Morleigh Limited

Clinton House Nursing Home

Inspection report

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

Summary of findings

Overall summary

We carried out a focused unannounced inspection at Clinton House on the 2 February 2016. At that inspection we identified breaches of the legal requirements. We issued three warning notices and two requirements and told the provider to take action to address the breaches of the regulations. Following the February 2016 inspection the provider sent the Care Quality Commission an action plan outlining how they would address the identified breaches.

Prior to this inspection the Care Quality Commission received information of concern relating to people not always having their care needs met. Concerns had also been raised about staffing levels and some aspects of the premises at Clinton House. We carried out this focused inspection to check on the actions taken by the service to meet the requirements of the regulations and to follow up on the information of concern received.

This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Clinton House on our website at www.cqc.org.uk

Clinton House is a care home which offers care and support for up to 46 predominantly older people. At the time of the inspection there were 30 people living at the service. Some of these people were living with dementia. The building is a detached house over two floors with a recently added extension on the ground floor comprising of five new en suite rooms. Clinton House is part of the Morleigh Group of homes.

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. The registered manager for Clinton House was working at a different service in the Morleigh Group. The manager working at Clinton House at the time of this inspection was the registered manager from another service in the group. This manager was in the process of applying to be the registered manager for Clinton House.

At the February 2016 inspection we found prescribed creams were not always dated when started and not always stored safely. A recent external pharmacy audit highlighted concerns which remained since the last audit which produced actions that needed to be taken a year before. Medicines for disposal were not stored in accordance with the advice given in January 2016. Out of date blood bottles and needles had not been disposed of. The medicine policy used at the service needed to be reviewed.

At this inspection the manager was unaware of any outstanding actions relating to the external pharmacy audit. The pharmacist told us they were unaware of any actions that had been taken by the service since the last Medicine Advice Visit in January 2016. We found prescribed creams were mostly dated upon opening and were stored safely. All items stored in the medicines room were regularly checked to help ensure any

item which was out of date was removed. The medicine policy had been fully reviewed since the last inspection.

At the February 2016 inspection we found hot water recorded at 50 degrees centigrade coming from a tap in a toilet used by people who lived at the service. Hot water at this temperature risks scalding people. There were incontinence odours at the service. Equipment had been left in corridors which posed a risk to people using the corridors. Inspection of the premises and equipment used at the service was not reviewed effectively in order to identify any defects or faults.

At this inspection we again found there was hot water recorded at 50 degrees centigrade coming from two taps on the first floor, which were used by people who lived at the service. This continued to pose a scald risk to people using the hot water. Checks were regularly carried out on pressure relieving mattresses. However, some of these records contained errors. There were no incontinence odours at the service at this inspection. There was no unused or inappropriate equipment found in corridors at the service.

At the February 2016 people's food and drink intake was mostly recorded but not monitored. This meant action was not always taken to address any reduction in a person's intake. Guidance provided for staff about people's needs was not always accurate.

At this inspection we found staff were effectively recording what people ate and drank. The total amount of food and drink taken by a person was totalled each 24 hours. However, these amounts were not always accurate.

At the February 2016 inspection a written complaint made to the new manager, three weeks before the inspection, had not been investigated, responded to or recorded in the complaints record. At this inspection we found that complaint had been fully responded to and resolved. There had been another concern raised to the service and the local authority, since our last inspection. A full investigation had been carried out regarding this concern.

At the February 2016 inspection we found moving and handling slings and net pants, used by people to secure their continence products were unnamed and shared communally. People were being weighed openly in the lounge in front of other people that used the service. We also saw uncovered hot food given to a person then left for 25 minutes before staff arrived to support the person with eating their meal. These examples of poor practice did not protect people's dignity.

At this inspection we were told new moving and handling slings had been purchased, named and allocated to each person who required such equipment. We found numbered slings in corridors and lounge areas which indicated some were continuing to be shared. Staff told us people were no longer being weighed in the communal lounge, and this was now taking place in private. People who chose to eat in their rooms were supported as necessary by staff who delivered the food.

At the last inspection we found guidance in care plans was being followed by staff. However, some guidance was not clear. We also found people's confidential care records were not held securely at the service. Handover records for shift changes that had taken place since 25 January 2016 were not found. The handover records we saw were often not dated. This meant it was difficult to establish what information had been shared by staff at shift handovers.

At this inspection we found guidance provided for staff in care plans, about people's needs, had been improved since the last inspection. However, we did identify two people whose needs had not always been

effectively met by the service. People's confidential care records were found to be securely stored at this inspection. We identified some instances of poor communication between the staff shifts. As found at the last inspection handovers sheets had not been dated and did not contain sufficient information to inform each shift.

The service had notified the Care Quality Commission prior to this inspection that they were having difficulty covering nursing shifts at the service. We were told there were six care staff on in the mornings with five in the afternoons and two at night. Each shift was supported by one nurse. We checked the staffing rotas held at the service at this inspection. The staff rotas were not always accurate.

The provider had made some improvements since the last inspection. However, we found continuing concerns remained.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014 you can see the action we have told the provider to take at the end of this 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 entirely safe. Hot water recorded at over 50 degrees centigrade, found coming from a tap used by people living at the service at the last inspection, remained a concern elsewhere at the service. This posed a scalding risk to people living at the service.

Handover sheets used by staff at each shift change were not always completed, dated and stored effectively. This was also found at the last inspection.

There were sufficient numbers of suitably qualified staff to meet the needs of people who used the service. However, the manager and agency staff were being used to cover some shifts and the staff rota was not always accurate.

Is the service effective?

Good

The service was effective. The corridors at the service were clear of equipment. There were no odours at the service.

Staff were supported by the management with regular supervision.

The service recorded and monitored people's food and drink intake where appropriate.

Is the service caring?

Good

The service was caring. People who used the service were positive about the service and the way staff treated them.

Staff were kind and compassionate and treated people with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not entirely responsive. People's needs were not always met in a timely manner.

The service had not taken action to respond to concerns raised

at previous inspections, such as issues with the weighing scales used at the service.

People were able to make choices and have control over the care and support they received.

Is the service well-led?

Requires Improvement

The service was not entirely well-led. The regular checks and audits in place to make sure that any areas for improvement were identified and addressed continued to not always be effective.

Inaccuracies in the records held at the service such as staffing rotas, quick check lists, weight records and mattress pressure checks, had not been identified by the manager.

The manager investigated complaints, addressed the issues and took action to help ensure they did not re-occur.

Clinton House Nursing Home

Detailed findings

Background to this inspection

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

The inspection took place on 7 March 2016. The inspection was carried out by two adult social care inspectors over one day.

Before the inspection we reviewed the information we held about the home. This included past reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with three people who lived at the service. Not everyone we met who was living at Clinton House was able to give us their verbal views of the care and support they received due to their health needs. We looked around the premises and observed care practices. We spoke with seven members of staff, the manager, the operations manager and the provider. We also spoke with two relatives of people who were visiting the service.

We looked at care documentation for two people living at Clinton House, three staff files, training records and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At our inspection in February 2016 we found prescribed creams were not always recorded when started and not always stored safely. This meant staff were not aware of the date when the item would no longer be safe to use. A recent external pharmacy audit had highlighted concerns which remained since the last audit which produced actions that needed to be taken a year before. Medicines for disposal were not stored in accordance with advice given in January 2016. Out of date blood bottles and needles had not been disposed of.

At this inspection the service was unaware of any outstanding actions relating to the external pharmacy audit. We contacted the pharmacist carried out the previous audit, who told us they were unaware of any actions that had been taken since the January 2016 Medicine Advice Visit. The pharmacist will follow this up. We found prescribed creams were mostly dated upon opening and were stored safely. We found all items stored in the medicines room were regularly audited to help ensure any item which was out of date was removed. Audits were regularly being carried out on all aspects of medicine administration and management. The medicines policy had been reviewed since the last inspection. The only homely remedy held at the service was Paracetamol. This was only given to people at the service once it had been checked with the GP that it would not interact with any other medicines they were taking. If it was required regularly it would be requested on prescription for the person.

At our inspection in February 2016 we found hot water recorded at 50 degrees centigrade coming from a tap in a toilet used by people who lived at the service. Hot water at this temperature risks scalding people.

At this inspection we again found there was hot water recorded at 50 degrees centigrade coming from two taps on the first floor, used by people who lived at the service. This posed an on going risk of people scalding themselves.

At our inspection in February 2016, and the previous inspection in October 2015 we found systems for recording staff communication between shifts were poor. For example at the February 2016 inspection the service were unable to provide us with the records of handovers that had taken place since 25 January 2016. Before 25 January 2016 the handover sheets contained ticks with occasional written amendments on some sheets to guide the new shift. There were also handover sheets which were undated. This meant it was difficult to establish what information had been provided for staff at each shift change.

At this inspection we continued to identify some issues of poor recording of communication between staff. Handover records were seen for the day of the inspection and the previous day. No other records were easily available to inspectors since 25 March 2016. The manager later found the missing handover records in a large pile of filing in the records office. This meant it continued to be difficult to easily establish what information had been provided for staff at each shift change.

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

Prior to this inspection we were told the call bell system at the service was not working correctly. At this inspection we were told a new call bell system had been installed. There had been a few issues with the new system and some people had needed to have their call bells changed to ensure they were working efficiently. The manager confirmed the call bell did occasionally need replacing if they became wet or the batteries ran out.

Prior to this inspection the provider had informed the Care Quality Commission that they were having difficulty covering all the nursing shifts. One nurse was away from the service at the time of this inspection. The manager and agency staff were being used to cover some shifts. The night before this inspection the manager had spent the night at the service to oversee any medicines required by people during the night. We checked the staffing rotas held at the service We found it was not entirely accurate. It showed there had been five staff on duty on the morning of the 4 and 6 April 2016. However, when we discussed this with the manager we were told this was not the case. One staff member had been off sick but had been covered by another staff member so there had been six staff on duty on both days. This amendment did not show on the rota. The rota showed the service planned for six staff every morning with five staff every afternoon. There were two care staff at night. Each shift was supported by one nurse.

Some people reported having to wait for carers to arrive when they had called for assistance. During the inspection inspectors monitored two call bells from when they had been rung to staff arriving. On both occasions staff arrived promptly within a few minutes. The service was recording the time it took staff to respond to people's calls for assistance. These were being monitored by the management team to help ensure they were sufficient numbers of staff to meet people's needs. We asked to see the last three weeks recordings audit, which were sent to us the week after this inspection. This was a random audit and only covered a small number of all the call bells over that period so we asked for all the call bells for the day before and the day of the inspection. These were sent in the post to the inspector. During this inspection call bells were heard being rung by people needing assistance. The call bell records sent to the inspector after the inspection showed staff took between one and eleven minutes to respond to call bells. Over two days there were 80 call bells recorded. 14 of these were recorded as taking over five minutes to be responded to. Nine took over ten minutes to be responded to.

At the February 2016 inspection we had concerns regarding the flannels that were used by staff to wash people, as these were not named and used communally. This created an infection risk. At this inspection we found flannels remained unnamed and used communally. We discussed this with the manager, the operations manager and the provider. We were assured that all the flannels had been named for specific people's use. However, the high temperatures used to wash items together with the strong stain removers used by the service to help ensure washing was effective, had removed the names. We were assured all flannels would be re-named immediately.

Prior to this inspection we had been told that there was not always a cleaner on duty at the service. The manager told us there had been one day when a cleaner was not available and staff carried out some cleaning tasks. At this inspection we saw there was a cleaner on duty in the service. The environment was clean and people told us they were satisfied with the cleanliness of the service.

Staff told us they worked well together as a team and shared the workload between each other. Staff we spoke with raised no concerns about working at the service or the support they received.

Good

Is the service effective?

Our findings

At the February 2016 inspection there were incontinence odours at the service mainly due to staff not disposing of bed pans and pads effectively. Equipment had been left in corridors which posed a risk to people using the corridors.

Prior to this inspection we were told some people did not always have access to continence products that they had been assessed as needing. We were also told that the heating in the new wing of the service was not always working efficiently.

At this inspection there were no incontinence odours and sluice areas were clear of any soiled items. There were no items of equipment left in corridors which posed a risk to people using the service. We checked to see if people had sufficient amounts of pads for their own use. We found there were stocks of pads in people's rooms and the manager told us; "There was no issue of people not having sufficient quantities of pads as there is a whole roomful downstairs." The heating in the new wing had not always worked efficiently prior to this inspection according to two people whose rooms were in this area. They told us; "It (the heating) isn't working" and "It's (the heating) been a bit on and off." People had noticed it had been colder sometimes in their room. There was a portable heater in one person's room. We found there were two rooms in the new wing which were cooler than the rest of the wing. The provider told us they were unaware of this issue and would address the matter immediately.

At the February 2016 inspection we found pressure relieving mattresses were not always checked regularly to help ensure they were working effectively and safe to be used. The control knob on one mattress was missing from the motor. This meant it was difficult for staff to judge accurately what the setting of the mattress was.

At this inspection we found pressure relieving mattresses were checked each day by senior care staff to help ensure they were set correctly for each person and were working effectively. We found the mattress which had been identified at the February 2016 inspection as missing a control knob, remained in this condition. We asked the nurse on duty how they knew this mattress was set correctly without a control knob to show the setting. The nurse told us they used the head of the screw, which used to hold the knob, as a guide to set the mattress. The nurse told us they had repeatedly requested a new knob to be fitted but this had not been provided. This meant it could not be ensured that this mattress was set correctly.

We checked the mattress pump settings in two rooms. We found they were different from the recorded setting of the previous day. We returned to both people's rooms later in the day following scheduled room checks. Staff had recorded that both mattresses were correctly set. We again checked both mattress pumps which continued to show different readings to that recorded by staff. We concluded that neither mattress pumps had been checked by staff and they had recorded the reading logged the previous day. This was incorrect and meant that both mattresses remained incorrectly set. The checks carried out by staff were not being efficiently monitored and did not ensure people were always protected from the risk of pressure damage to their skin. However, we did not find any impact on people's skin condition at the time of this

inspection.

At the February 2016 inspection we found some people living at Clinton House needed to have their food and drink intake monitored to ensure they had a healthy diet. Minimum and maximum amounts of food and drink were recorded on the charts so staff would be aware of what had been assessed as an appropriate intake for each person to have in a day. However, information on these charts was not always accurate. Charts were being photocopied and specific information relating to people's assessments remained on the photocopies used for different people. This meant staff were not provided with accurate information relating to each person who was having their intake monitored. Totals of food and fluids received were not recorded at the end of each day and there was no record the information being monitored regularly.

Prior to this inspection we were told there were concerns about the quality of the food provided at Clinton House. We were told there had been many staff changes in the kitchen and that the kitchen staff were not required to work past 2.30 pm. We visited the kitchen and spoke with the chef and the kitchen porter. Both confirmed there were kitchen staff on duty till the early evening each day. They told us there had been some staff changes but there were sufficient kitchen staff to provide food for people living at the service. There were no concerns raised by the kitchen staff who told us they had sufficient resources to provide meals for people and they were happy working at Clinton House.

We observed the lunch time meal. Staff were available in the dining room to support people as needed. There was a relaxed atmosphere. One person, who liked to walk around was gently encouraged by staff to sit and eat which they did. At this inspection we found staff were recording all food and drink taken by some people living at the service who had been assessed as requiring this monitoring. Prescribed supplements were recorded by staff appropriately. These charts were being totalled each night by the night staff. However, some of the calculations made by the night staff were inaccurate. Charts were removed from the file held in the dining area each day to be audited and to check staff were completing them correctly. This was being done to help ensure people received any support from health professionals, such as dietitians and speech and language therapists if required. The audits of these charts was not always effective.

Following the last inspection the service had sought professional advice from healthcare professionals about how they should assess if people were having enough to drink each day. We saw relevant training had been arranged for staff.

At the last inspection we found two nurses and two care staff who had no recorded individual supervision sessions recorded. At this inspection we found all staff had recently received recent supervision and support from the manager or clinical lead. Staff confirmed they received good support from management.

Good

Is the service caring?

Our findings

At the February 2016 inspection we found moving and handling slings were unnamed and being used communally. They were hung out in main corridors throughout the service. Net pants used to secure continence pads remained unnamed, and were also shared communally. People were regularly weighed on mobile scales in the main lounge in front of other people. This did not respect people's dignity.

At this inspection we were told that new slings had been purchased and each person who required such equipment had been allocated their own named sling. We saw there were slings in some people's rooms. However, we did find other slings in corridors and lounges. Some slings were numbered and some had names on them. We were shown an audit of slings used at the service. Each sling was numbered on this audit. However, the number did not appear to easily relate to the room number or the person for whom it was to be used. Staff told us that people did have their own slings. However, when they needed to be washed staff used other people's slings. Slings found in the corridors and lounges were numbered but the rooms to which they related were not nearby. This meant that in practice staff were continuing to use slings communally for some people. We discussed this with the manager, the operations manager and the provider. We were told spare slings were available in the laundry for use when people's own slings were in the wash. We were assured that a different method of identifying people's slings was planned by the manager.

We checked the net pants stored in people's bedrooms and found most of them had been named. However, unnamed pants were found on the laundry trolley for staff to use for people. The management team told us that the laundry processes used at the service had removed the names and assured us all net pants would be re-named to ensure people had their own pants.

Staff told us people were now weighed in private and not in the lounge. This meant people's dignity was being protected.

At the February 2016 inspection we found a hot meal was seen delivered uncovered to the room of a person lying on their back in bed at 12.50pm. Staff did not arrive to provide support for this person to eat their meal until 1.15 pm. When we questioned staff about the now cold meal, they offered the person a sandwich instead, which was provided. These practices showed the service did not consider people's dignity.

At this inspection we found no evidence of hot food being left to go cold before staff arrived to support people to eat their meal. The manager supported the care staff in the dining room during lunch time. There was a system whereby whoever delivered the hot meal to a person's room, stayed to support them at that time. People were seen to be supported with their meals as needed. Staff sat at people's eye level and chatted throughout the meal.

At the last inspection we found one person who had moved rooms at Christmas to a ground floor room did not have their name on their door. This person was confused and living with dementia and not having their bedroom clearly identified for them did not support their needs. At this inspection we found all people's

bedrooms were marked with their names. There was some additional signage to support people to recognise places such as the lounge, toilet and bathrooms.

During this inspection we saw kind and caring interactions between people and staff. Staff appeared to be calm and patient and there was no rush or pressure evident whilst staff assisted people.

Requires Improvement

Is the service responsive?

Our findings

At the February 2016 inspection we had concerns staff were not always provided with accurate and up to date information about people's care needs. For example, how often a person should be weighed or re positioned in their bed. Also weight changes recorded by staff were not always monitored and action taken to address the weight loss.

At this inspection most care plans had been reviewed regularly and there was sufficient guidance and direction for staff to meet people's needs. We found staff had improved the timeliness of their recording of people's weights according to their assessed needs in their care plans. Some people's care plans stated they were to be weighed weekly. We saw this had been done. There were changes in some people's weekly weights which had been recorded. Some weight changes had been calculated by staff incorrectly. This meant it was not easy to establish what people's accurate weight was.

At the inspection in February 2016 a visiting healthcare professional had reported to us that the weights recorded at the service were 'unreliable' because they were concerned about the accuracy of the weighing scales being used in the service. We discussed this with the manager, the operations manager and the provider. We were told the discrepancies found in the weekly weights were was probably down to 'user error' such as how each staff member used the scales. The weight changes were seen by the management as a recording error rather than any actual weight loss. Staff used mobile chair scales and there was no specific guidance for staff about when, where and how the scales were to be used. The recorded weights had not been monitored by the manager. This meant it was unclear as to whether the issue was with the scales or how staff were using them. The reliability of the scales had not been addressed since the last inspection and any potential weight loss could have been missed. We were assured by the provider that this would be addressed immediately.

When we arrived at Clinton House, we saw a Quick Check Sheet was pinned on the notice board of the records office. This sheet contained information about which person was in which room and details of their needs such as when they needed to be weighed and what their dietary needs were. We used this sheet to inform our inspection and visit people in their bedrooms. However, this sheet was not entirely accurate. It showed one room was vacant. We found a person had been living in this room for the past two weeks. The previous occupant of this room had died some weeks earlier, however, their care check records remained on top of the chest of drawers in this room. The new occupant of this room did not have a care file of their own. This meant staff were not recording regular care checks for this person.

We spoke with the person now living in this room and their family, who were visiting. We were told that the person preferred to stay in their room and watch TV. However, the TV in their room had not been working when they had arrived and this had been reported. We were told it had taken some days for this to be repaired. The TV was working at the time of this inspection. The family of this person told us they had found the person was not wearing their hearing aids and had very dirty fingernails when they visited. Also their dentures had not always been cleaned each day and fixed adequately in their mouth so the person had difficulty keeping their teeth in place. This person had a bandage on their leg since they had arrived at the

service. The family were concerned this had not been reviewed. The family were concerned that staff were not always aware of their relatives care needs and raised these concerns directly with the nurse on duty at the time of this inspection. The nurse assured the family these issues would be checked each time staff visited this person in their room. This person's name was not printed on the handover sheet used at the shift change on the day of this inspection. Their name had been handwritten on the handover sheet but there was no specific information against their name about their needs.

One person's care plan stated they needed to have specific equipment applied to help them to keep part of their body comfortable. However, this piece of equipment was not in place. Care staff who told us the use of this equipment had been discontinued. This meant this person's care plan did not provide current guidance for staff and had not been updated to take account of changes that had taken place.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014,

We checked each person in their room early on the morning of our inspection visit. Everyone was clean and dry and had records which showed they had received regular care and support from staff throughout the night where necessary. Staff told us there had been a problem with some night staff not always providing care for people during the night but this had been addressed now.

At this inspection we found people living at the service had a file in their bedroom which informed and directed staff about their specific care needs. For example, how often the person needed to have their skin checked for any red areas, or when and where prescribed creams were to be applied. Staff were also required to record when they had changed people's continence pads and when people had been to the toilet. We found these files to have been completed regularly by staff when care and support had been provided. These files were regularly audited by the manager to ensure all staff had completed them each time care had been provided. However, it had not been identified that the person referred to above did not have such a file in their room.

Staff also recorded all the care and support provided each day in daily notes in the care plans. We were able to see when people had attended activities, had visitors, had assistance from staff with meals and when people were supported to have baths or showers according to their wishes and needs. We saw staff sitting with one person looking at photographs. This was reflected in their care plan as something they enjoyed. The family of a person who used to live at Clinton House came each week to show films to people living at the service. We heard conversations going on about which film people would like to see during the morning of the inspection. Films were shown throughout the afternoon of the inspection. Staff confirmed they arranged for activities to take place in the main lounge in the afternoons.

One person's care file stated they were at risk from falling from their chair. The service had sought advice and guidance from external healthcare professionals about this concern. Whilst the service had not received the guidance they had requested they had chased this up on several occasions. In the meantime the service was caring for this person in a chair that could be reclined. This helped reduce the risk of this person falling out of their chair. The care plan stated this person should only stay in this chair for up to three hours then return to their bed after lunch as they became agitated. We saw this care was provided for this person in accordance with the guidance in their care plan.

At the February 2016 inspection staff told us some people living at the service could behave in a way which challenged staff. They told us they had not been provided with training to assist them in managing this issue. At this inspection the manger assured us that some staff had attended specific training on this issue. Staff did not raise any concerns with us about supporting people who may present behaviour that

challenges staff and other people.

Requires Improvement

Is the service well-led?

Our findings

At the February 2016 inspection we found that monitoring of the premises and equipment used at the service was not reviewed effectively in order to identify any defects or faults. This inspection found some of the concerns from the last inspection had been addressed. However, there were some that remained and where no action had been taken by the provider. The manager, supported by the operations manager, had made further improvements to the auditing processes used at the service. However, these were not always effective in identifying the concerns we found at this inspection. For example the hot water found coming from two taps at the service, the errors in the recording of pressure relieving mattress checks and the errors in the recording of people's weights had not been identified. The missing control knobs on one mattress had not been replaced since it was raised at the February 2016 inspection. The weighing scales continued to record 'unreliable' weights. This meant the audit processes used at Clinton House were still not consistently or effectively identifying areas of concern.

The manager stated at an external meeting held the day before the February 2016 inspection that two staff had been subject to a disciplinary process for failing to provide care and complete documentation, for the person found by the tissue viability nurse some days before this inspection. We checked these staff members' files. There was not record of disciplinary action being taken against either member of staff. This meant we were unable to establish whether the disciplinary process had taken place and what action, if any, had been taken.

At this inspection we checked these staff files for details of disciplinary action that we had been told had been taken due to concerns about the recording of care and an allegation of theft. We found details of action taken by the service against two members of staff. One staff file was not available for inspectors, it was being held at another location as the member of staff had left the service. This meant the service had recorded the disciplinary action they had taken appropriately.

Prior to this inspection we were told by the operations manager, that regular checks were taking place throughout the day by senior care staff. This was to help ensure all staff were recording the care they had provided to each person. We found an increased amount of recording was being done by care staff. However, as detailed earlier in this report some of the recordings were not accurate and the errors had not been identified through the monitoring checks.

We found examples of poor communication between staff that had led to poor outcomes for some people. We asked to see the information shared between each shift change about people living at the service. The manager, the senior carer and the nurse were not easily able to find these records for inspectors. Some handover sheets were found as loose sheets in a pile with many other records in the records office. The handover sheets had not always been dated and completed with details of people's needs. This meant it was not clear what information had been passed to staff at each shift change regarding any changes in people's needs. The manager told us; "They (staff) are supposed to hand these (handover sheets) in every day to the office." This had not been done. These issues were also identified in two previous inspections. This demonstrated action was not being taken to address concerns highlighted in inspection reports in a

timely manner.

The staffing rotas did not accurately reflect the numbers of staff present on shifts. Sickness cover was not amended on the rota. This meant it was not clear how many staff had worked on shifts in the past.

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

At the last inspection we found the service was not acting upon complaints they had received. The service was not following its own complaint policy.

At this inspection we found the complaint received three weeks prior to the February 2016 inspection had been fully investigated and responded to. We found the service had also responded to a concern that had been raised by external healthcare professionals, in a timely manner.

At the February 2016 inspection we found people's confidential care records were not held securely. There was a cupboard in a main corridor containing many care files which was unlocked and accessible to anyone using the corridor. Also the office, containing care files for each person living at the service, was open throughout the inspection.

At this inspection we found the cupboard in the corridor to be secured. The office containing care records was closed and a coded lock was in place on the door for staff to access the room. Inspectors were given the code for this room during the inspection. This meant people's private personal information was held securely at the service.

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 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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. The registered person must assess the risks to the health and safety of service users of receiving the care or treatment. Regulation 12 (1) (2) (a) (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes must be established and operated effectively to ensure compliance with the requirements. The registered person must assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity. Regulation 17 (1) (2) (a)