Care Quality Commission

Clarence Lodge (Great Yarmouth) Limited

Clarence Lodge

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?	
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

We carried out an unannounced comprehensive inspection of this service on 15 January 2015. A breach of legal requirements in relation to cleanliness and infection control was found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet the legal requirements in relation to the breach.

We undertook this unannounced focused inspection on 15 July 2015 to check that the provider had followed their plan and to check whether they met legal requirements. This report only covers our findings in relation to this requirement and other areas that were found to require improvement at the last inspection. These areas were under the relevant key questions of; is the service safe, effective, responsive and well-led. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Clarence Lodge on our website at www.cqc.org.uk.

Clarence Lodge is a service that provides accommodation and care to older people and people living with dementia. It is registered to care for up to 28 people. At the time of this inspection, there were 23 people living at Clarence Lodge.

Summary of findings

This service requires a registered manager to be in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 is a registered manager in place at Clarence Lodge.

Some areas of the home and some equipment that people used remained unclean. These included the food storage area, the laundry and the communal lounge and toilets. Some chairs that people were sitting in were worn and stained. Equipment such as hoists, standaids and walking frames were not clean.

Risks to people's safety had not always been assessed or the actions deemed necessary by the provider to protect people from a risk had not always been implemented. These included risks in relation to the safety of the premises, evacuating people from the building in the event of an emergency and monitoring people's risk of not eating.

The quality systems that were in place to assess people's safety in respect of the premises and some risks to their health and safety were not effective, placing people at risk of poor care.

This meant that there were some breaches of the legal regulations and you can see what action we told the provider to take at the back of the report.

We found that the provider had made some progress to other areas we identified as requiring improvement at our last comprehensive inspection in January 2015, although further improvements were required. These were in relation to staff knowledge of the Mental Capacity Act and associated training, the development of the premises into a more suitable environment for people living with dementia and the provision of activities for people that complemented their interests and hobbies. We will check these areas in detail at our next comprehensive inspection.

We have recommended that the provider considers current guidance on adapting their environment to assist people living with dementia.

Summary of findings

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.

Some areas of the premises and equipment that people used were unclean.

Risks to people's safety had not always been assessed or mitigated.

Actions identified by the provider to protect people from the risk of harm were not always being followed by the staff.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Some of the staff we spoke with did not have a clear understanding of their obligations to work within the Mental Capacity Act 2005 when caring for people who lacked capacity to consent to their care. The staff were in the process of receiving training within this subject.

Work was ongoing to improve the layout of the premises for the people who lived there.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

The provider was working on a programme of activities but these had not yet been fully implemented.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The monitoring of some areas of the quality and safety of the service provided was not effective.

The provider had not implemented the changes to monitoring the service that they said they would.

They had not always followed specialist advice on how to improve the quality of the service provided.

Clarence Lodge

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.

We undertook an unannounced focused inspection of Clarence Lodge on 15 July 2015. This inspection was done to check that improvements to meet legal requirements planned by the provider after our 15 January 2015 inspection had been made. The team inspected the service against four of the five questions we ask about services: is the service safe, effective, responsive and well led. This is because the service was not meeting one legal requirement and required improvements in other areas. The inspection team consisted of two inspectors.

Before the inspection, we reviewed the information we held about the service, this included the provider's action plan that they sent us following our last inspection in January 2015.

On the day we visited the service, we spoke with four people living at Clarence Lodge, two visiting relatives, five care staff, the cook, the deputy manager, the registered manager and a visiting healthcare professional.

The records we looked at included five care plans, records relating to the maintenance of the premises and equipment and records relating to how the provider monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

During our last inspection in January 2015, we found that there had been a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was due to the provider not ensuring that some areas of the premises and equipment that people used was clean. During this visit, we found that improvements had been made to the cleanliness of items relating to people's beds, bedding and commodes. However, a number of communal areas at Clarence Lodge and equipment that people used remained unclean.

The people we spoke with were happy about the standard of cleanliness at the service. However, our observations were that the standard of cleanliness was not adequate.

We saw that in some people's rooms, the skirting boards were very dusty. One person's en-suite bathroom had a visible build up of dirt around the edge of linoleum. Dead flowers were in stagnant water in another person's room and the chair in their room was stained, with food debris and dust under the cushion.

Some chairs within the communal lounge were stained and unclean under the cushions. We saw that areas behind some chairs required vacuuming. One person's cushion that they had been sitting on was covered in food debris. Another person's walker was dusty and unclean. A further person's cushion was split which meant that it could not be cleaned effectively.

Although there was a domestic member of staff working, debris remained on a number of the communal carpets for the duration of our inspection. The communal toilets were not cleaned as regularly as we were told they should be by the deputy manager. One toilet had faeces on the door frame for over two hours. When we were told that the toilet had been cleaned, we found that some faeces remained on the door frame. This toilet was frequently used by the people living at the service.

The laundry area was cluttered and unclean. There was a sink in the laundry for staff to wash their hands after handling unclean laundry but it contained vases and glasses making it impossible for them to do so. The sink was also contaminated with lime-scale and was unclean but clean clothes were being stored on it which increased the risk of them becoming contaminated.

Staff told us that the kitchen was used to wash their hands after they had given people personal care. However, it is poor practice to enter the kitchen after giving personal care because of the risk of cross-contamination.

Staff were seen to use lifting equipment that was dusty and contaminated with dust and debris. Equipment that was used to clean the home were either not clean or was not being stored appropriately. Colour coded mops and buckets were used to clean different areas of the home. However, these were being stored outside in the rain and there was a snail in one of the buckets. This custom of storing buckets outside had been raised with the service in January 2015 by an infection control specialist who told the provider that this was poor practice. The deputy manager told us that the mops should not have been stored outside but did not remove them throughout the duration of our inspection. We also saw that a dustpan and brush that the deputy manager told us was used to clean the dining room was unclean and packed with dust and dirt.

Two of the five staff we spoke with felt that Clarence Lodge was not as clean as it should be and that they did not have time to assist the domestic staff with cleaning duties.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some risks to people's safety had not been adequately assessed and the provider had not always done all that was practical to reduce the risk of harm to people. For example, some areas of the premises were seen to be unsafe and presented trip hazards to people and staff. Outside in the garden area we saw that there was a hosepipe on the floor and there were loose screws on the ground. People who lived at the service were seen walking around in this outside area unattended. Some of the flooring in the communal corridors and in people's rooms was worn or raised which also presented a trip hazard.

The lighting within the communal corridors on the first and second floors was poor. The registered manager confirmed that some people living on these floors had poor mobility. Therefore, their safety was compromised by the poor lighting.

Requires Improvement

Is the service safe?

The service did not always follow good practice to make sure that people were safe in the event of a fire. We observed that some doors to people's rooms were propped open. These doors are designed to close automatically if the fire alarm went off to prevent the spread of fire and protect people from harm and therefore would not work effectively when propped open. The door to the laundry room was also open for a number of hours and a tea trolley blocked the fire door to the kitchen.

Areas that contained chemicals such as washing powder and cleaning products were not stored in a locked cupboard as they should have been. Therefore people could gain access to these areas and potentially harm themselves. We saw people living with dementia walking near these areas.

Building work was being carried out to change the layout of the building. The risk of this work had not been assessed and we saw tools such as hammers and planes unattended on tables within the room being worked on that people could access.

We also found that one person's risk of being evacuated from the building in the event of an emergency had not been assessed even though they had been living at the service for over one month. Other risks in relation to this had not been re-assessed for people over the last 18 months.

The provider had identified people who were at risk of not eating and drinking and had therefore specified how often their weight needed to be monitored to make sure the action they were taking to reduce this risk was effective. However, this monitoring was not always taking place. One person had been assessed on 28 April 2015 as being at high risk of not eating. The provider stated that they should be weighed fortnightly from this date. However, they had not been weighed until 8 June 2015 where they had lost weight. They had also not been weighed since this date. Another person who also been identified as requiring close monitoring had not been weighed regularly in line with the providers requirements.

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

At the last inspection, we found that some people's creams that had been prescribed to them were not secure and could therefore be taken or tampered with. At this inspection we found that the provider had arranged for a locked cabinet to be placed in each person's room which was used to store people's creams. We did not see any creams stored unsafely during this inspection and were satisfied that the required improvements had been made to make sure that people's creams were stored safely.

Requires Improvement

Is the service effective?

Our findings

During our last inspection of the service on 15 January 2015, we found that the premises required improving so that people had access to a safe outside space and that the design was a more appropriate environment to assist those people who lived with dementia. Staff also needed to improve their understanding of the Mental Capacity Act 2005 so that they could effectively support people who were unable to consent to their own care.

We found that some work to the premises had commenced. A room at the back of the home was being changed into a café. The registered manager told us their plans were to change this room into an old fashioned tea room where people and relatives could relax in an environment to stimulate reminiscence. This would provide a second communal area for people to spend time in in as currently there was only one communal area where people could sit during the day.

Some re-decoration of the service had occurred. However, these were still in neutral colours and we had previously advised the provider that these may not assist people living with dementia to help them orientate themselves around the home.

There was a secure outside space at the back of the property where people could sit outside. The registered manager told us that since they had told people about this area, it had been in use often. They said that people liked to eat their food outside and sit in the sun. However, we found that some areas of the outside space presented a hazard to people as described within the 'safe' domain of this report and therefore required further work. Therefore, further improvements are required to provide people with a safe and secure outside space and to make the environment more appropriate for people living with dementia.

Some of the staff we spoke with understood their legal obligations to work within the Mental Capacity Act 2005 when providing care to people who could not consent to their own care. However, others did not. The registered manager told us that they were in the process of providing training for all of the staff at the service. Therefore, further improvements are required to ensure that the rights of people who lack capacity to make their own decisions are protected.

We recommend that the service considers current guidance on adapting their environment to assist people living with dementia.

Requires Improvement

Is the service responsive?

Our findings

During our last inspection of the service on 15 January 2015, we found that people did not have access to activities that complemented their own hobbies and interests and that this required improvement.

During this inspection we received mixed views from people about the activities that were on offer. One person told us, “Oh yes, there is always plenty to do.” However, another person told us, “There is nothing to do, we just sit about all day.” A relative told us, “They have started more group activities.”

Since the last inspection, the provider had employed a member of staff to concentrate specifically on providing people with activities that they would find interesting. We spoke to this member of staff. They told us that they were currently in the process of speaking to each person and their close family members to work out what their interests were. They were also making contact with services within the local community such as schools, the church and local shops. Plans were in place to get people involved in flower arranging, baking and picture making. A coffee morning for the female residents was planned to be held, as was a ‘gentlemans club’ for the male residents. A potting area had also been set up outside where some people liked to grow flowers and vegetables.

We saw a petting dog arrive during our inspection for approximately 30 minutes which people enjoyed making a fuss of. However, we did not see anybody participating in any other activities on the day of our inspection. We were satisfied that the provider had started to make improvements but further improvements are required to make sure that people have regular access to activities they enjoy.

Requires Improvement

Is the service well-led?

Our findings

During our last inspection of the service on 15 January 2015, we found that the provider did not have effective quality assurance systems in place to monitor the cleanliness of the service and equipment that was used by people. The provider sent us an action plan to tell us how they were going to improve this. We also found that the provider was not making sure that people who were at risk of not eating enough were being monitored closely so that they could review and revise any action they were taking. We told the provider that improvements were required within these areas. However, during this inspection we found that sufficient improvements had not been made.

The monitoring of some areas for cleanliness had improved, such as of people's beds, bedding and commodes which were being checked daily by the care and domestic staff. However, monitoring of other areas of the service such as communal toilets and lounges and equipment that people used had not been conducted. In their action plan, the provider had told us that they had implemented a more effective monitoring process in relation to the cleanliness of the environment but this had not been the case. They also told us that the equipment people used would be checked regularly and the laundry would be kept clean and tidy. This had also not been done.

The provider had not always followed professional advice that had been received from an infection control specialist in January and March 2015, therefore increasing the risk of potential harm to the people who lived at the home.The provider had also not made sure that staff were adhering to the organisation's policy on how to control the risk of the spread of infection. This policy clearly stated that there should be regular audits regarding the cleanliness of the service and that the environment and equipment should be clean.

During our inspection in January 2015, we found that people who had been found to be at risk of not eating enough were not being weighed as frequently as the provider had identified they should be. At this inspection, we found that no improvements had been made. Therefore we concluded that the current systems in place to monitor the quality and safety of some areas of the service provided were not always effective.

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

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. 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 Risks to people's health and safety had not always been assessed. Where the provider had identified actions to reduce the risk of harm, this was not always followed. Some areas of the premises were unsafe. (Regulation 12 (2) (a), (b) and (d)).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment Some equipment that people used and areas of the service were unclean. (Regulation 15, (1), (a) and 15 (2)).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The systems in place to monitor the quality and safety of the care provided were not always effective and did not mitigate risks to people's safety and welfare. The provider did not always act fully on feedback received from professionals. (Regulation 17 (1) and (2) (a), (b), (e)).