Cleggsworth Care Home Ltd

Cleggsworth Care Home

Inspection report

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Ratings

Overall rating for this service	**Inadequate**
Is the service safe?	**Requires improvement**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

Cleggsworth Care Home is registered to provide personal care and accommodation for up to 38 people. The home is located in the village of Smithybridge and is close to local amenities, bus routes and the train station. This was an unannounced inspection which took place on 9 June 2015. There were 26 people living in the service at the time of our inspection.

We last inspected this service on 21 January 2014 and found the service to be compliant in the outcome we assessed.

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We found a number of breaches of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of the full version of this report.

Safeguarding procedures were robust and members of staff understood their role in safeguarding vulnerable people from harm.

Summary of findings

We found that recruitment procedures were thorough so that people were protected from the employment of unsuitable staff.

People who used the service and their relatives expressed concerns about staffing levels. We saw that people were kept waiting for some time when they required assistance from staff.

The standard of cleanliness throughout the home was below an acceptable standard. There were also unpleasant odours in some areas of the home.

A member of staff qualified to administer first aid was not on duty for all shifts. This put people at risk of inappropriate care in the event of an emergency.

People's views about the meals varied. Some people told us the meals were good others said their personal preferences were ignored.

Only one of the showers in the home was fully operational. The other two showers and both baths were out of order.

People were registered with a GP and had access to a full range of other health and social care professionals.

Visitors were welcomed into the home at any time.

We saw that members of staff were respectful and spoke to people in a friendly manner. Although people said staff listened to them they did not always take any action.

Although a member of staff was designated to organise activities within the home people told us there were not enough and there was nothing suitable for people with a dementia.

A copy of the complaint's procedure was displayed in the home. Although the registered manager had investigated seven complaints in the last year some people said the concerns they had raised had not been addressed.

Members of staff told us they liked working at the home and found the registered manager approachable and supportive.

People who used the service and their representatives had not been given the opportunity to express their views about the service by completing a survey or attending meetings.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe."

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe. Members of staff knew the action they must take if they witnessed or suspected any abuse.

People who had developed pressure sores did not receive appropriate care and treatment.

There was not a sufficient number of staff on duty to fully meet the needs of people using the service.

Requires improvement

Is the service effective?

The service was not always effective. Significant areas of the home were dusty and dirty.

Only one of the showers in the home was fully operational. The other two showers and both baths were out of order.

People were registered with a GP and had access to other health and social care professionals.

Inadequate

Is the service caring?

The service was not always caring. We saw that members of staff were respectful. However, we were told that staff were sometimes sharp when speaking to people and did not always listen.

Visitors were welcomed into the home at any time.

Requires improvement

Is the service responsive?

The service was not always responsive. Members of staff did not always respond to the needs of people who used the service.

People told us that not enough activities were organised at the home.

A copy of the complaint's procedure was displayed in the home.

Requires improvement

Is the service well-led?

The service was not always well-led. People who used the service and their representatives were not given the opportunity to formally express their views about the care and facilities provided at the home.

Members of staff told us the registered manager was approachable and supportive and they enjoyed working at the home.

There was a recognised management system which staff understood and meant there was always someone senior to take charge.

Inadequate

Cleggsworth 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 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.

Our unannounced inspection at Cleggsworth Care Home took place on 9 June 2015. During the inspection we spoke with 12 people who used the service, the relatives of five people who used the service, four care workers, the cook and the maintenance person.

The registered manager was not on duty at the time of this inspection. However, the assistant director and the provider were present in the home.

The inspection team consisted of two inspectors and an expert-by-experience. 'An expert-by-experience is a person who has personal experience of using or caring for someone who uses services for older people.

Before our inspection visit we reviewed the information we held about the service. This included notifications the provider had made to us and the Provider Information Record (PIR) that they had completed. This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We contacted the local authority safeguarding team and the commissioners of the service and Rochdale Healthwatch to obtain their views about the service.

During the inspection we carried out observations in the public areas of the home and undertook a Short Observation Framework for Inspection (SOFI) during the lunchtime period. A SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

During our inspection we observed the support provided by staff in communal areas of the home. We looked at the care records for six people who used the service and medication administration records for 11 people. We also looked at the recruitment, training and supervision records for six members of staff, minutes of meetings and a variety of other records related to the management of the service. There were 26 people living in the service at the time of our inspection.

Requires improvement

Is the service safe?

Our findings

People who used the service and their relatives had varying opinions about the safety of the service. One person who used the service told that Cleggsworth was a safe place to live. Another person said, “I feel safe here, the staff are nice and kind.” However, one person said, “I have not been bullied but I have seen staff be nasty to other residents.” The relative of one person said, “I do not feel safe when I leave my mother here; there is not enough staff and no security.” The relative of another person said, “There is a lady here who can be quite aggressive and sometimes she shouts and hits out but no one seems to bother”.

Discussion with the assistant director and the training records we looked at confirmed that members of staff had received training in safeguarding vulnerable adults from harm. We discussed safeguarding with one member of staff and found they had a good understanding of safeguarding procedures and were clear about the action they must take if abuse was suspected or witnessed.

The staff team had access to the 'Whistle Blowing' policy. This policy ensured that members of staff knew the procedure to follow and their legal rights if they reported any genuine issues of concern. The member of staff we asked told us they would report any concerns to the manager and were confident that appropriate action would be taken.

We looked at the care plans of six people who used the service. These plans identified the risks to people’s health and wellbeing including falling, nutrition and the formation of pressure sores. However, the relative of one person expressed concerns about the care provided to prevent and treat pressure sores and said, “My mum has had a pressure sore on her bottom for over a year, they don’t move her about enough.”

We were told that that gloves and aprons were available for staff to wear in order to protect themselves and people who used the service from infection. We saw that gloves were readily available near the toilets and people’s bedrooms. However, we did not see any plastic aprons available for use.

We saw that medicines were stored securely which reduced the risk of mishandling. We looked at the medicines administration records of eight people who used the service and found they included details of the receipt and administration of medicines. A record of unwanted medicines returned to the pharmacy was also available. We saw that there were no gaps or omissions in the records. A senior care worker told us that night staff was not allowed to give people medicines except for Paracetamol. This meant that people were given their medicines between 8am and 8pm and medicines prescribed to be given three or four times a day was not being given at regular intervals. Not allowing sufficient time between doses of medicine could seriously affect the health and wellbeing of people who used the service. One person said, “I should have had my medication an hour ago and I’m still waiting for it.” Another person said, “I'm on medicines and I know what most of my medicines are for. Medicines are given more or less on time.”

One person expressed concerns about the senior care worker who was giving people their medicines and said, “The girl that is doing the medication is not qualified.” This senior care worker explained that she was currently receiving training for the management of medicines. However, she was working unsupervised and we were not shown any evidence to demonstrate that her competence to undertake this task had been assessed.

We looked at the recruitment files of four members of staff. These files included an application form with details of previous employment and training, an interview record, two written references and a criminal records check from the Disclosure and Barring Service. These checks helped to ensure that people who used the service were protected from the employment of unsuitable staff.

During our inspection we saw that people in the lounges were left unsupervised for long periods of time. We saw that one person kept asking to go to the toilet and was kept waiting for at least half an hour. We also saw three people walking about in wet clothes waiting to be taken to the toilet.

Two visitors told us, “It’s just basic care here. There are not enough staff and the lounges are left unattended for long periods of time.” The relative of one person said, “Sometimes he needs to be supported to eat but staff are not always to hand. They are not neglectful there just is not enough staff.” Comments from people who used the service included, “I need support with my personal care and some mornings I have to wait a long time.”; “I ask my daughter to take me to the toilet before she goes because if not the carers leave me to wait.” and “There is never

Requires improvement

Is the service safe?

enough staff on". However, one person said, "On the whole the staff come pretty quick when the call bell is pressed." We saw that people sitting in the lounges could not easily reach a call bell. This meant that people were not always able to alert staff when they needed assistance.

The assistant director explained that staffing levels were determined by the care needs of people who used the service. This involved completing a dependency assessment which we saw in the care plans of six people. However, we were not shown any evidence to demonstrate how these dependency assessments had determined the overall staffing levels for the home.

We were shown a copy of the duty rota which provided details of the grades and number of staff on duty for each shift. In addition to the care workers ancillary staff were also employed to do the cooking, cleaning and the laundry. The duty rota stated that five care workers were on duty from 8am to 2pm, four care workers from 2pm to 8pm and two care workers were on duty for the night shift which commenced at 8pm. However, we were told that on the day of our inspection one care worker was off sick and other members of staff had not been available to cover the shift.

Insufficient numbers of suitably qualified, competent, skilled and experienced staff on duty to meet people's needs is a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw records to demonstrate that equipment used at the home was serviced regularly.

This included the fire alarm, electrical installation, gas appliances, portable electric appliances, fire extinguishers and emergency lighting. The fire system and procedures were checked regularly to make sure they were working.

We noted that a personal evacuation plan (PEEP) was in place for each person who used the service. These plans provided directions for staff to follow about the support each person required to safely evacuate the premises in the event of an emergency. There was also a business continuity plan in place which provided information for staff about the action they should take in the event of an emergency.

Inadequate

Is the service effective?

Our findings

Two care workers told us that it was only senior members of staff that had access to people's care plans. This meant that care workers did not have access to all the information they needed in order to provide effective care for people who used the service. Discussion with one care worker confirmed that they were unaware of the care needs of people who used the service.

Two members of staff told us about the training they had received. This included fire prevention, safeguarding adults, food safety, infection control, moving and handling, health and safety, diabetes, dementia, nutrition, catheter care and prevention of pressure sores and nationally recognised vocational qualifications in health and social care. However, one care worker told us they had not received any formal moving and handling training but had been shown these procedures by more experienced staff. The lack of moving and handling training by qualified trainers puts people using the service and members of staff at risk of injury.

One of the senior care workers told us that the first aid training consisted of watching a DVD about first aid awareness. The assistant director and provider confirmed that the first aid training provided only involved watching the first aid awareness DVD and did not include any practical training. One care worker explained that they had completed first aid training in a previous job and had an up to date first aid certificate. However, this meant that a member of staff qualified to administer first aid was not usually on duty on each shift which put people at risk of inappropriate treatment in the event of an accident or medical emergency.

Insufficient numbers of suitably qualified, competent, skilled and experienced staff on duty to meet people's needs is a breach of regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The assistant director showed us records which identified when members of staff had completed training and when further training was planned. We looked at the personnel files of six members of staff and found they contained records of the training they had completed. Although this confirmed that a programme of training was in place the training needs of some members of staff had not been addressed.

New members of staff were required to complete a structured induction programme which also included completing the recently introduced 'Care Certificate.' New care workers employed to work on the day shifts shadowed more experienced staff for one shift and staff employed for night duty shadowed experienced staff for two shifts in order to become familiar with the home and people who used the service.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS) and to report on what we find. Senior members of staff and several care workers had been trained in the Mental Capacity Act 2005 (MCA 2005). This legislation sets out what must be done to make sure the human rights of people who may lack mental capacity to make decisions are protected. The Deprivation of Liberty Safeguards (DoLS) provides a legal framework to protect people who need to be deprived of their liberty to ensure they receive the care and treatment they need, where there is no less restrictive way of achieving this. At the time of our inspection an authorisation for DoLS was in place for two people who used the service. These authorisations ensured that people were looked after in a way that protected their rights and did not inappropriately restrict their freedom. Urgent applications for DoLS had been made for another eight people who used the service.

One care worker told us that she had regular supervision meetings with the registered manager. She explained that these meetings were helpful and gave her the opportunity to talk about anything relevant to her work at the home including training. The staff files we looked at included records of supervision meetings. We were shown records kept by the registered manager of when supervision meetings had taken place and the date of the next meeting for each member of staff.

People who used the service had varying opinions about the meals. One person said, "The meals are lovely." However, comments for other people included, "I had toast for breakfast but as you can see it was burnt"; "The food is just ok" and "The meals are rubbish there's no choice." The relative of one person said, "Mum only eats brown bread but they keep giving her white and when I told them about

Is the service effective?

this they said if we haven't got any brown she will have to have white". The relative of another person said, "I tell the staff what he likes but they just ignore it. The food is revolting."

The meal served at lunch time which consisted of fish cakes, chips and vegetables or sweet and sour pork looked bland and unappetising. We saw that most people left part of the meal. We saw that drinks and snacks were served between meals.

We found that people's care records included an assessment of their nutritional status so that appropriate action was taken if any problems were identified. This assessment was kept under review so that any changes in a person's condition could be treated promptly. People's weight was checked and recorded monthly or more frequently if weight loss or gain needed to be monitored. When necessary advice was sought from the doctor and dietician.

We saw that the kitchen was clean and had achieved the 5 star very good rating at their last environmental health visit which meant kitchen staff followed very good practices.

Each person was registered with a GP who they saw when needed. The care plans we saw demonstrated that people had access to specialists and other healthcare professionals such as dieticians, speech therapists, podiatrists and opticians. Records were kept of all appointments and any visits from health care professionals so that members of staff were aware of people's changing needs and any recurring problems. The relative of one person said, "If mum needs a professional the staff will get someone and if her needs have changed they keep us informed."

We looked round the home and saw that the cleanliness of the home was below an acceptable standard. The relative of one person said, "The home is filthy." Throughout the home we saw that the skirting boards and window ledges were dusty and dirty. Almost all of the toilets in the home were dirty. One person who used the service said, "The toilets have been bunged up and dirty."

The carpets were dirty and the in some areas the decorations looked shabby.

There was an unpleasant odour in five of the bedrooms. In one bedroom dirty underwear had been left on the floor. Waste paper baskets were full of rubbish in the lounges and the bedrooms. In one of the bedrooms a dirty incontinence pad had been put into the rubbish bin causing and unpleasant odour. In another bedroom we saw that the rubbish bin was overflowing with dead flowers which again caused an unpleasant odour. One person who used the service said, "The atmosphere here stinks." A dirty environment did not promote the dignity and wellbeing of people who used the service and increased the risk of infection. Although we were told that the cleaner was off sick on the day of this inspection the dust and dirt we found had clearly accumulated over some time.

There were three showers in the home but members of staff told us that two of these had not been working for two weeks. There were two bathrooms and four care workers told us that they did not know how to use the assisted baths and neither of these baths were in full working order. This meant that throughout the home only one shower was available for use by the 26 people accommodated in the home on the day of our inspection.

The maintenance person told us that the control on one of these baths was broken and said, "It's been out of action for a long time and it needs a specialist to mend it but so far nothing has been done." Although the care workers told us that people who used the service preferred to have showers due to the lack of appropriately maintained equipment people's choice was limited.

A visiting healthcare professional told us there were not enough paper towels and also expressed concerns about the cleanliness of the home and the full rubbish bins.

Dirty premises and the failure to adequately maintain equipment is a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people had personalised their own room with photographs, ornaments and pictures for the walls to make them look more homely.

Requires improvement

Is the service caring?

Our findings

During the inspection we saw that members of staff spoke to people in a courteous and friendly manner. Most of the people we asked said that members of staff were kind and caring. Comments from people who used the service included, “The staff treat me with respect and dignity.”; “Some staff are kind and caring, they are respectful but they do not listen”; “With my personal care they treat me with dignity, the staff do not help me to be independent.” and “The staff can be sharp sometimes when they speak to me but I just laugh it off”.

The care plans we looked at contained information about people’s individual likes and dislikes and their life history. However, some care workers were not allowed access to the care plans. This meant that people were at risk of receiving care that did not meet their individual needs and personal preferences.

Where possible information about each person’s wishes regarding end of life care and resuscitation had been discussed and documented in their individual care plan. This informed staff what people wanted to happen at the end of their life.

Arrangements were in place for the manager or a senior member of staff to visit and assess people's personal and health care needs before they were admitted to the home. The person and their representatives were involved in the pre-admission assessment and provided information about the person’s abilities and preferences. Information was also obtained from other health and social care professionals such as the person’s social worker. This process helped to ensure that people’s individual needs could be met at the home.

We noted that visitors were welcomed into the home at any time. People who used the service could choose to receive their visitors in communal areas or in the privacy of their own room.

Requires improvement

Is the service responsive?

Our findings

The six care plans we looked at included information about people's personal preferences. One person said, "The staff respect my choices." Another person said, "The staff support me to be independent." However, one person said, "They listen but do not act upon it." The relative of one person said, "In the main the staff are ok. They listen but do not act on it. My dad's toe nails had not been cut for weeks and I had to get a chiropodist in to do them."

We saw that the fitted bed sheet in one of the bedrooms was too small, very thin and torn. We also saw that some of the towels were very thin. One person said, "We have ripped up towels and no face cloths." The relative of one person said, "I bring pillows and bedding in for my husband. My husband is six foot three and the bed he is in is far too small I have told them about this but nothing has been done."

The care plans we looked at included information about people's interests, hobbies and religious needs. However, all the people we asked told us there were not enough activities organised within the home and there was nothing suitable for people with a dementia. A member of staff was responsible for organising activities and showed us her monthly activities plan. This included games such as skittles, bingo, snakes and ladders, armchair exercises, singing and dancing and reminiscence. There were also plans to take people out to visit the local coffee shop and Hollingworth Lake. During our inspection we were not aware of any organised activities taking place except in one the lounges where people watched the same film twice.

Local clergy and people from a variety of local churches regularly visited the home and offered services including Holy Communion for people who wished to practice their faith in this way.

We saw that people's care plans were reviewed monthly and updated when necessary to reflect people's changing needs and any recurring difficulties. Where possible people who used the service or their representatives were involved in these reviews. However, one person who used the service and their relative told us that they had never seen the care plan.

A copy of the complaint's procedure was displayed near the main entrance to the home and included in the service user guide. This procedure told people how to complain, who to complain to and the times it would take for a response. The registered manager had investigated six complaints in the last year. Two complaints were because personal items were missing, one complainant was concerned about how often people were checked at night and one complaint was from a member of staff. Records of these complaints were available and indicated that these four complaints had been satisfactorily resolved. However, two complaints from a person's relative related to personal care. Although these were investigated the complainant was unhappy with the outcome.

One complaint had been made to the CQC during the last year. However, one person who used the service said, "I have made lots of complaints and nothing has been done about it." Another person said, "My concerns are not acted upon." The relative of one person said, "Clothes disappear all the time."

Inadequate

Is the service well-led?

Our findings

The home had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager was supported by the assistant director and the provider who frequently visited the home.

All the people we spoke to said the manager was approachable but their concerns were not being addressed. People's comments included, "There is no routine and no organisation."; "The staff are not organised." and "They are always running out of things like toilet rolls, bread and milk."

Members of staff told us they liked working at the home and the registered manager was approachable and supportive.

The assistant director told us that staff meetings were held every three months. Minutes of these meetings indicated that cleaning, record keeping and sick leave had been discussed.

Staff handover meetings took place at the beginning of each shift. This informed staff coming on duty of any problems or changes in the support people required in order to ensure that people received consistent care.

We saw that policies and procedures for the effective management of the home were in place. These included, infection control, medicines management, health and safety, fire safety, complaints, disciplinary and grievance procedures, management of accidents and incidents and safeguarding. However, it was of concern that the issues were identified during our inspection demonstrated that some of these policies and procedures were not being followed.

We saw that audits completed regularly by the registered manager included infection control, health and safety, accidents, care planning and the environment. However, these audits had not identified the shortfalls we found during our inspection.

The care plan for one person lacked clear directions for staff to follow about the care and treatment of a person who had a pressure sore. The records of positional changes indicated that these had taken place infrequently. The record of the day before our inspection stated that the person's position had only been changed twice, once in the morning and again in the afternoon. On the day of our inspection again there were only two recorded positional changes and both had taken place in the morning. Having clear and accurate records in place for the prevention and treatment of pressure sores helps to ensure that people who use the service receive the care they need in order to promote their health and wellbeing.

A visiting healthcare professional was also concerned about the lack of records detailing the positional changes of people who had developed pressure sores.

Although the management of medicines was audited this did not include staff competence. Accidents were monitored in order to identify and address any trends.

The arrangements in place for assessing and monitoring the quality of the service provided had not included obtaining the views of people who used the service and their representatives. One person said, "There are no residents meetings and no relatives meetings." There was no evidence to demonstrate that any such meetings had taken place or were planned. The assistant director showed us records which indicated that the last time people had been asked to complete satisfaction surveys was in 2013. Providing opportunities for people and their representatives to express their views helps to identify any concerns and areas for improvement.

Failure to have an effective system in place to assess and monitor the quality of the service provided is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a recognised management system which staff understood and meant there was always someone senior to take charge. The staff we spoke to were aware that there was always someone they could rely upon.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing People who use the service were at risk of receiving inadequate care because an Insufficient numbers of suitably qualified, competent, skilled and experienced staff were not on duty.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment People using the service were not protected against the risks associated with premises that were not clean and inadequately maintained equipment.

The enforcement action we took:
We issued warning notices.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People using the service were not protected against the risk of unsafe care and treatment because the system in place to monitor the quality of the service provided had failed to identify areas of the service that required improvement.

The enforcement action we took:
We issued warning notices.