handed over at the beginning of each shift.

The Accessible Information Standard (AIS) aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, along with any communication support that they need. Since 1 August 2016, all publicly-funded adult social care providers have a legal duty to meet the standard in full. Each person had a communication care plan which indicated whether they needed any aids to support them to communicate. We saw some thought had been given to presenting information in a way that was accessible to people. For example, the menu was in a pictorial format which was a visual prompt for people living with dementia. However, we found some improvements could be made in making information more accessible, such as pictorial signage to help people orientate themselves around the home.

People had access to some social activities. There was no member of staff specifically employed to provide activities, and there was no fixed activities programme. However, each day one member of care staff was designated to spend time in the afternoons doing a variety of activities with people. This included crafts, painting, bingo and playing board games. Some people were supported to continue their interests and hobbies. For example, one person had always enjoyed knitting so staff supported them to continue with this. However, it was less clear what activities were available to people who chose or needed to stay in their rooms because of ill-health. Staff assured us they regularly checked people and spent time talking with them to ensure they did not become socially isolated.

One person went to a local community club twice a week so they could maintain their links with friends and the local community. However, some people told us they would like more opportunities to go on trips outside the home. We discussed this with the registered manager who told us people were supported to go on shopping trips and to a local pub when staff were available. They also told us that when the weather improved, people enjoyed spending time in the garden.

People were supported to remain in the home at the end of their life if this was their wish. Staff worked with other healthcare professionals to ensure end of life care was co-ordinated and the right medicines were available so people were as pain free as possible. The registered explained the importance of supporting people to spend their final days in the home and said, "If people have been here for three, four or more years, they want to be surrounded by familiar faces. It is also important for families to be in as homely an environment as possible rather than a hospital."

The provider had a complaints procedure, but had received no complaints since our last inspection. People told us they could talk to the staff or their families if they were not happy. Comments included: "I don't have to complain because everything is good" and, "If I have any concerns, the carer is helpful." Staff said they would support people to raise their concerns. One staff member explained, "As a senior, if they come to me, if I can sort it out I will try and sort it out. If I couldn't, I would go to the manager."

The provider had received a number of compliments. These included: "[Name] has advanced dementia and other physical issues but the staff are very good and they get looked after well" and, "The establishment is not the most modern or the most high-tech but the care provided is excellent."

Requires Improvement

Is the service well-led?

Our findings

At the last inspection in February 2017 we rated this area as requires improvement because the systems and processes that monitored governance were not always effective. Improvements were required in the provider's oversight of the home because their monitoring visits were not formally recorded to provide an audit trail of the actions taken to address issues. At this inspection we found the provider's checks were still not sufficiently robust and detailed to identify the issues we found during our visit and ensure action was taken to improve the quality of care in the home.

Systems that kept people safe and protected were not consistently effective. Environmental risks were not monitored and in some cases, not considered a risk by staff or the management team. Electric heaters were left next to a person with limited mobility who was unsupervised for periods of time. Trip hazards were not always recognised or removed. An area that could put people of risk of harm or injury was not secured because the lock to the door was broken. Appropriate window restrictors had not been fitted to all the upstairs windows. None of these issues had been identified in checks of the premises.

There was limited managerial oversight to identify the risks we saw. Some people had been identified at risk of skin damage and had pressure relieving equipment to reduce the risks. However, there were no effective checks and information to ensure the registered manager and staff knew what the right settings should be, and how to check. We checked three pressure relieving mattresses which should be set to people's weight and found these were not set correctly. In some cases, they exceeded the person's weight by 130kg. The lack of consistent and effective checking placed people at increased risk. We had identified exactly the same issue at an inspection of another of the provider's homes in April 2017.

When issues had been identified at inspections of other homes within the provider's organisation, learning had not been taken to improve service provision in Clarendon Manor. For example, when we visited one of the provider's other homes in April 2017, we found there was a lack of security measures to protect people's important information being easily accessible to people without authority. Staff used handheld devices to access people's care and health records. Once staff logged on at the start of the shift, there were no further security measures so if a device was lost, stolen or had unauthorised access, people's details would be made available. Learning had not been shared because we found similar concerns at our visit at Clarendon Manor.

As we had identified issues with security measures and pressure mattresses at another home operated by the same provider, we asked the registered manager whether learning was shared when improvements were identified at other services. They told us they had not been made aware of these issues and said, "I didn't know…nothing was said to me. I will have to go and look at their report."

Reviewing the provider's audit systems we identified a lack of proactive management and leadership which had potential to affect the quality of service. On 29 December 2017 the provider had visited the home and carried out a series of checks and audits over a period of seven hours. At the time of our visit, they had not produced a report of that visit or indicated whether they had identified any areas where improvements were

required so action could be taken. Incidents, accidents and falls were analysed, however there were discrepancies between the individual records held and what the provider had recorded. In the December 2017 falls audit they had recorded five falls, but there had been six.

Following our last visit, the provider agreed to focus on making improvements from people's feedback. People completed questionnaires, but there was no effective way of getting a complete picture of how people felt, what they liked, disliked and what they wanted improving. There was no overall analysis so it was not possible to know whether people's voice was heard and what actions had been taken. All the people we spoke with could not remember completing or being asked for their feedback. Comments included: "Never had a meeting of any kind and not done a survey", "Not been to any meetings and never done a survey either" and, "We don't have meetings with anyone at all and I haven't actually filled in a survey."

Improvements were needed to ensure people had accurate information. For example, the complaints procedure was dated 2013 and referred people to us, which was not accurate, and at an address which was incorrect.

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

Overall, people were happy living at Clarendon Manor. One person said they would give the service nine out of ten and explained, "There could be more activities in the lounge." Another said, "You couldn't wish for anything better than the girls here. Nothing to improve, it is all good."

Staff told us they felt supported by the registered manager. One member of staff described the registered manager as "very supportive" and "very understanding". Another care worker explained one of the reasons they enjoyed working at Clarendon Manor was because the registered manager was approachable and they felt supported. They said, "If there is a problem she will do her best to work round it for you." Another said, "[Name of manager] is easy to talk to and she is always there to resolve any issues."

The registered manager told us they were proud of the staff team and confident they put people's needs first. They explained they regularly called into the home unannounced and said, "I want to check on my staff, but I also want to build a trusting relationship with them. I am there to support them as much as they are here to support me. I want them to come to me and tell me if they have seen anything or whatever. I want staff to feel valued and I appreciate them." Staff we spoke with confirmed they felt valued.

The registered manager told us the provider had recently introduced a 'quality assurance and compliance' report which they had to complete and submit each month. They told us that as the implementation of the report developed, it would become a useful tool to assess the quality of care provided in the home.

The registered manager told us which notifications they were required to send to us so we were able to monitor any changes or issues within the home. We had received the required notifications from them. They understood the importance of us receiving these promptly so we are able to monitor the information about the home.

It is a legal requirement for the provider to display a 'ratings poster'. The regulation says that providers must 'conspicuously' and 'legibly' display their CQC rating at their premises. The provider had displayed the front page of our last inspection report, however this was not in the preferred format.

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 12 HSCA RA Regulations 2014 Safe care and treatment Systems to identify and manage risks were not always effective to ensure people's safety.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider's quality assurance system was not sufficiently robust to monitor and improve the quality and safety of the services provided within the home.