

# Sovereign Care Limited

# Caroline House

## Inspection report

7 – 9 Ersham Road  
Hailsham  
East Sussex  
BN27 3LG

Tel: 01323841073

Date of inspection visit:  
17 May 2017  
18 May 2017

Date of publication:  
02 June 2017

## Ratings

Overall rating for this service

Good ●

Is the service safe?

**Requires Improvement** ●

Is the service effective?

**Good** ●

# Summary of findings

## Overall summary

We inspected Caroline House on the 17 and 18 May 2017 and the inspection was a focused unannounced. Caroline House provides accommodation for up to 28 older people. On the day of our inspection there were 24 people living at the service. Caroline House is a residential care service that provides support for older people living with dementia, mental health needs and sensory impairment. Accommodation was arranged over two floors with stairs and a lift connecting each level.

There was a registered manager in post. 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.

At the last comprehensive inspection on the 6 and 10 October 2016, the service was rated as 'Good' overall and Requires Improvement in the 'effective' domain. A breach of legal requirements was found. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Need for Consent. We undertook this focused inspection to check that they had followed their plan and to confirm that they now met legal requirements. We identified concerns in relation to infection control and staff deployment. Due to these concerns, we also considered whether the service was safe. We therefore looked at two key questions, is the service safe and effective? This report only covers our findings in relation to those requirements. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Caroline House on our website at [www.cqc.org.uk](http://www.cqc.org.uk)

The service had made improvements since the last inspection. Decision specific mental capacity assessments were now in place. Staff had received training on the Mental Capacity Act 2005 (MCA) and understood the importance of obtaining consent from people. Deprivation of Liberty Safeguard (DoLS) applications had been made and any associated conditions had been documented and acted upon. However, we found new concerns in relation to infection control and staff deployment. The rating for the safe domain of this service has been revised from 'Good' to 'Requires Improvement'.

During the inspection, we identified concerns with the management of infection control. Certain areas of the service had a malodour and some people's beds had been made with stained linen and food debris still within the bed. Some people's individual continence aids also omitted a strong odour and risk assessments had not always been reviewed or updated. We have identified a new breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we told the provider to take at the back of the full version of the report.

Systems were in place to determine staffing levels and people and staff felt staffing levels were sufficient. However, the deployment of staff was not always safe. We have identified this as an area of practice that needs improvement.

Staff were not consistently knowledgeable about the people they supported. Staff were not consistently aware that one person required fluid thickener in their drink. A number of people required the use of falls sensor mat. Care plans and risk assessments had not always been updated to reflect whether they required the use of the sensor mat just at night or during the day. We have identified this as an area of practice that needs improvement.

Staff knew how to recognise and respond to abuse. Regular health and safety checks were undertaken to ensure the environment was safe and equipment worked as required. Regular fire drills were completed. Staff were checked before they started working with people to ensure they were of good character and had the necessary skills and experience to support people effectively.

Arrangements for the supervision and appraisal of staff were in place. Staff told us they felt supported and recognised the part that regular scheduled supervision played.

People's health and wellbeing was continually monitored and the registered manager regularly liaised with healthcare professionals for advice and guidance. People received medicines on time and records of people's health and emotional wellbeing had been maintained. People were encouraged and supported to eat and drink well. There was a varied daily choice of meals and people were able to give feedback and have choice in what they ate and drank.

## 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** ●

Caroline House was not consistently safe.

The registered provider had not ensured the premises were clean and hygienic to reduce the risk of the spread of infection in the service. People felt staffing levels were sufficient, but the deployment of staff was not always safe.

Staff's knowledge on the use of fluid thickener varied which placed people at risk. Care plans and risk assessments had not always been updated to reflect the level of support required to minimise the risk of falls.

Staff received training on how to safeguard people and were clear about how to respond to allegations of abuse. The management, administration and storage of medicines were safe.

### Is the service effective?

**Good** ●

Caroline House was effective.

Staff received training and supervision to support them in providing effective care to people.

Staff had a clear understanding of the Mental Capacity Act (MCA) 2005 and there were procedures in place to ensure that the service was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS).

People were supported to have enough to eat and drink and to access health care services to maintain their health and wellbeing.

# Caroline House

## Detailed findings

### Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 Caroline House on 17 and 18 May 2017. This inspection was carried out to check that improvements to meet legal requirements planned by the provider after our 10 October 2016 inspection had been made. One inspector inspected the service against two of the five questions we ask about services; is the service safe and is the service effective? This was because the service was previously not meeting some legal requirements. This inspection was carried out by one inspector.

The provider had not completed a Provider Information Return (PIR), because we had not requested one before this focused inspection. This is a form that asks the provider to give some key information about the service, what the service does well and the improvements they plan to make. Before the inspection we reviewed all the information we held about the service; we looked at previous inspection reports and any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

We spoke with the registered manager, six care staff members and five people who live at Caroline House. We looked at five care plans and the associated risk assessments and guidance. We looked at a range of other records including medicines records and audits, maintenance records, three staff recruitment files and staff rotas. We observed people receiving their lunchtime medicines.

We last inspected this service on 6 and 10 October 2016. Breaches in the regulations were identified at this inspection and the service was rated as 'Good.'

# Is the service safe?

## Our findings

People told us they felt safe living at Caroline House. One person told us, "Of-course I am safe here." Another person told us, "I am definitely safe here." People told us that they felt there were sufficient numbers of staff to meet their care and support needs. Despite people's positive comments, we found areas of care which were not consistently safe.

Guidance produced by the Department of Health identified that 'the steps taken in care homes to protect residents and staff from infection represent an important element in the quality of care, particularly as some infections have the capacity to spread within environments where susceptible people share eating and living accommodation.' Cleaning schedules were in place to ensure that all areas of the home were cleaned regularly including people's bedrooms and bathrooms. The registered manager was the infection control lead and completed a monthly infection control audit. However, despite these systems in place, we found areas of practice where adequate standards of hygiene had not been maintained. For example, during the inspection, we identified that a number of people used a kylie washable bed pad (these are continence aids). The registered manager told us that systems were in place to ensure that these were washed each night and a fresh kylie would be placed in the individual's bed the following day. However, despite systems in place to ensure that people had a fresh kylie each day, we found two kylie's on people's beds omitted a very strong odour which indicated they had not been washed. There were potential infection control risks for people sleeping on kylie's that were inadequately washed. We brought these concerns to the attention of the registered manager who took action immediately by replacing the kylie's with fresh clean ones.

Within certain areas of the home, we found a malodour. The malodour was primarily present within the communal lounge and dining room. The registered manager told us, "We have identified the malodour within the lounge and dining room and are in the process of sourcing quotes to replace the carpet with laminate flooring instead." The registered manager acknowledged that the carpet was primarily omitting the odours and although cleaned regularly, a laminate floor would be more appropriate for the service. After the inspection, the registered manager informed CQC that new laminate flooring had been installed in the dining room and would soon be installed in the lounge area.

People and staff felt overall the service was clean and tidy. The registered manager was open and responsive to our concerns and started taking steps immediately to address the concerns. However, these steps were not yet embedded into practice. We have identified this as an area of practice that needs improvement.

The service employed a dedicated team of housekeepers who supported with laundry alongside care staff. Systems were in place to keep dirty and soiled laundry separate from clean linen which prevented the risk of cross-contamination. Designated washing machines were in place to disinfect soiled and dirty laundry which included a setting to wash the laundry at over 65 degrees to remove any potential contamination. However, despite these measures in place, we found that people's beds had been made with stained bed linen. Guidance produced by Social Care Institute for Excellence advised that dignity in care involves supporting people to maintain their personal hygiene and appearance, and their living environment, to the

standards that they want. We discussed with the registered manager whether it was dignified for people to be sleeping in stained linen. The registered manager told us, "I have identified this as an issue, as it isn't very nice. Memos have been sent to staff and I have been talking to staff during supervisions." The registered manager had identified these concerns as an issue; the improvements required were not yet embedded into practice. We also identified that a number of people's bed's had been made with debris of food still in the bed. Although steps were being taken, these improvements had not yet been embedded into practice. We have identified this as an area of practice that needs improvement.

Some older people with health impairments such as dementia and Parkinson's can be at heightened risk of choking or swallowing difficulties. For people assessed with swallowing difficulty, the use of thickened fluids when drinking is required to minimise the risk of choking and aspiration. On the first day of the inspection, we saw fluid thickener within one person's bedroom. We asked staff if anyone required the use of fluid thickener and one staff member confirmed that one person did. However, four other staff confirmed that no one required the use of fluid thickener. We addressed these concerns with the registered manager who confirmed that one person was being trialled with fluid thickener due to concerns over coughing when drinking, especially when the individual was not fully alert. The registered manager told us, "We have been trialling one scoop within their drink to see how they get on." Despite these concerns, the care plan and risk assessment had not been updated to reflect the use of fluid thickener. A patient safety alert had been cascaded by NHS England in February 2015 which warned care providers to the dangers of ingesting thickener. During the inspection, we observed that this person's bedroom door was left open all day and other people were walking around the service and some people had a history of walking into other people's bedrooms. Due to the potential risk to people of fluid thickener being digested accidentally, there were no established systems in place to determine whether it was safe for the fluid thickener to be left unattended in a person's bedroom. The registered manager was responsive to these concerns and during the inspection, amended the individuals' care plan and implemented a risk assessment on the safe storage of fluid thickener. However, we raised concerns around staff's knowledge on the use of fluid thickener.

Risks to individual's safety and wellbeing had been assessed and people were supported to be safe without undue restrictions to their freedom. During the inspection, we observed people walking around, spending their day as they pleased. Guidance produced by AGE UK advises that some older people living with dementia can be at heightened risks of falls. Falls risk assessments were in place which considered the risk of falling and the actions required to minimise the risk. A number of people required two hourly safety checks and some people had falls sensor mats in place. However, we found that a number of sensor mats were unplugged even when people were in bed or spending time in their bedroom. One person's care plan stated, 'they have a buzzer mat in their room as they are at risk of falls and they often alert staff using this.' During the inspection, this person was in bed and the sensor mat was unplugged. The registered manager told us, "Some sensor mats are only used for night-time and others are unplugged during the day due to people walking in and out of the room and setting off the mat." People's care plans failed to reflect if they required the sensor mat only at night or whether it was safe for the mat to be unplugged during the day. We brought these concerns to the attention of the registered manager and during the inspection they had started to review and update falls risk assessment.

The registered manager was responsive to our concerns. However, there was the risk that care plans and risk assessments were not always updated and reviewed regularly to provide sufficient guidance for staff to follow. Failure to assess and review the risks to the health and safety of people is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Staffing levels were sufficient and based on the needs of people. The registered manager had devised a staffing level audit form which reviewed staffing levels and considered people's individual level of needs and

the number of care hours required by staff to meet people's needs. People and staff felt staffing levels were sufficient. One staff member told us, "Staffing levels are fine; we get time to spend with people." One person told us, "I think staffing levels are ok." Another person told us, "I have no worries, staff seem to be around." Despite people's praise for staffing levels, we found the deployment of staff required improvement. For example, on the second day of the inspection, we spent the morning with people in the lounge. During a thirty minute time frame, only one staff member entered the lounge, they walked in and then out. They made no contact with people apart from smiling at one person. During this timeframe, one person was continually saying, 'where am I' and 'I want to go home'. People that were sitting in the lounge area provided comfort to this individual by telling them where they were. However, no staff were present to provide this comfort. We brought these concerns to the attention of the registered manager who was responsive to our concerns and agreed the visibility of staff in the lounge could be improved. We have identified this as an area of practice that could be improved.

Guidance produced by AGE UK advises that for people living with dementia they can sometimes display behaviours which challenge, however, these behaviours are a clear expression of their feelings and needs. Staff were knowledgeable about the people they supported and how to respond to behaviours which challenge. One staff member told us, "We have one person who can walk in and out of other people's bedrooms which can cause distress. We manage this by explaining that the room they are in isn't their bedroom and offer them a cup of tea and re-direct to the lounge. We find they respond well to the offer of a cup of tea." Behaviour management strategies were in place which considered the triggers for any behaviour which might challenge and the interventions staff should follow. For example, one person's behaviour management strategy identified that a person could display agitation around night time when staff are supporting them to get ready for bed. Clear guidelines were available for staff to follow.

Staff recruitment practices were thorough; people were only supported by staff who had been checked to ensure they were safe and suitable to work with them. Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). A DBS check helps employers make safer recruitment decisions and prevent unsuitable people from working with people who require care and support. All potential employees were interviewed by the manager to ensure they were suitable for the role. All new staff were required to undergo a probationary period during which they received regular opportunities for practice supervision.

Appropriate steps had been taken by the registered provider and manager to reduce the potential risk of people experiencing abuse. Staff members demonstrated a good understanding of the different types of abuse and provided clear explanations of the actions they would take if they thought abuse had occurred. One staff member told us, "If I had any concerns, I would report those to the manager. If the manager didn't do anything or it was the weekend, I would potentially contact the police or the local authority." Staff confirmed that they had received training in safeguarding people and records confirmed this. The manager had raised safeguarding concerns where required and worked in partnership with the local authority to ensure the safety of 'residents' when concerns had been raised. Where safeguarding concerns had been raised, the registered manager was able to demonstrate how they had learnt from the safeguarding process and what changes they had made to the provision of care. The registered manager told us, "Following one safeguarding, we have now changed the code on the front door and this code is only given out to permanent staff members. Visitors such as family members are no longer allowed the code."

Medicines were stored, administered, recorded and disposed of safely. Medicines were delivered from the pharmacy already dispensed in monitored dose packs. We observed staff administering people's medicines during our inspection and saw that good practices were followed. For example, the staff member wore a red tabard to advise other staff they were supporting with medicines. They stayed with people while they took



their medicine and offered them a drink of their choice. People knew what their medicines had been prescribed for and staff sought consent from people before giving them their medicines. We saw that medicines administration record (MAR) sheets were signed when the medicines had been given. Regular auditing of medicine procedures had taken place, including checks on accurately recording administered medicines as well as temperature checks for medicines stored in the fridge. This ensured the system for medicine administration worked effectively and any issues could be identified and addressed.

## Is the service effective?

### Our findings

Staff and the registered manager knew people well. They spoke warmly of the people they cared for and were able to explain people's support needs and individual qualities. People told us and indicated that they were happy with how they were looked after and the staff knew what to do to make sure they got everything they needed. One person told us, "I am very comfortable here." Another person told us, "I'm very lucky to be in a place like this."

At our last comprehensive inspection in October 2016, the provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because the provider was not adhering to the principles of the Mental Capacity Act (MCA) 2005. An action plan had been submitted by the provider detailing how they would be meeting the legal requirements by February 2017. At this inspection, we found improvements had been made and the provider is now meeting the requirements of the regulation.

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. Staff were aware of their responsibilities under the MCA. They were able to tell us about the principles of the Act. One staff member told us, "It is about people's ability to make specific decisions. We always assume that people can make their own decision and if they lack capacity, we will make decisions in their best interest." Staff also understood the importance of consent and throughout the inspection; we observed staff gaining consent from people before providing care.

Caroline House had range of restrictive practices in place, such as key coded entry to the service and key coded doors throughout the service which prevented people from freely moving around the service at times. At the last inspection, decision specific mental capacity assessments were not in place and people's ability to consent to those restrictions had not been assessed. Improvements had been made and decision specific assessments were now in place. For example, people's ability to consent to the use of bed rails and the front door being locked had been assessed. Where people lacked capacity, mental capacity assessments were in place along with best interest meeting minutes. Consideration had also been given to people's capacity to consent to their care plan. Where people lacked capacity, mental capacity assessments had been completed which demonstrated that they lacked capacity to make that specific decision.

People can only be deprived of their liberty so that they can 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). We checked whether the provider was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Appropriate applications to restrict people's freedom had been submitted to the DoLS office for people who needed continuous supervision in their best interest and were unable to come and go as they pleased unaccompanied. The registered manager told us, "Four applications have been authorised and we are awaiting the results of the other applications we have made."

People's health was monitored and when it was necessary health care professionals were involved to make sure people were supported to remain as healthy as possible. Staff actively sought support when people needed it and did not work in isolation. One person told us, "They are very good at looking after us." People had regular access to GPs, district nurses, chiropodists, dieticians and speech and language therapists. On a weekly and monthly basis, people's weights were monitored and documentation reflected that where people had been losing weight, referrals were made to the dietician. Staff also recognised the importance of working in partnership with the mental health team, psychiatrist and care home in reach team. On the first day of the inspection, a psychiatrist was visiting one person providing advice to staff.

The management of diabetes was effective. People living with diabetes have an increased risk of disability, pressure ulcer development and hospital re-admission. Staff worked in partnership with the district nursing team and clear diabetic guidelines were in place for staff to follow. Diabetic care plans were in place which included guidance on the signs of high and low blood sugar and the steps for staff to take. Staff monitored people's blood sugar levels on a regular basis which enabled them to have oversight of people's blood sugars and provide effective monitoring.

People continued to speak highly of the food provided. One person told us, "I enjoy having my lunch cooked for me and I always look forward to it." Another person told us, "The food is very good and we always have a choice every day." Guidance produced by Alzheimer's society advised that 'eating and having a good meal is part of our everyday life and important to everybody, not least to people living with dementia.' With permission, we joined people at lunchtime. People were offered the choice of eating at the dining room table, in the lounge or in their bedroom. Most people chose to eat in the dining room. Tables were neatly laid and people sat talking amongst themselves. People were encouraged to be as independent as possible. For example, some people had plate guards to aid independence and where people required a soft diet, this was provided.

Staff commented they felt sufficiently trained and spoke positively of their training opportunities. Training records confirmed staff received training that was essential in meeting people's needs including first aid, moving and handling, food safety, medication administration, health and safety and infection control. Training was also provided that was specific to the care needs of people. For example, staff received training on dementia awareness. Staff were also supported in their role. New staff had an induction period where they worked alongside more experienced staff. Staff received a yearly appraisal and supervision meetings with the registered manager. Supervision is a formal meeting where training needs, objectives and progress for the year are discussed. Staff told us they found supervision and appraisals helpful. They commented that these meetings provided them with the opportunity to raise any concerns or discuss practice issues.

Effective management of dementia care entails seeing the person for who they are and not their dementia. This continued to be embedded into practice by the registered manager and staff. Staff understood the importance of meeting people's individual care needs and told us how they effectively met people's needs. One staff member told us, "One person can become physically aggressive. In that situation, we calm them down by talking calmly and sensitively to them and we work together to try and identify any triggers." Guidance produced by the Alzheimer's society advises that people living with dementia can often experience difficulties with orientation around their home and in relation to time. During the inspection, we found that a number of people experienced confusion as part of their dementia. Staff told us how they managed this. One staff member told us, "This can be tricky, as we don't want to upset them if they are asking for their parents. One lady can often call out for her Mum, so we will provide reassurance and ask them about their Mum. For example, what they do and where they work. This helps calm that lady."

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	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had failed to assess the risks to the health and safety of service users; of receiving the care or treatment. Regulation 12 (2) (a).</p>