

Beechrise Limited

Clifton Lodge - Southbourne

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 3 August 2016. It was carried out by one inspector.

Clifton Lodge provides accommodation and personal care for up to 14 older people. There were 13 people living in the home at the time of our visit.

There was a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People had their risks assessed and plans were developed to ensure care was provided for people safely. When people's risks changed their risk assessment was reviewed however the documentation was not always clearly updated so that the most up to date care plan reflected the current risk assessment. This meant people were at risk of not receiving safe care and support.

The provider had recruited five new staff. One new member of staff did not have all the appropriate pre-employment checks carried out to ensure they were suitable to work with vulnerable adults. The registered manager told us they had taken precautionary measures to ensure the member of staff did not work with people unsupervised. However they had not completed a risk assessment and could not evidence the actions they had taken during our inspection.

The registered manager told us that there had been challenges earlier on in the year when they had staff vacancies. The implications of this were they had to provide hands on care and had fallen behind with maintaining and updating records. They told us they had since appointed a senior care worker who supported them with day to day management of the home; they told us they were in the process of working through a back log and were confident all records would be updated as needed.

The registered manager had not always followed correct processes when making a decision in a person's best interests. This meant that the person's rights had not been fully protected to ensure that care was provided in the least restrictive way. The registered manager had made appropriate applications to the local authority for Deprivation of Liberty Safeguards (DoLs).

Staff had received training in safeguarding adults however two staff we spoke with had difficulty explaining to us how they would recognise abuse and what actions they would take. The registered manager told us they would take action immediately and would provide refresher training for staff. When we asked the registered manager for a list of the staff training records they were unable to provide it to us during our inspection. They agreed to compile a list and send it to us following our inspection. We received this as agreed. This confirmed staff had received training which supported them to carry out their job roles.

Medicines were stored and administered appropriately, the registered manager had put measures in place to identify gaps in recording of administration of medicines which meant errors could be identified promptly and rectified.

People told us they enjoyed the food and were offered a choice of where they would like to sit and that they could request alternatives if they did not like what was on the menu.

People were positive about staff and told us they were kind and caring. We saw staff were unhurried and worked well as a team. We saw staff being reassuring to one person who was anxious and one other person told us staff were encouraging and promoted their independence. The person told us since living in the home they were able to do more for themselves.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe. People had risk assessments but care records were not consistently updated to reflect new and emerging risks. This meant that staff did not always have sufficient guidance to support people safely.

Safe recruitment processes had not always taken place. One person started work without the appropriate checks with the Disclosure and Barring service to ensure they were safe to work with vulnerable adults.

Staff had received training in safeguarding vulnerable adults; some did not demonstrate they had sufficient knowledge to be able to report concerns appropriately. This meant people were not supported by staff who knew how to recognise potential abuse or how to report it. The registered manager told us they would take action immediately.

There were systems in place to ensure people received the correct medicines at the correct time. Checks had been put in place to rectify errors which the provider had identified and improvements had been made.

Requires Improvement 

Is the service effective?

The service was not always effective. The correct processes in relation to the Mental Capacity Act 2005 (MCA) had not been followed when making decisions in a person's best interests.

People had choices about where they sat to eat their meals and were offered choices at mealtimes.

People had access to healthcare from a range of healthcare professionals.

Requires Improvement 

Is the service caring?

The service was caring. People told us the staff were caring and friendly.

People had their privacy and dignity maintained.

Good 

People were generally involved in decisions about their care.

Is the service responsive?

The service was not always responsive. People were not always engaged in activities which interested them. There was not opportunity for people to go out of the home with staff support and activities were limited.

People had personalised plans which took into account their likes, dislikes and preferences.

People told us they knew how to raise concerns. There was a complaints policy and complaints were investigated by the registered manager.

Requires Improvement ●

Is the service well-led?

The service was not always well led. There were insufficient quality monitoring systems in place to monitor that the care people received was based on their assessed needs. This meant care plans did not always reflect people's identified risks and also that there was not always a record of when activities took place.

People and staff told us the registered manager was accessible and available

Requires Improvement ●

Clifton Lodge - Southbourne

Detailed findings

Background to this inspection

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

This unannounced inspection took place on 3 August 2016; it was carried out by one inspector.

Before the inspection we received a Provider Information Return (PIR). A 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 spoke with four people and five staff which included the registered manager, the housekeeper, two care workers as well as the cook. We also spoke with one visiting healthcare professional. We looked at three care records and a sample of the Medicine Administration Records (MAR) and three staff files. We also contacted a representative from the local authority quality improvement team.

We looked around the service and observed care practices throughout the inspection. We saw four weeks of the staffing rota and other information about the management of the service. This included accident and incident information and quality assurance audits. The registered manager was in the process of compiling a record of staff training which they sent us following our inspection.

We used the Short Observational Framework for Inspection (SOFI). This is a way of observing care to help us understand the experience of people who could not talk with us.

Is the service safe?

Our findings

People told us there were enough staff. One person told us "I get help when I need it." Another person told us there were enough staff and they did not feel rushed. The registered manager told us they had recruited five new staff since February 2016. Prior to this they had used agency staff on a regular basis. The registered manager told us they invariably used the same agency staff to ensure continuity of care. They had also promoted a member of staff to a senior care worker position. They told us staffing had now stabilised, the rosters confirmed staffing was at the assessed level and was covered by permanent staff. The registered manager told us they had advertised for a cook as the existing member of staff was leaving. They had made interim arrangements to cover the cooking which they told us consisted of rotating some staff including themselves. They were confident this would not impact the service provided for people.

Staff were not always recruited safely. One member of staff had not had sufficient pre-employment checks to ensure they were safe to work with vulnerable adults. They commenced employment in February 2016 however their check with the Disclosure and Barring Service (DBS), was not received until June 2016. We raised this with the registered manager who was not able to show us a written record of how they had risk assessed this member of staff. However they told us the member of staff did not provide care to people and they considered that people were safe. They reassured us that they had taken measures to ensure the member of staff did not have contact with people unsupervised.

The risks people faced were not always well managed. People had a full assessment of their needs which included specific risk assessments, such as pressure areas, eating, drinking and mobility. When a risk was identified there was a plan developed to provide guidance for staff on how to support the person safely. However risk assessments and care plans were not always updated in conjunction to reflect changes which had been made. For example one person's risk assessment had specific guidance around their risk of falls. A care plan dated seven months later referred to the risk assessment. However the guidance in the original risk assessment had not been updated to reflect the newer care plan. This meant that the guidance associated with minimising the risk of harm for the person was unclear and there was a risk of the person not having the right support to meet their needs.

Another person was assessed as at risk of developing a pressure sore. There was a plan to reduce the risk of this happening. The provider had referred the person to a healthcare professional and support such as a pressure relieving mattress and regular repositioning was provided. The registered manager reviewed the person's risk assessment relating to this on 1st April 2016 and considered the person did not require a pressure relieving mattress and it was removed as it was not deemed necessary as the person's skin had improved. On the 26th April 2016 the person had developed skin damage. The registered manager told us the pressure mattress had been reinstated, however this had not been documented. During our inspection we noted that the person's skin damage was improving and there had been involvement from a healthcare professional. The registered manager who told us they would take action to ensure risk assessments and care plans were up to date and amended as required.

Not all staff knew how and when to report safeguarding. Staff had received training in safeguarding adults but not all were able to explain to us how they would recognise potential abuse and what actions they would take. The registered manager told us they would address this immediately and planned to provide refresher training for staff as well as discuss it in supervision.

The registered manager had liaised appropriately with the local authority safeguarding team to ensure any potential safeguarding concerns were dealt with appropriately. There were no current safeguarding investigations outstanding.

The registered manager reported to us in the PIR that they had recorded 64 medicine errors in a twelve month period, we asked them what the impact of the errors had been. They advised us the errors had been gaps in signing the Medicine Administration Record (MAR) or discrepancies in balances of medicines. The registered manager had taken actions to ensure there was a system for checking medicines including the MAR and balances. We saw the checks were effective and people were receiving their medicines correctly. Dedicated staff had received training to ensure they were competent to administer medicines. Medicines were stored appropriately and at the correct temperatures.

There were appropriate safety checks within the environment such as testing of electrical goods and checks on equipment. Health and safety checks were made and we saw actions were taken to rectify when a risk was identified. For example a risk of falls was identified in a toilet area and grab rails were fitted to mitigate the risk. Accidents and incidents were reported according to policy and we saw the registered manager completed analysis of the reporting.

Is the service effective?

Our findings

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

The provider had not always followed the correct processes when making a decision in a person's best interests. For example, one person was identified at risk of causing harm to them self or others when using a particular piece of equipment to support them to walk independently. Their care records indicated that they used the equipment incorrectly therefore was at risk of causing harm to themselves or others. The registered manager had made a decision in the person's best interests to remove the piece of equipment. There was not a decision specific mental capacity assessment associated with the decision to remove the equipment and there had not been consultation with a healthcare professional. The registered manager told us they had discussed the decision with family however had not documented it. This meant the persons' rights had not been protected in a way that ensured when a decision was made in their best interests the least restrictive option was considered and relevant family and healthcare professionals were involved.

The person reported to the registered manager that they were feeling restricted by the removal of the equipment and the registered manager updated the best interest decision to allow supervised use of the equipment. There had been reviews following this decision in which it was reported that supervised use of the equipment was working well although there had still been occasions when the person had used it unsupervised. During our visit the person was not using the equipment and one member of staff told us the person did not use it. We spoke with the person who did not tell us of any concerns related to the care and support they received.

Another person had a decision made in their best interest and the provider showed us they had liaised with a healthcare professional and the person's relative.

The registered manager had made four applications for DoLS; they had not been assessed by the local authority.

The registered manager told us staff had received appropriate training however they were unable to show us up to date training records for staff as they were in the process of compiling them. We saw training certificates in staff files. They told us that they were behind with administration jobs because of staffing problems earlier in the year. They agreed they would update the training spreadsheet to demonstrate to us that staff had received the appropriate training which we received following our visit. Staff received regular

supervision; one staff member told us they experienced supervision as supportive.

People told us they enjoyed the food. One person told us they get plenty of choice and told us they had bacon and eggs every morning because that's what they wanted. The registered manager told us they talked with people informally about their food choices and preferences and said that people could select alternatives from the menu. One person told us "I get a choice, I have a word with the chef and (name) knows what I like they'll give me what I ask for." One member of staff told us if they observed people not eating they checked with them if it is to do with the food or if it was because they were unwell. They told us about one person who had lost their appetite and we saw a GP had been consulted and staff monitored the person's food intake and weight. During lunch people told us the food was good.

People had access to healthcare when they needed it. During our inspection one person was referred to a district nurse and we saw evidence that other people had appointments with a range of healthcare professionals. For example GP's, district nurses and occupational therapists. Staff recorded the outcome of appointments with healthcare professionals in people's care records. One visiting healthcare professional told us staff were responsive to people's needs and liaised with them appropriately.

Is the service caring?

Our findings

People were positive about the support they received from staff and told us staff were friendly and got to know them. One person told us "Staff are lovely, they're cheerful and kind-they know what I like." Another person told us "Staff are very good to me." Staff were able to talk to us about people in a way which showed us they knew people's individual needs and how people preferred to be supported. We saw staff talking with people with familiarity and there was appropriate use of humour. One person told us humour was important for them and they enjoyed a joke with staff.

One person told us staff were respectful of their privacy and were able to give us some examples such as staff closing curtains during personal care. During our inspection we saw staff knocking on people's doors and personal care was carried out discreetly.

During a short SOFI we observed staff working well as a team. For example we saw staff talking with others in a relaxed manner. Staff sat with people when they supported them with their lunch and were unhurried. Staff gave people encouragement and reassurance as needed for example one person was nervous when walking.

People had mostly been included in making decisions about their care and one person talked with us about how staff encouraged them to be independent. People had been involved in planning the care they needed and we saw they had signed to confirm this. For example one person had identified a particular goal they hoped to achieve and this was documented in their care plan with guidance for staff how to support the person to achieve their goals.

One person told us their family could visit whenever they liked, they commented they could go out when they liked and had all their personal items around them. They told us it was their home and they felt supported by staff to be happy and comfortable living there.

Is the service responsive?

Our findings

People had opportunity to engage in some activities but these were limited. One person told us they had enough to do although they were able to organise their own entertainment. Feedback from relatives included that their relation sometimes sat with nothing to do and another relation commented it would be nice if their relative was supported to go out along the seafront or local shops. Staff told us they did not take people out.

We spoke with the registered manager who told us they did not have a formal programme although they did offer daily morning exercise sessions and arranged for entertainers to visit the home. Staff recorded in a diary when activities took place and we saw entertainers usually visited the home at least once a week. Other activities listed included the morning exercise sessions, eye spy, quizzes, soft ball and watching a film. In general there were exercises in the morning and one other activity in the afternoon, for example exercises and then watching a film in the afternoon. There were some gaps in the activity diary and it was unclear if activities took place on these days.

This meant that there were limited recreational and leisure activities for people and there was a risk that people did not have enough social and mental stimulation. We saw that people had person centred care plans which included important information about their background and life story as well as likes, dislikes and preferences. For example one person had always taken particular attention to how they dressed and liked to be well presented at all times. They told us staff supported them to achieve this. Staff talked with us about another person and told us they liked to have their television on all the time which was identified in their care plan. However activities were not planned around people's individual interests.

Concerns and complaints were managed appropriately. There was a complaints policy and complaints were logged and investigated within a stipulated timeframe. We saw that any complaints had been dealt with according to the policy and a satisfactory resolution had been achieved. One person told us they would go to the registered manager if they had any concerns although told us "I have no complaints."

People's feedback was sought to improve the service. People and their relatives were invited to complete an annual quality questionnaire and the registered manager told us they spoke with people informally to seek their views on the service. One person verified that they were asked for their opinion regarding the care and support they received. Feedback from relatives and people confirmed people felt involved in planning their care and that people and their relations knew how to raise concerns.

Is the service well-led?

Our findings

The service was not always well led. There were insufficient quality monitoring systems in place. This meant areas for improvement were not always identified so that actions could be taken. For example the registered manager told us one care plan was audited each month however this meant that care plans would be audited once every 13 months based on the occupancy at the time of our visit. This was not sufficient to ensure gaps were identified. The impact of this was people's care records did not always have care plans and risks assessments which reflected their care and support needs. The auditing process was not robust and was not based on people's needs and any presenting issues. This was also evident as gaps in recording the activities had not been identified and therefore it was unclear if they had happened.

The registered manager was open and transparent, they told us about challenges earlier in the year when they had staff vacancies. They told us this impacted their day to day management of the home as they were working hands on to provide cover from the roster to ensure that people's needs were met. They told us this had some positives as it meant they got to know people well and they were accessible to people, relatives and staff. However it also meant they had fallen behind with updating and maintaining records.

A senior care worker had been appointed to support the registered manager with the day to day running of the home. The registered manager told us this meant they were able to work on the back log of administration which included updating and reviewing people's records. They had also identified roles and responsibilities for the senior care worker which included auditing of care plans.

The business plan had identified the appointment of a senior care worker and also plans to introduce a computerised records system. The registered manager told us planning for this was still in progress. This demonstrated that the provider had plans to develop the service and make improvements.

The registered manager was visible and had a rapport with people living in the home. People told us the registered manager was approachable and they had confidence they would listen and respond to any concerns they had. Staff agreed the registered manager was approachable and told us they felt supported. One member of staff gave us examples of when they had made suggestions to the registered manager and changes had been made.

The registered manager told us they received support from the managing director which included daily contact. They also attended local networks to keep up to date with developments in the provision of care in residential settings and partnership working with other agencies.