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Clifford House Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 19 and 20 September 2017. The inspection was undertaken to check whether the provider had made improvements and was now meeting all of the legal requirements and regulations associated with the Health and Social Care Act 2008. The inspection was also to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Clifford House is a small family owned residential care home located in a residential area of Andover. The home is arranged over two floors and can accommodate up to 21 people. At the time of our inspection there were 20 people living at the home. The home supports people with a range of needs. Some people were quite independent and only needed minimal assistance. Others were more dependent and needed assistance with most daily living requirements including support with managing their personal care and mobility needs. Some of the people being cared for in the home were living with dementia and could at times display behaviour which challenged others.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. The registered manager was also the registered provider. For the last 12 months, the registered manager had not been providing day to day management of the service but had instead appointed a manager to perform this role. The manager had been appointed in October 2016, but had not yet submitted an application to the Care Quality Commission to become the registered manager.

People had not always been protected from risks associated with the environment.

The provider had not taken proper steps to ensure that all of the required checks had been completed before staff started working at the service.

Improvements to the cleanliness of the home were needed.

Medicines were not always managed safely. We could not be confident that people were receiving their medicines as prescribed.

The provider had not adequately assessed risks to people's health and safety and done all that was reasonably practicable to mitigate such risks.

Changes to people's needs had not always been effectively communicated within the staff team.

Improvements were needed to the governance arrangements within the service. The provider and manager did not operate a robust programme of audit and checks to ensure the safety and quality of the service was

being maintained.

Records were not available which demonstrated that staff had received an appropriate induction, supervision and an appraisal.

More needed to be done to ensure that staff provided people with increased opportunities for meaningful interaction.

There were sufficient numbers of staff deployed to meet people's needs.

Staff had received training in safeguarding adults, had a good understanding of the signs of abuse and neglect and knew how to report any concerns.

Staff acted in accordance with the principles of the Mental Capacity Act 2005. Where people's liberty or freedoms were at risk of being restricted, the proper authorisations were in place or had been applied for.

People told us they enjoyed the food provided and staff were informed about whether people were nutritionally at risk and measures put in place to address any risks.

The home worked effectively with a number of health care professionals to ensure that people received co-ordinated care, treatment and support.

Staff were kind and caring in their interactions with people and treated them with dignity and respect?

People and their relatives were involved in making decisions and planning their care.

People knew how to make a complaint and information about the complaints procedure was included in the service user guide.

Everyone spoke positively about the manager and the friendly and homely culture within the home.

We found three breaches of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People had not always been protected from risks associated with the environment.

The provider had not taken proper steps to ensure that all of the required checks had been completed before staff started working at the service.

Improvements to the cleanliness of the home were needed.

Medicines were not always managed safely. We could not be confident that people were receiving their medicines as prescribed.

The provider had not adequately assessed risks to people's health and safety and done all that was reasonably practicable to mitigate such risks.

There were sufficient numbers of staff deployed to meet people's needs.

Staff had received training in safeguarding adults, and had a good understanding of how to identify and report any abuse and neglect.

Is the service effective?

Requires Improvement

The service was not always effective.

Records were not available which demonstrated that staff had received an appropriate induction, supervision and an appraisal.

Staff acted in accordance with the principles of the Mental Capacity Act 2005.

People told us they enjoyed the food provided. Staff took action to support people who were nutritionally at risk.

Staff worked effectively with a number of health care professionals to ensure that people received co-ordinated care,

treatment and support.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect and staff were kind and caring in their interactions with people.

Staff provided gentle reassurance when people felt unsettled or upset.

Staff knew people well and involved them in planning their care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had not always received care that was responsive to their individual needs.

More needed to be done to ensure that staff provided people with increased opportunities for meaningful interaction.

People knew how to make a complaint and information about the complaints procedure.

Is the service well-led?

Requires Improvement

The service was not always well led.

Improvements were needed to the governance arrangements within the service. The provider and manager did not operate a robust programme of audit and checks to ensure the safety and quality of the service was being maintained.

Recommendations and actions from our previous inspection had not been addressed.

Everyone spoke positively about the manager and the friendly and homely culture within the home.

Clifford House Residential Care 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 was planned to check whether the provider had made the improvements required from our previous inspection. We also checked to make sure they were meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19 and 20 September 2017 and was unannounced.

The inspection team consisted of an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Prior to the inspection we reviewed previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is where the registered provider tells us about important issues and events which have happened at the service. We used this information to help us decide what areas to focus on during our inspection.

We spoke with five people who used the service and three relatives. We also spoke with the registered provider and seven care workers. We reviewed the care records of five people in detail and the recruitment records for four staff. We also reviewed the medicines administration record (MAR) for all 20 people. Other records relating to the management of the service such as staff rotas, training records and policies and procedures were also viewed. We also spoke with two healthcare professionals who shared their views about the home and the quality of care people received.

The last inspection of this service was in July 2016 when we found that the provider was not meeting one of the fundamental standards. This was because they had not maintained accurate, complete and up to date records relating to people's care and to the running of the home. We continued to find concerns regarding

this.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at Clifford House. One person told us "Yes I do [feel safe] because I am well looked after and I have got my bell to ring". Another person said, when asked if they felt safe, "Oh yes, there's always somebody around if necessary".

Whilst people told us they felt safe, we found some improvements were needed. People had not always been protected from risks associated with the environment. The water being discharged from a sink in the communal shower room/ toilet was regularly being recorded as being in excess of safe limits as determined by the Health and Safety Executive. Action had not been taken to address this. This placed people at risk of scalding.

The week prior to our inspection, daily records showed that a person using the service had been found in the sluice room. We also found the sluice room unlocked. It is important that sluice rooms remain secure to prevent people from gaining access to hazardous substances which can cause harm.

The storage and management of creams and toiletries was not always safely managed. We found a number of toiletries, that might prevent a risk of harm to some people living with dementia, had not been stored securely. For example, we found bars of soap, shampoos and prescribed creams readily accessible in communal bathrooms. One bathroom had a lockable cabinet, but this was not locked and contained a number of prescribed creams, a disposable razor and open steristrips. On the top of the cabinet was a spray air freshener.

Despite there being 20 people currently using the service, there were only seven personal evacuation plans (PEEPs) in place. PEEPs describe the level of assistance people would need to safely evacuate the home. A number of the PEEPS in place had not been reviewed since 2013. This could impact upon the emergency services being able to safely evacuate the home in the event of an emergency such as a fire. This had been identified as an area which needed to be addressed in an external health and safety audit completed in June 2017.

A fire risk assessment undertaken in July 2017 had made a number of recommendations to improve fire safety within the service. The assessment said that the recommendations should now be considered urgent. The recommendations had not yet been acted upon.

Records showed that the lifting operations and lifting equipment regulations (LOLER) certificates had been due for renewal in November 2015. These certificates monitor the safety of equipment used for lifting, such as hoists. We spoke with the provider about this who immediately took action for this work to be booked. We will check to see that this has been completed.

When staff assisted people to bathe they normally tested the temperature of the bath water using a thermometer and recorded this on a chart in the bathroom. Two entries had recently been made on the chart but no temperature had been recorded. We could not find a functioning thermometer within the

home. We discussed this with the registered manager who told us the thermometer was broken. They ordered a replacement.

The provider had not ensured the ongoing safety of the premises. This was a breach of Regulation 12 (2) (d) (e) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

The provider had not taken proper steps to ensure that all of the required checks had been completed before staff started working at the service. In the case of four staff members, a full employment history had not been taken.

This was a breach of Regulation 19 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Fit and Proper Persons Employed.

Other recruitment checks had been made including checks with the Disclosure and Barring service and obtaining references.

Improvements to the cleanliness of the home were needed. A cleaner was employed for four and a half hours each weekday and cleaning schedules were in place that set out the frequency with which areas of the home and items of furniture were to be cleaned. However, records were not being maintained to show that the cleaning schedules were being followed. At weekends, staff had to complete cleaning tasks alongside their caring duties. Some staff told us that this was at times difficult to achieve. They felt that cleaning staff were needed at weekends too. In the hair salon we found a walking aid covered with hair trimmings. In one of the communal toilets there was no bin. We found that a number of the raised toilet seats were stained on their underside. In one of the bathrooms there was a heavily stained jug. There were two bath/shower puffs on the floor. In another bathroom, the bath mat was torn and stained. In the shower room, the toilet brush appeared to contain pieces of faecal matter.

The provider had not ensured there were effective systems in place to prevent, detect and control the spread of infections. This was a breach of Regulation 12 (2) (h) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Protective clothing, including gloves and aprons, were available and used by staff appropriately.

Medicines were not always managed safely. During the inspection we found a number of examples where there was a gap in the people's MARs but no code had been used to indicate the reason why. Where people were prescribed topical creams, MARs were not being consistently completed to demonstrate that these were being applied. This meant we could not be confident that people were receiving their medicines as prescribed. We found prescription topical creams in the communal bathrooms. The name of the person these had been prescribed for was no longer legible. One of the prescribed creams had passed its expiry date.

Staff were meant to complete daily records showing that the medicines fridge and area where medicines were being stored were being maintained within recommended temperatures ranges. This is important as it helps to ensure that the medicines remain effective. These records contained a significant number of gaps. For example, the temperature of the fridge had only been recorded on six of the 20 days so far in September 2017. The records for the medicines cupboard indicated that the temperature for this area was consistently slightly in excess of recommended levels. There was no evidence that action was being taken to address this.

Processes for administering and recording the use of homely remedies needed to be reviewed to ensure they were in line with best practice guidance. Homely remedies are medicines the public can buy to treat minor illnesses like headaches and colds.

The provider had not ensured the proper and safe use of medicines. This was a breach of Regulation 12 (2) (g) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Monitored dosage systems (MDS) were used for the majority of medicines with others supplied in boxes or bottles. Medicines, including controlled drugs, were stored securely and only administered by staff that had been appropriately trained and assessed as competent. We observed some people being given their medicines during our visit; this was managed in a person centred manner. The staff member stayed to ensure that the medicines had been taken and then, signed the medicines administration record (MAR) to confirm this.

Some people's care plans did not always provide sufficient detail about the key risks to their health and welfare and how these should be monitored and managed. For example, where people were at risk of skin damage, nationally recognised risk assessments tools were not being used to monitor this. People administering their own medicines did not have risk assessments in relation to this. Screening for the risk of malnutrition and skin damage was not routinely carried out. One person's risk assessment said they could 'be at risk of skin breakdown'. This person did not have a skin integrity care plan to guide staff in how to support the person with their skin care. Another person was noted to be at 'High risk of falls' but they did not have a falls care plan. It was not always evident that the provider's post falls protocols had been followed. These protocols ensure that people are appropriately monitored following falls in case their condition deteriorates allowing medical advice to be sought. We could not be confident that people had always received care that was responsive to their individual needs. It was not evident that key information about changes in people's needs or new risks had always been shared effectively amongst the staff team. For example, staff had noted in the daily notes on the 15 September 2017 that a person had a sore area on their bottom. There was no mention of this again either in the handover book, the communication book or in the person's daily notes until the 18 September 2017 when the notes read, 'Bottom still sore, appears to have an open area'. A check of this person's MAR for the period concerned did not reflect that their barrier creams had been applied consistently during this period. We were concerned that a lack of effective communication might have had a negative impact upon this person's skin integrity. We found similar concerns in another person's care records.

The provider had not adequately assessed risks to people's health and safety and done all that was reasonably practicable to mitigate such risks. This was a breach of Regulation 12 (2) (a) (b) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

The provider had developed a detailed business continuity plan which set out the arrangements for dealing with foreseeable emergencies such as fire or damage to the home and the steps that would be taken to mitigate the risks to people who use the service. Checks were undertaken of the fire, gas and electrical safety and of the water system to ensure the effective control of legionella.

Food was being stored safely and in line with guidance from the Food Standards Agency. Temperatures were being taken daily of the fridge and freezer to ensure that foods were being stored at safe temperatures. The service had recently been awarded a food hygiene rating of five by the local council's food standards team.

People told us there were usually sufficient staff to meet their needs. One person said, "Oh yes there are

always enough staff, they always just say ring your bell". Another person said, Sometimes it's a little while". A relative said, "Yes there are enough staff, I have got to know them all". Day shifts were currently staffed by four care staff, one of whom started at 9am rather than at 7.30am. This reduced to three care workers after 3pm. Night shifts were staffed by two waking care workers. We reviewed the staffing rotas for a four week period and found that the service had been staffed to these target levels. The rotas showed that care was provided by a small and consistent staff team which helped to ensure that people were cared for by staff who knew them well. A small number of ancillary staff were also employed including a full time chef, a cleaner and a maintenance person. The service did not employ staff specifically to manage the laundry or to provide activities or entertainment and this remained the responsibility of the care staff as did cleaning at the weekends.

Overall the staff we spoke with told us that the staffing levels were adequate and enabled them to perform their role and responsibilities. Some staff told us that occasionally sickness or annual leave could leave a shift short, but that this was not often. They also said that it was sometimes difficult to find time to carry out their cleaning duties at weekends, when the cleaner did not work. Staff told us the manager was always willing to step in and assist staff if necessary. However, we found that some improvements were needed to how staff were deployed. We observed that were short periods of time during which the main lounge was not supervised by staff. Some of the people sitting in this area had been assessed as being at high risk of falls. The provider was unable to demonstrate that there was a systematic approach to determining these staffing numbers or that the numbers of staff deployed was regularly reviewed and adapted in line with people's changing needs. This had been a concern at our previous inspection also.

We recommend that the provider ensures they have a systematic approach to determining the numbers of staff deployed and how they are allocated to ensure people's safety.

Staff had received training in safeguarding adults, and had a good understanding of the signs of abuse and neglect. Prospective staff were asked to think about safeguarding scenarios at their interview and the provider told us that staff were also reminded at staff meetings of their responsibilities with regards to keeping people safe and reporting any concerns. The contact numbers of the local authority safeguarding teams were readily available within the service. This ensured staff had clear guidance about what they must do if they suspected abuse was taking place. Staff were aware of the whistle-blowing procedures and were clear they could raise any concerns with the manager of the home. They were also aware of other organisations with which they could share concerns about poor practice or abuse.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us Clifford House provided effective care. One person said, "We're well looked after". Another person said, "On the whole I find it very well indeed". A relative told us, "We are quite happy, there is nothing they could do better". Another relative said, "It's a fantastic care home…the personal care is second to none". We heard a person describe one of the staff as "Always helpful and obliging' to their friend.

Records showed that staff were not having regular supervision in line with the frequency determined by the provider's policy. One care worker told us they had not received any formal supervision within the last year. Another said they had received one. The provider's policy said supervision should be provided every two months. Staff had also not had an appraisal in the last 12 months. Supervision and appraisals are important as they help to ensure staff receive the guidance required to develop their skills and understand their role and responsibilities. Where supervision had taken place, the records relating to these were good and demonstrated that staff were being encouraged to reflect upon their practice and where this could be improved. Staff also told us that they felt very supported and able to approach the manager for advice or guidance at any time. However, improvements were needed to ensure a robust programme of supervision was consistently provided to all staff.

Whilst staff told us they had completed an induction which included reading care plans, learning about the fire procedures and shadowing the existing staff, the provider was not able to show us any records which confirmed this. Inductions ensure that new staff learn about their role and responsibilities, read policies and procedures and became acquainted with the environment and people using the service. The registered manager /provider showed us documentation which they and the manager had developed to act as a checklist of areas to be covered in the induction of new staff. We viewed the staff files of four care workers who had started work within the last six months. None of these contained a completed induction checklist.

Staff told us that they had been enrolled on the Care Certificate, but no further records relating to this were available. The care certificate sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate. We were unable to see that this was being completed in line with the provider's policy which stated that within 12 weeks of employment, staff would have completed this nationally recognised social care qualification.

Staff had completed training in a range of subjects such as infection control, fire safety, first aid, safeguarding, health and safety, dementia care and manual handling training. Staff that administered people's medicines had received training to do this and had been assessed as competent to do so. Staff had also completed training in end of life care an in helping maintain people's nutrition and healthy eating. Additional training was planned on dignity and person centred care in September 2017. The training was delivered face to face and records showed this was mostly up to date. All of the staff we spoke with said that the training provided was adequate to enable them to perform their role effectively.

Where people lacked capacity to make decisions about their care staff had acted in accordance with the

Mental Capacity Act. 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 had received training in the Mental Capacity Act 2005 (MCA) and were aware of the principles of the Act and how they should be applied. We reviewed people's records and found that mental capacity assessments had been carried out to determine whether people had the capacity to consent to living at the home for example. The assessments had been carried out in line with principles of the MCA (2005). Where it was deemed that the person lacked capacity to make a decision about living at the care home, there was evidence that staff had consulted with relatives and the professionals involved in the person's care to reach a decision that was in the person's best interests. We noted, however, that the mental capacity assessments had not been reviewed when people's cognition or ability to consent to aspects of their care changed. This is an area for improvement.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). Relevant applications for a DoLS had been submitted by the home and had either been approved or were awaiting assessment by the local authority.

Staff were seen to offer people choices and explanations and to seek their consent before providing care. For example, we heard a care worker ask one person 'Is it ok if I wipe your face' and another say, "Would you like to come and sit in a comfy seat". We saw staff effectively supporting one person to stand. They provided clear instructions and encouraged the person throughout the process. Care plans contained signed consent forms covering areas such as having photographs taken or for the administration of medicines. Where people had appointed a legal representative to make decisions on their behalf copies of these were available in the office.

People were positive about the food and comments included; "Yes the food is good, you have a choice every day and a dessert if you want it". Another person said, "The food is very nice". A relative told us, "The food is excellent".

Each day people were offered a choice of cereal and toast, fruit and juices for breakfast. Two main course options were offered at lunch and high tea was usually a choice of soup or sandwiches or a range of lighter meals such as egg on toast. Home baked cakes were offered in the afternoon and people were offered regular hot and cold drinks throughout the day. People were able to choose where they ate their meals and plate guards and specialist drinking cups were available and used when necessary to support people's independence.

We observed the lunch time meal on the first day of our inspection. Dining tables were laid with cutlery and serviettes but no clothes, place mats or salt and pepper. We heard one person asking for salt which was then brought to them from the kitchen. People were being offered a choice of different flavoured squashes. We did hear one person ask for a sherry, but this was not available. The person agreed to have a squash instead. The food looked appetising and there was very little food wastage and each person appeared to eat well. Staff readily chatted with people throughout the mealtime, providing encouragement and asking them if they were enjoying their lunch which helped make the meal a pleasurable experience for people. We observed one staff member sit with a person, encouraging them to eat. They said, "Take as long as you like there is no rush".

We did note some areas for improvement. On two occasions people were given biscuits with their hot drink but no plate was provided. The food was placed directly onto the table. We saw one person trying to eat their pudding with their spoon the wrong way up. A care worker noted this but did not offer any help or assistance to turn the spoon up the right way. Another person preferred to eat with their hands rather than with cutlery, however, they had not been provided with a suitable meal for this purpose. A member of staff instead helped the person to eat their meal which they ate well.

We recommend that the service explore options for providing a nutritious and balanced diet that can be eaten in this person's preferred manner and which would promote their independence.
This was not a dignified way to provide the person's food.

Staff were well informed about people's special dietary needs including those that required a modified or diabetic diet. People were weighed on a regular basis and if there were concerns about weight loss, people were referred on to their GP for advice.

Since our last inspection, the provider had undertaken a number of improvements to the premises such as refitting two bathrooms and replacing the flooring in the lounge. Another bathroom had been changed into a hair salon. However, some aspects of the premises and of the fixtures and fittings within it continued to be in need of updating or repair. For example, we noted that many of the lounge chairs were stained or worn. The provider had recognised that the lounge chairs needed to be repaired and quotes were being obtained for this. They anticipated that these would all be replaced by December 2017. The building design and layout could be improved to fully support the needs of people living with dementia. The provider's had recognised this and their refurbishment plan included plans to redecorate the communal areas of the home in a manner that would help counter the impairments that people living with dementia experience. It was anticipated that this work would be completed by April 2018.

We found evidence that a range of healthcare professionals including GP's and community mental health nurses, opticians, speech and language therapists and chiropodists had been involved in supporting people to maintain good physical and mental health. Staff told us how they had recently been working with the community mental health team and GP to review how they were managing one person's levels of agitation and aggression. Staff told us they were now seeing positive benefits from this with the person being more settled. Staff maintained records which demonstrated that prompt medical advice was sought when they suspected people might be suffering with a urine infection, for example. This helped to ensure that people received co-ordinated care, effective treatment and support.

Good

Is the service caring?

Our findings

People told us they were supported by staff who were kind and caring and were mindful of their privacy and dignity. One person said, "They respect that I am old". Another person told us the staff were, "Very nice, very kind, they encourage me to be independent". A third person said, "There is not much wrong here, all the carers are very kind, I get on with them all, I like [care worker], there is nothing they won't do for you…the night staff are lovely too, they bring me a cup of tea, they [the staff] are very considerate, there is not one of them who does not care".

Overall staff were mindful of people's privacy and dignity. They spoke with people in a polite and respectful manner. Most staff, though not all, were seen to knock on people's doors before entering their room and doors were kept closed when staff attended to people in their rooms.

The staff spoke positively about their role and about caring for people. One staff member said, "I love caring, every part of it I enjoy". Another staff member said, "I adore looking after the residents, they are a great bunch". Staff had good relationships with people and chatted with them about every day matters such as the food or the news. At lunchtime staff joined one person in singing their favourite song. Staff knew people well. We observed one staff member knock on a person's door and then enter saying, "Happy birthday, it's your birthday today". A staff member was seen discussing lunch choices with a person, they said to them, "You don't like quiche do you as its egg". Staff knew that another person's favourite sandwich was corned beef.

Staff used touch appropriately to convey their care and concern for people. For example, we saw one care worker take a person's hand gently and say, "[person's name] there is a nice cup of tea for you". Another care worker, put their arm around a person who was a little unsettled and gently stroked their back. The person seemed reassured by this. Both staff and a relative told us how the manager had sat with one person who was receiving end of life care. The relative said, "She did her hair, massaged her and promised her she wouldn't leave her".

Care plans contained information about people's preferred daily routines, where they preferred to eat breakfast or whether they preferred a bath or a shower. People told us that their choices were usually respected. For example, one person said, "You can choose a bath or a shower, I think it's on a Friday or Saturday I have one". Regarding their choice of meal, another person told us, "I have a choice, I usually ask for small portions which I get". One person said they were not always given a choice about whether to have a male or female care worker. They told us, "No I have to have the fella as well, he's very nice but I definitely prefer the girls". The care records also noted what aspects of their care people needed assistance and what they were able to manage independently. Staff explained how they encouraged people to care for themselves even if this was by completing a small task.

All of the relatives we spoke with felt they were kept informed about their loved ones care and that their views and ideas were valued and acted upon. One relative said, "Yes we have been through the care plan". People's relatives and friends were able to visit without restrictions, and told us they were made to feel

welcome. One person told us, "They [the staff] always bring up a tray of tea when my [family member] visits".

Requires Improvement

Is the service responsive?

Our findings

Where necessary, people had condition specific care plans which described how staff might best support the person with this need. For example, one person had a communication care plan which described their sensory impairments and how to compensate for this; they might use a pad to write down their thoughts and wishes. People had eating and drinking plans which described the size of portion the person liked to have, the level of help they needed at mealtimes and their food likes and dislikes. However, some of the care plans viewed were simplistic and would benefit from further detail. For example, one person's 'Management of behaviour' plan identified that the person could 'show signs of challenging behaviour toward staff due to dementia and could 'hit out' and 'refuse support'. The guidance provided for staff to respond to such incidents was 'Staff to allow me my own space'. There was no further guidance about what other strategies might be effective or necessary when supporting this person. We noted similar concerns in relation to people's catheter, skincare and diabetic care plans. A community healthcare professional has agreed to support the service with developing and personalising these care plans.

Care plans contained detailed information about people's choices and preferences. For example, people had a 'My typical day' which described how they liked to spend their day and their favoured foods and drinks. Some people also had detailed life histories in their care plans which helped staff have an understanding of them as a person before they to live at the home. From our observations and from speaking with staff it was evident that staff were aware of people's personal preferences and did try to meet these.

Whilst there was evidence that people's care plans were being reviewed and updated, there was little evidence that the person or their relatives had been involved in these reviews. This is an area where improvements could be made.

The home maintained records which provided information about what activities had been provided, which people had participated and whether the activity had been enjoyed. These showed that on average, organised activities took place between five to ten times a month. Photographs showed people being involved in, and enjoying some of these activities. During the inspection, we saw staff engaging people in a game of 'Famous Faces' which they seemed to be enjoying. People were also supported to take part in painting and colouring. Records showed that people also played games, had manicures and got involved in more physical activities such as catching flashing balls and playing volley balloons. Twice a month external entertainers visited to provide sing a longs or other entertainment and local churches visited to lead prayer and communion services. However, overall we found that improvements were needed to ensure that people were offered increased opportunities to participate in meaningful activities. The majority of people and staff told us more could be done to ensure that people had regular opportunities to take part in a range of activities providing stimulation or enjoyment. For example, one person told us, "Activities? I don't know that they do a lot. I wish they had a minibus, I would love to go out". Another person told us, "I'd like to keep going out more". A third person said, "We used to play skittles, have quizzes, but that was a little while ago now". A staff member said, "There is always place for more activities, but we try". Another staff member said, "The activities are hit and miss…they can be quite repetitive, we used to have armchair exercises but they

have not been for a while".

We observed that people spent long periods of time in the lounge sitting passively or sleeping as staff went about other tasks. Some of the people using the service were very tactile and liked to pick up or collect items to interact with. Whilst there were some sensory items available for people there was scope to build upon this to include more items such as rummage boxes or reminiscence objects. This would provide more opportunities to engage people in discussions and provide a more stimulating and interesting environment for them. One person told us, "We have an artificial lawn, last year they put lots of flowers in but no one takes care of them".

The provider encouraged people and their relatives to give feedback about the service. Surveys had just been sent out which sought people's views about the quality of care provided. The feedback was largely positive with comments including, 'staff promote my independence' and 'I'm always very happy with my dealings with Clifford House'. The provider told us arrangements were being made to analyse the result following which an action plan would be developed to address any areas for improvement.

No complaints had been received since our last inspection, but people and their relatives were confident they could raise concerns or complaints and these would be dealt with. One person told us, "Oh yes I would definitely talk with [the manager]. Another person told us, "They [the manager] sit in the office and if you have any problems you can go and speak to her". We were able to see that the service had received a number of compliments about the care provided.

Requires Improvement

Is the service well-led?

Our findings

People, their relatives and the staff team were positive about the management of the home. One person told us, [The manager] often pops up, she is alright, a very good manager, always chats…they do a good job". Another said, [Manager] is very nice indeed, very pleasant and very helpful…she's always popping in". A relative said, "The manager comes and chats and we have the occasional meetings". A staff member told us, "[the manager] is very willing, they will cover staff sickness and when [person] was dying they stayed with [their family member] to support them". Another staff member said, "They are a very good manager, things have changed for the better, things get done". Staff told us that improvements included better and more detailed daily notes and clearer care plans. They felt communication with people's families had improved and with other professionals. A staff member told us, "They are the best manager I have ever had. They interact with the residents, lend a hand and are caring and considerate".

Staff told us they were encouraged to contribute their ideas and make comments or suggestions about how the service might improve. One care worker said, "You are free to give ideas, the manager is very supportive of this". Other staff told us how the manager was fostering a more positive culture promoting team work and encouraging a wish to constantly improve. One care worker said, "Since they [the manager] have stepped in the building, it has felt good, many things have changed". Another care worker told us, "I feel like I am in a family, its all good, I have nothing bad to say". The homely nature and positive culture of the home was something that relatives commented on.

Despite this positive feedback, we found that improvements were needed to the governance arrangements within the service.

Our last inspection had found that the provider had not ensured that records relating to people's care and in relation to decisions about the numbers of staff deployed were accurate and up to date. This was a breach of Regulation 17 (2) (c) of the Health and Social Care Act; Good Governance. The provider sent us an action plan that said they planned to seek external professional advice regarding a structured dependency tool to determine staffing numbers. This inspection found there was still no systematic method in place for determining the numbers of staff deployed. We also found that in some cases the care plans viewed were simplistic, did not provide adequate information to guide staff, and would benefit from further detail. This meant the provider had not made the required improvements. We also found new concerns regarding the records relating to the induction of new staff.

We also found new concerns regarding the governance arrangements within the service. Records were maintained of incidents affecting the safety and wellbeing of people, however, it was not evident that these records were analysed to help identify themes or trends that might require remedial actions to be taken. For example, we identified that one person had fallen in the same location within the home on four occasions. It was not evident that a range of measures had been put in place to prevent this from happening again. It was not evident that following a medicines error a full investigation had taken place to identify learning or whether there might be additional training requirements for the staff members involved. An external audit completed in June 2017 had identified that there was no evidence of management oversight of the incidents

and accidents that had occurred within the service. We had similar concerns.

We found a number of the other recommendations from this external audit had not been acted upon. The registered provider had not taken timely action to ensure the safety of all aspects of the premises and of equipment within it. We found that some parts of the service were not clean, but no evidence of infection control audits. We found concerns regarding the management of medicines, but no medicines audits were taking place. The registered provider had not ensured that recommendations made following a fire risk assessment had been acted upon. The provider had not put adequate systems in place to check the quality and safety of the service.

Following our recommendations about improving the activities provided at our previous inspection we were advised that trips would be planned. This had not happened. We were advised that additional staff would be employed to provide domestic support at weekends. Rotas showed this was not happening. The provider's action plan said they would ensure there was a programme of audit in place and that these would be analysed and actions taken in response. We found no evidence that such a programme of audit was in place. This meant the provider had not had due regard to requirements and recommendations issued by the Care Quality Commission.

The provider did not have adequate systems and processes in place to ensure they met the requirements of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Good Governance. This was a continued breach.

The registered manager was also the registered provider. For the last 12 months, the registered manager had not been providing day to day management of the service, as required by their registration, but had instead appointed a manager to perform this role. The manager had been appointed in October 2016, but had not yet submitted an application to the Care Quality Commission to become the registered manager.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not adequately assessed risks to people's health and safety and done all that was reasonably practicable to mitigate such risks. This was a breach of Regulation 12 (2) (a) (b) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. The provider had not ensured the ongoing safety of the premises. This was a breach of Regulation 12 (2) (d) (e) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. The provider had not ensured there were effective systems in place to prevent, detect and control the spread of infections. This was a breach of Regulation 12 (2) (h) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment. The provider had not ensured the proper and safe use of medicines. This was a breach of Regulation 12 (2) (g) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have adequate systems and processes in place to ensure they met the requirements of Regulation 17 of the Health

and Social Care Act (Regulated Activities) Regulations 2014. Good Governance. This was a continued breach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not taken proper steps to ensure that all of the required checks had been completed before staff started working at the service. This was a breach of Regulation 19 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. Fit and Proper Persons Employed.