Achieve Together Limited

Cleveland House

Inspection report

1 Cleveland Road
South Woodford
London
E18 2AN

Tel: 02085302180
Website: www.achievetogether.co.uk

Date of inspection visit:
10 October 2023
21 October 2023

Date of publication:
16 November 2023

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We expect health and social care providers to guarantee people with a learning disability and autistic people respect, equality, dignity, choices and independence and good access to local communities that most people take for granted. 'Right support, right care, right culture' is the guidance CQC follows to make assessments and judgements about services supporting people with a learning disability and autistic people and providers must have regard to it.

About the service
Cleveland House is a care home registered to accommodate and support up to 11 people with mental health needs, learning disabilities and/or autism. At the time of the inspection, 9 people were using the service.

People's experience of using this service and what we found

Right support
Staff, people and relatives told us that the service was good and that they could speak with the peripatetic manager as and when they wanted. There were sufficient staff to meet people's needs and recruitment processes were safe. The provider had a system in place to record and monitor accidents and incidents. They worked closely with other professionals and had regular contact with them to ensure people's needs were met fully.

Right care
Risk assessments were not always completed fully meaning staff did not always have the correct information on how to deliver safe care. People's medicines were not always managed safely. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Right culture
There were quality assurance and governance systems in place to drive continuous improvement; however, the systems were not always working effectively because the provider had not identified some health and safety issues. Staff had received training of what constituted abuse and how to report any concerns to keep people safe. Staff and relatives commented positively about the changes being made by the new peripatetic manager.

For more information, please read the detailed findings section of this report. If you are reading this as a separate summary, the full report can be found on the Care Quality Commission (CQC) website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was good (published 3 November 2022).

Why we inspected
The inspection was prompted in part due to concerns received about how people were safeguarded at the service. A decision was made for us to inspect and examine those risks.

This was a focused inspection, and the report only covers our findings in relation to the key questions Safe and Well-led. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement:
We have identified breaches of regulations in relation to safe care and treatment and quality assurance at this inspection.

The overall rating for this service has now changed from good to requires improvement.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Cleveland House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection, we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by 2 inspectors.

Service and service type
Cleveland House is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Cleveland House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post. However, they were not available on the days of our inspection. A peripatetic manager facilitated the inspection.

Notice of inspection
The inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications we had received from the service. A notification is information about important events, which the provider is required to tell us about by law. We used all this information to plan our inspection.

During the inspection
We spoke with 3 people who used the service, 4 members of staff, 1 senior staff and the peripatetic manager. We reviewed a range of records. This included 3 people's care records, training records, risk assessments and medicine administration records. We also looked at audits and a variety of records relating to the management of the service, including policies and procedures.

We were able to get limited views from people due to their needs. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not speak with us. Following the inspection, we continued to seek clarification from the provider to corroborate evidence found. We spoke with 4 relatives by telephone to obtain their views of the service.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as good. At this inspection this key question has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely

● People's medicines were not always managed safely because we found shortfalls around the provider's arrangements to make sure people received their medicines safely.

● We noted the temperature in the room where the service kept their stock of medicines as well as the controlled drugs was above the recommended level. We observed the thermometer read 32C (degrees centigrade). Medicines must be stored in conditions that will not affect their potency. Active drugs used in medicines are temperature sensitive. When stored in hot or cold places, they can become unstable and even degrade, posing a risk of negative side effects and decreasing their effectiveness. Most medicines come with directions from the manufacturer to store below 25C. Some state store below 30C.

● This was discussed with the peripatetic manager, and they took action on the day of the inspection to bring the temperature to the recommended level by using portable fans and placing ice packs in the metal cupboard. They also requested for an air conditioner to be installed in the room. We asked them to monitor the temperature in the meantime.

● We found where people were prescribed medicines to be administered when required, staff did not follow the prescription. For example, a person was prescribed a medicine to be administered only when the pollen was high. However, we noted the medicine had been administered daily for a period of 28 days. This was brought to the attention of the senior staff who was unable to comment. We explained that it was unlikely the pollen was high each day when the medicine had been given to the person.

● We also found another person was prescribed a medicine to be administered when they were in pain. The service did not have this medicine in stock. Staff ordered the medicine on the day of our first visit.

● A third person had a medicine to be administered when required, however we noted the medicine was given on a regular basis. We were unable to find out if this was discussed with the person's doctor. The senior staff mentioned they would clarify this with the GP.

● There was no clear guidance for staff on protocols they should follow for PRN [when required] medicines. For example, a person was prescribed a medicine to be administer when there was a change in their behaviour. The guidance was not clear on when this medicine needed to be given. For example, how long do staff wait until they decide to administer the medicine if the person's behaviour changed or when to seek further advice.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate medicines were managed safely and effectively. This placed people at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Each person had a medicines administration record [MAR] where staff documented when a person had taken their medicines.
● Staff had received training in the management of medicine.

Assessing risk, safety monitoring and management
● We found that systems were not always in place to effectively assess and manage risks to people while they received a service.
● We noted there were no risk assessments for 2 people who used the service but did not wear any footwear when walking around the service. There was a risk plan of them hurting themselves with sharp objects. This was discussed with the peripatetic manager who said they would put a risk assessment in place. A copy was forwarded to us following our inspection.
● We also found the risk assessment for a person was last reviewed in March 2021. This was brought to the attention of the senior staff.
● The provider had a system to maintain and service equipment at the service. We saw the portable appliances had been tested in August 2023 and the legionella testing had been done in June 2023. However, we found that the weekly fire alarm testing was last carried out on 16 September 2023. This could compromise the safety of everyone in the event of a fire.
● We also found the daily health and safety check was last completed on 27 September 2023 and the monthly health and safety was last done on 30 September 2022.
● We also noted the provider was failing to ensure people had access to clean drinking water as we found the shower heads in 2 shower rooms could drop below the water level when the showers were in use. This was also the case with the shower head in the bath. This could create a backflow (an unwanted flow of water in the reverse direction) and could be a health risk for the contamination of drinking water.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people, staff and visitors at risk of harm. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We have also signposted the provider to resources to develop their approach. We noted some of the flooring needed deep cleaning or renewed and some areas of the service needed redecorating. This was discussed with the peripatetic manager who assured us the work would be carried out within the next 4 to 6 weeks. They said they would inform once the work had been completed.
● A member of staff told us, "We have to wear apron and gloves when supporting with personal care and use apron in kitchen duty and cleaning duty."

Visiting in care homes
● Relatives told us they were made welcome and there were no restrictions on them visiting their family members. A relative told us, "I can visit at anytime, most time I go unannounced."

Systems and processes to safeguard people from the risk of abuse

● People were safeguarded from abuse and avoidable harm.

● There was a policy for the safeguarding of people. We saw staff had received training on safeguarding procedures.

● Most relatives told us they had no concerns on the way staff provided their family members with the care and support they needed. A relative told us, "[Family member] is definitely safe where they are, I would know if something was wrong, they would tell me too." However, another relative felt their concerns had not been looked into fully, these were currently still being investigated.

● There had been a number of safeguarding concerns raised recently about staff working at the service. The local safeguarding team was currently carrying out an investigation. The provider was also conducting their own investigation using an external investigator.

● Staff were aware of their responsibilities in relation to safeguarding people. Staff were able to explain who to report abuse to. A member of staff said, "I will speak to lead key worker and the manager if there is concern."

● The provider also had a whistleblowing policy and procedure in place. A whistle-blower is a person who raises a concern about a wrongdoing in their workplace. Where staff had raised concerns, the management team took actions to investigate them and report them to the local safeguarding team where applicable.

Staffing and recruitment

● The provider ensured there were sufficient numbers of suitable staff.

● The provider operated safe recruitment processes.

● There were enough staff employed to meet the needs of the people using the service. A relative told us, "There seems to be enough staff around when I visit."

● We looked at the staffing rota for the last 4 weeks and found sufficient numbers of staff available to support people with their care needs.

● The service did not use agency staff, so this helped people to receive care and support from staff who knew them and their needs.

● During our inspection, we noted the interaction between staff and people could be further improved. We noted a person was left sleeping in the dining room on a chair and no staff attended to their needs. We also noted a member of staff helping people to eat their lunch, again there was very little interaction between them. This was discussed with the peripatetic manager who said they would remind staff of the importance of interacting with people whilst supporting them.

● The provider had effective recruitment and selection processes in place. A number of checks were undertaken before new staff started working at the service. This helped to ensure staff employed to support people were fit to do so and showed the provider understood their legal responsibilities regarding safe staff recruitment.

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 MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

● The management team and staff understood the importance of people having the right to make their own

decisions. Where people did not have the capacity to consent, the provider acted in accordance with legal requirements.

● We noted the DoLS authorisations for 2 people had expired, 1 in August 2023 and the other in June 2023. The management team had applied for them to be renewed.

Learning lessons when things go wrong

● There were systems and processes in place for recording and reviewing accidents and incidents. The management team reviewed the records to identify any action needed to reduce the likelihood of incidents happening again.

● Learning from incidents and accidents was shared with staff to prevent recurrence. For example, a person had a fall and following a review of the incident, the person was encouraged by staff to take their time rather than rushing when using the staircase as well as using the handrails.

● There was an on-call system in place so there was always a member of the management team available to advice staff in the event of an emergency.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Continuous learning and improving care

- The provider's quality assurance systems and checks were not always robust.
- There were quality assurance and governance systems in place to drive continuous improvement; however, the systems were not always working effectively because the provider had not identified and improved some of the issues we found during the inspection.
- Risks associated with people's care and support had not been fully assessed. People's medicines were not always managed safely because we found shortfalls around the provider's arrangements to make sure people received their medicines safely and as prescribed. Medicines were not stored within their recommended temperatures. PRN protocols were not always comprehensive. Health and safety audits and fire safety checks were not being done as per the provider's policy and procedures. There was a health risk for the contamination of drinking water within the service.

The above evidence shows that the provider did not have effective systems to assess, monitor and improve the quality and safety of the service This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The peripatetic manager had identified some of the areas where improvements were needed and had an action plan in place.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- There was a positive and open culture at the service.
- The provider had systems to provide person-centred care that achieved good outcomes for people.
- The peripatetic manager operated an 'open door' policy. They were in regular contact with people, relatives, and staff to ensure the service ran smoothly. One person told us, "Manager is good. They come and talk to me every day."
- Relatives told us that they were always kept up to date with what was happening with their family members. They mentioned they were able to contact the service and speak with a member of the management team if they had any queries.
- Staff told us the peripatetic manager was approachable and very supportive. A member of staff told us, "The manager is very helpful and friendly." Another member of staff mentioned they could talk to the peripatetic manager about anything and felt well supported. They told us the atmosphere in the service was positive and staff morale was good.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● The provider understood their responsibilities under the duty of candour.

● The peripatetic manager was aware of their responsibility to inform CQC of events and incidents that happen within the service or when people received care and support from staff.

● The provider had submitted notifications to CQC in an appropriate and timely manner in line with CQC guidelines.

● As mentioned above, there had been some safeguarding concerns raised about people who used the service, the peripatetic manager had contacted their relatives and acted in accordance with the duty of candour.

● The provider had a range of policies and procedures, which gave staff guidance on how to care and support people in a safe manner.

● Staff knew who they were accountable to and understood their roles and responsibilities in ensuring people's needs were met. They had a clear understanding of what was expected of them.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People and staff were involved in the running of the service and fully understood and took into account people's protected characteristics.

● There were meetings held for staff and these enabled them to raise any issues or concerns they had. We saw a number of areas were discussed during those meetings, such as any changes in people's needs, activities and completion of records.

● The provider continually sought feedback from relatives and other professionals. This was gained by satisfaction surveys.

● Staff had received training in equality and diversity. People were respected and treated equally regardless of their abilities, lifestyle and beliefs.

Working in partnership with others

● The management team worked closely with the local authority and other professionals to ensure they improved the care and support they offered to people.

● People were supported to maintain good health and to access healthcare services when they needed. They were referred to other health care professionals such as GPs, as needed. For example, we noted a chiropodist visited a person regularly to do their nails.

● The management team kept themselves up to date with best practice as far as health and social care was concerned. For example, the peripatetic manager recently attended a meeting where CQC new assessment approach was discussed.

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 Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The procedures for administration of medicines were not being followed and left people at risk of not having their medicines as prescribed. The provider had not ensured there was effective system in place to maintain the premises and ensure the safety of people, staff and visitors. Risks associated with people's care and support had not been fully assessed. Regulation 12(1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured there was effective governance and quality systems in place to ensure the quality and safety of care was assessed, monitored and improved when needed. The systems and processes did not always mitigate risks relating the health, safety and welfare of people using services and others. Regulation 17(1) (2)