Deepdene Care Limited

Clifton House

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We inspected Clifton House on 05, 06, 07 and 25 January 2016. The first day of the inspection was unannounced. This meant that the service did not know we were coming.

Clifton House provides care and accommodation for up to 32 people with enduring mental health needs. At the time of our inspection there were 26 people living in the home. People were supported in one building over three floors. Nine people lived on the ground floor, eight people lived on the first floor and seven people lived on the second floor. All 32 bedrooms were single occupancy and 11 had an ensuite toilet. Each floor had one or two communal bathrooms, a shared lounge and shared kitchen facilities. There was a lift to all floors; however, it was out of order during our inspection. A sheltered smoking area was provided in the garden.

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

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures 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.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Our last inspection took place on 30 September 2014. At that time the service was not meeting all the legal requirements. During this inspection we checked to see if improvements had been made.

At this inspection we found that support workers had not received the right training to ensure they provided care and treatment safely. This included training on how to manage people who may present behaviours which challenge.

The registered manager had not reported all incidents to CQC as is required by the regulations. A representative of the provider said that the home would review and improve their notification procedure.

A gas cooker was in use nearly three months after it had been deemed unsafe to use by a gas engineer. The premises were not clean and various items of equipment and facilities, such as a washing machine and the lift, were out of use and had been for some time.

Support workers did not receive regular supervision. Records showed that more than half of the regular support workers had not had supervision in 2015.

At our last inspection we found that Clifton House was not supporting people to become independent; this was partially due to a lack of staff. We also found that care plans did not include people's goals and aspirations. At this inspection we could find no documented evidence that this had improved and people living at the home said it had not. We also found that people did not have support plans for all of their identified needs, for example, learning disabilities or continence issues.

The home did not comply with either the Mental Health Act 1983 or Mental Capacity Act 2005. Staff knowledge of both sets of legislation was mixed and documentation showed that people were not being assessed or supported properly.

At the last inspection we found effective systems for regularly assessing and monitoring the quality of service people received was lacking. At this inspection we found this had not improved.

The registered manager was focused on supporting the people and lacked oversight of the home. He acknowledged this during the inspection and made a commitment to improving his overall management of the home.

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

Most aspects of medicines management were done well at the home; however, we found people's topical creams and lotions had not been dated upon opening so there was a risk expired medicines could be used. We recommended that the home reviews and improves current practice in line with nationally available good practice.

We found that there were enough support workers on duty to help people meet their basic needs, but not enough to support their recovery or rehabilitation.

Staff meetings were not held regularly and were not well attended. Meetings that had been held in 2015 had focused on staff issues rather than the people and their care.

People told us they felt safe. Most staff had received safeguarding training, could describe the different types of abuse and said they would report any concerns. The registered manager made sure all the necessary checks were done on new staff before they were employed at the home.

People's feedback on the food served at the home was mixed. The cook knew people's likes and dislikes and undertook surveys so that the menu could be changed according to people's feedback.

Support staff helped people to book appointments and accompanied them when they needed it. We saw from records that had access to GPs, podiatrists, dentists, social workers and mental health specialists.

People and their relatives told us that the care staff were caring. Support staff we spoke with could tell us details about people's personal histories and their likes and dislikes. We saw warm and caring interactions between support workers and people during our inspection, as well as humorous banter on both sides.

People had access to advocacy services if they needed them. The registered manager told us that the home would provide end of life care when needed and had previously spoken to one person about their wishes in this regard.

The complaints procedure was displayed in the home although no people or their relatives said they had ever made a formal complaint. People, their relatives and staff told us they liked the registered manager and found him both approachable and supportive. Relatives were happy with the way the home communicated with them.

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.

A gas cooker deemed unsafe in October 2015 was still in use. Other equipment and facilities had been broken for some time.

Some parts of the home were not clean. We were concerned about the possible risk of infections spreading.

Staff had not received training to support people who present behaviours which challenge others, thereby putting other people and themselves at risk.

Is the service effective?

Requires Improvement

The service was not always effective.

The home was not compliant with either the Mental Health Act 1983 or Mental Capacity Act 2005.

Some people at the home liked the food and others did not. The cook could describe people's dietary needs and preferences.

The people were supported to maintain their holistic health. We saw that they had access to a range of healthcare professionals.

Is the service caring?

Good

The service was caring.

People and their relatives told us that support workers were caring. The interactions we observed were positive and supportive.

People were involved in their planning and had weekly one-to-ones with a named keyworkers. Support staff knew the people well and could describe their personalities and personal histories.

We saw information about advocacy services was displayed throughout the home and staff said they would refer people to advocates if they needed it.

Is the service responsive?

Inadequate

The service was not responsive.

Support did not focus on recovery and rehabilitation, which was the primary purpose of the home. Due to issues with staffing, people's access to activities was restricted.

We found that people did not have care plans in place for all of their identified needs, for example, learning disabilities and continence.

People's risk assessments and care plans were reviewed regularly but were not evaluated. Daily records did not correlate with people's care plans.

Is the service well-led?

Inadequate

The service was not well-led.

Proper audits and checks on the quality and suitability of the service were not undertaken regularly to ensure people were kept safe.

Staff meetings were infrequent, poorly attended and did not focus on people's care and support. Support workers did not receive regular supervision or appraisal.

The home did not notify the Care Quality Commission about certain incidents which had occurred, as is required by regulation.

Clifton House

Detailed findings

Background to this inspection

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

The inspection took place on 05, 06, 07 and 25 January 2016. The first day was unannounced which meant the service did not know we were coming.

The inspection team consisted of two adult social care inspectors, a specialist advisor and an expert by experience on the first day, two adult social care inspectors on the second day and fourth day and an adult social care inspector and inspection manager on the third day. A specialist advisor is a healthcare professional with relevant experience of the care setting being inspected; the specialist advisor on this inspection was a mental health social worker. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience on this inspection lived with mental and physical disabilities.

Before the inspection we reviewed the information we held about the service. We also asked for feedback from the Local Authority, the Clinical Commissioning Group (CCG), Healthwatch Trafford, contacts at Greater Manchester West Mental Health NHS Foundation Trust (GMW) who were involved with people living at the home and a drug and alcohol service used by some people living at the home. The Local Authority, CCG and Healthwatch Trafford had no concerns. The GMW contact provided positive feedback about the home.

At the last inspection in September 2014 we found that the home was not compliant in all of the areas we looked at. At that time there were issues with insufficient staffing to provide activities for people, people's care plans did not include rehabilitation or recovery and there were issues with the way the home was audited and monitored for safety and quality. We checked to see if improvements had been made at this inspection.

During this inspection we talked with twelve people who lived at Clifton House. In addition, we spoke with three people's relatives, seven support workers, the clinical lead, an activities coordinator, an administrative

worker, the registered manager, the cook and the maintenance person. We also spoke with the clinical director, the operations and human resources director and the compliance director, who were visiting the home on behalf of the provider. The registered manager was not available for half of the second day of inspection and all of the third day. On these days we liaised with directors who were visiting the home on behalf of the provider.

We looked around the building including in bedrooms, bathrooms, the main kitchen and smaller kitchens for people's use on each floor, the main laundry room and smaller laundry rooms on each floor, the clinic room and in communal areas across all floors. We also spent time looking at records, which included a detailed review of eight people's care records, three staff files, the training matrix and records relating to the management of the service.

Inadequate

Is the service safe?

Our findings

We asked the people living at Clifton House if they felt safe. All of the people we spoke with said that they felt safe. One person replied, "Yeah, I feel safe here", another said, "Yeah I like it", and a third said, "Yes, I feel safe." A fourth person told us, "I feel safe. It's the best place ever." We asked people's relatives if they thought people were safe. One relative said "Yes I do", another said, "I do, yes", and a third said, "Yes."

We asked staff to describe the different forms of abuse that people might be vulnerable to and what they would do if they were concerned about a person living at the home. Support staff could give examples of the different forms of abuse and said they would report it. One support worker said they would report any concerns to the registered manager, and, if they were not satisfied with the outcome, would also consider informing the local authority, Care Quality Commission or the police. Another support worker said, "If saw abuse I'd hand it over to the team leader and may say something to person." Staff we spoke with said they had received training in safeguarding adults. We checked the staff training matrix and found that of the 18 regular care staff, 11 had received safeguarding training in 2015, three had received it in 2014 and four had not received safeguarding training at all. This meant that most support staff had received safeguarding training, the workers we spoke with were able to recognise abuse, they knew how to report it and people felt safe.

As part of this inspection we looked at how incidents and accidents had been investigated and followed up. It is important that incidents are investigated to see whether any follow up action can to be taken to prevent a re-occurrence or whether other measures need to be taken. We found that most incidents had actions that had been identified and followed up or had been deemed to not require follow up. One incident that occurred in November 2015 involved one person physically assaulting another. The description of the incident stated that a support worker intervened and restrained the person being aggressive. We discussed this incident with the registered manager who confirmed that Clifton House had a 'no restraint' policy; staff were not trained to restrain people if they displayed physically aggressive behaviour and in this incidence the police, who were called, should have dealt with the situation. The investigation of the incident did not identify that restraint had been used when it should not and its use was not discussed with the member of support staff. We checked the training matrix to see if the support workers had received training in personal safety and breakaway; this is essential training for staff that may come into contact with people who may become physically aggressive. Records showed that of the 18 regular support workers only three members of staff had received personal safety and breakaway training since 2013 and 10 members of support staff had never had this training. This meant that the majority of regular support workers had not received training on how to deal with people who might become physically aggressive. In addition, by practising restraint against the home's policy to manage a recent incident, a person was placed at risk of harm because support staff had not been trained to use restraint techniques.

This was a breach of Regulation 12 (1) and (2) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service did not ensure that support staff had received the right training to care for people safely.

We looked in the home's main kitchen where the cook prepared meals for the people living at Clifton House. We saw that there were two large gas cookers in the kitchen, both with hobs and ovens. Both cookers had safety stickers attached to their oven doors stating that they were not safe to use and that to do so would be an offence under the Gas Safety (Installation and Use) Regulations. The cook was still using one of the ovens at the time of our inspection despite being unsure of whether it had been repaired since October 2015 to make it safe. The gas safety certificate dated October 2015 for the cooker in use was ambiguous as it stated that the cooker was safe but that it had been turned off; the safety sticker stating that the appliance could not be used had been applied the same day suggesting that the cooker was in fact unsafe. There were no other records at the home to show that the cooker had been fixed since the safety sticker had been applied in October 2015. On 22 January 2016 we were informed by the provider that confirmation had been received from the gas safety company that the cooker was unsafe. When we returned on 25 January 2016 for the final day of inspection we found that the kitchen had been closed since our third day of inspection and work had begun to upgrade it, including replacement of the cooking appliances. This meant that a gas cooker condemned as unsafe had been in use for over two months at the home, thereby placing all the people and staff at risk. We were very concerned and raised this issue with health and safety colleagues at the local authority who did their own inspection and began an investigation.

The service did not ensure that equipment used for providing care or treatment was safe for use. This was a breach of Regulation 12 (1) and (2) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people and their relatives if they thought Clifton House was clean. One person said, "I think it's clean", whereas another person said, "The bathrooms and toilets are disgusting." Relatives we asked with told us, "Yes and no. It depends on the time of day. Generally the cleaners manage OK", "It's reasonably clean but tired", and, "Whenever I've been there's someone cleaning."

We inspected the building to see if it was clean and were concerned about some of the things we found. In the main kitchen where people's meals were prepared we found that some areas were dirty. This included the flooring, which was cracked in places and therefore could not be cleaned properly, the gaps between appliances which contained a build-up of food waste and the seal on the fridge which contained dirt and food waste. The main kitchen had no extraction unit. This meant that grease had accumulated on ceilings in the kitchen, particularly in the dry food storage area. We also saw that a vent above the cooker opened into a loft upstairs. This loft area was dirty and the cook told us that dust sometimes dropped down into food when it was on the hob. The cook also said that they struggled to keep on top of both the cooking and cleaning since a kitchen assistant left their job nearly a year previously. We noted that an audit undertaken by the provider in December 2015 had given a rating of two out of five for the statement, 'There is an up to date cleaning schedule for the kitchen area', where five was the highest rating. This meant that the premises and equipment used to cook people's food was not clean, which could therefore put people at risk of foodborne illnesses. We were concerned about the cleanliness of the kitchen and informed environmental health colleagues at the local authority who undertook their own inspection.

Each floor had a laundry room. On the ground floor the washing machines and dryers were for laundering bedding and contaminated clothing. We saw that there was an accumulation of dirt and debris behind the machines. The room also contained a large ceramic sink and various coloured mop buckets that were used to clean the home; there were no separate handwashing facilities for those doing cleaning or laundering. On the first and second floors there were smaller rooms containing a washing machine and dryer for people to use. Both of these rooms also contained various mops and buckets and cleaning products. The room on the first floor had a handwashing sink but no sluice sink for the washing of mop buckets and equipment and the room on the second floor had a sluice sink for washing equipment but no handwashing sink. This meant

that on all floors items were laundered in the same room in which cleaning equipment was cleaned and stored; this could lead to cross contamination and infection.

We looked at the provision of cleaning staff at Clifton House. The home had one cleaner working Monday to Saturday for eight hours a day; there was no cleaner at the home on Sundays. A cleaning supervisor sometimes helped out at the home, however, they also covered the other two services run by the same provider locally and did tasks such as ordering supplies as well and so could not do this often. We asked two of the directors visiting the home on behalf of the provider if they thought Clifton House was clean. They both agreed that in places it was not and that this needed to be addressed.

During our tour of the premises we noted that various appliances and facilities were known to be broken but had not been fixed in some time. One person told us that the shower on the ground floor had not worked for a few months; this meant that the person had to shower on the first floor instead. One of the two large washing machines on the ground floor used for bedding and laundry that required decontamination was not in use and we were informed by staff that it had not been for over a year. We were also told that a dryer available for people's use on the second floor and a cooker in the ground floor communal kitchen had been out of use for some time. This meant that people who wanted to cook or do laundry had to access facilities on a different floor and may therefore have to wait.

People and staff commented on the building's plumbing and heating system. One member of staff said that some rooms got too hot, particularly the main kitchen as it had no working extractor fan or ventilation system. Another member of staff told us the air conditioning in the main kitchen had stopped working over three years previously. One person told us, "Could do with doing the place up, needs new boilers, some radiators are not working." The maintenance person said that they needed to drain the hot water system in the main kitchen each morning to remove air as without this the water would be cold. Another member of staff told us, "The plumbing system is awful. Taps running, taps not running", and one person said about the hot water, "Sometimes it's hot and sometimes it's freezing." We also noted that the lift to all floors was broken and one member of staff estimated it had been for at least six years. All of the people living at the home were capable of using the stairs to access their rooms, however one member of staff stated that it was an issue when furniture and heavy items needed to be moved between floors. This meant that when equipment and facilities stopped working properly they were not always repaired or replaced in a timely way which in turn affected the quality of life of people using the service.

We looked around the communal areas of the home on different floors, in the laundry rooms and sluice rooms. In a downstairs toilet near the main kitchen we noted that the paint on skirting boards was blistered which meant they could not be cleaned properly. We also noted blistered paintwork and cracked tiles in both of the second floor bathrooms; both baths were old and stained and one had rotten wooden bath panels. The shower room on the first floor had cracked and mouldy tiles and a rusty shower head. We saw that corridor carpets in various parts of the home were heavily stained. This meant that parts of the home were in a state of disrepair such that they could not be cleaned effectively which could put the people at risk of cross infection.

However, during the inspection we were shown documentation from the provider dated December 2015 that described planned improvements that had been costed; one of the directors visiting on behalf of the provider told us that funding for the work had been approved and it was due to commence early in 2016. Improvements included the replacement of bathroom facilities and the flooring in communal areas. On our final day of inspection we were informed that a total refurbishment of the main kitchen had started that day and we noted that the level of cleanliness had improved considerably in communal areas since the first three days of the inspection.

The issues with cleanliness and broken equipment constituted a breach of Regulation 15 (1) (a) and (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we looked at the systems in place for the receipt, storage and administration of medicines. All the people living at the home were having their medicines managed for them (no one was self-medicating), no one was receiving their medicines covertly and there were no controlled drugs in use at the time of our inspection.

Monitored dosage systems were used for most of the medicines with others administered from bottles or boxes. Monitored dosage systems are made up by a pharmacist and consist of blister packs of each person's tablets set out for the different times of the day in separate pots. We looked at medication administration records (MARs) for three people living at Clifton House. Each person's MAR for tablets and liquid medicines were up to date with no gaps in recording. This meant that medicine administration was being recorded properly.

We checked the procedure in place for the use of prescribed creams and lotions. Topical medicines were kept in the clinic room in the drug trolleys. We checked several creams and lotions and found that they had not been dated on the day they were opened; these included diprobase and hydromol creams and olive oil ear drops. This is important as topical medicines can expire when they have been opened too long. This meant that topical creams and lotions might be used after their expiry date and may cause people harm.

We recommend that the home reviews and improves medicines management practice in line with current national guidelines and standards.

The people had Personal Emergency Evacuation Plans (PEEPs) in place and we saw these were kept in their care files with a copy in the fire manual kept in the office. A PEEP is usually a one-page summary which includes a photograph of the person, their bedroom location, how they mobilise and the number of staff they need to do so and any other information emergency personnel attempting to evacuate the person might need to know. The fire manual contained a list of people at the home that would need to be evacuated in case of emergency. We saw this list contained the names of people who no longer lived at the home and was therefore out of date; we discussed this issue with the directors during the inspection and the list of names was amended to reflect the people currently living at the home.

We saw records which showed that fire alarm practice evacuations had taken place five times in 2015, in line with the home's policy; the home also kept a record of false alarms which had occurred when people smoked inside the building. The fire extinguishers at the home had been checked within the previous 12 months and we were told that night support staff completed a walk around each evening to check various safety aspects, such as fire extinguishers being in place, that escape routes were clear of obstructions and the fire doors were shut. This meant that fire precautions and checks were being undertaken.

We looked at how Clifton House was staffed to see whether there were enough workers on duty to support the people who lived there. At our last inspection in September 2014 it was found that there were not enough staff on duty to meet the needs of the people using the service, particularly for providing activities and extra stimulation. Support workers either did day shifts or night shifts with hours 7.45pm until 8am or 7.45am until 8pm. The day shift was staffed by one team leader, a keyworker and three support workers. This was in addition to the registered manager and clinical lead/deputy manager when they were also on duty. We found that the number of support workers on duty during the day had increased by one since our last inspection. There was also an office administrator, a cook, a cleaner and a maintenance person. The night staff consisted of one team leader and two support workers. The purpose of Clifton House is to

improve people's practical, social and psychological functioning so that they can move on to live independently within the community. With this in mind, a new 'recovery team' had been recruited in October 2015. The team consisted of an occupational therapist and two assistants; their role was to support people to recover in terms of health and addiction issues, to become more independent and to undertake activities. The recovery team covered two other services run by the same provider as Clifton House.

We asked people, their relatives and staff if they thought there were enough staff to support the people living at the home. One relatives we spoke with said, "There's always staff about", another relative told us, "There's always staff available", and added, "My relative has never mentioned a shortage of staff." We asked staff members if they thought there were enough staff; they told us, "The level of staff is OK for nights. If we need more staff we can ask for more", "It could be better. We need more staff on days, basically to attend to residents", "Yeah we've got five staff, tend to manage" (referring to a team leader, keyworker and three support workers per day shift), "I feel there is enough staff", and, "I do think there's enough staff, but there won't be enough when we do more activities." One staff member stated that support workers did not have enough time to spend with people because they had to do cleaning.

We spent three days inspecting the home and observing the support people at the home received. The majority of people were free to come and go from the home and we saw people popping to the shops for items. We noted that people tended to congregate on the ground floor by the main doors and in the garden area. Most interactions we saw between people and staff were brief, friendly greetings and quick enquiries as to people's well-being. We did not see support staff sitting with the people or engaging them in activities or conversation; the support staff we saw were either completing paper work in the office or busy with other tasks around the building. One person told a member of our inspection team, "I am pleased that you have spent time talking to me, the staff don't." Whilst it was clear that people's basic support needs were being met, there were not enough staff to provide rehabilitative engagement and stimulus to the people living at the home.

We checked the files of three staff members to see how they were recruited. We found that appropriate pre-employment checks had been made to make sure the staff were suitable to work with vulnerable people; this included checks made with the Disclosure and Barring Service (DBS). The DBS is a national agency that keeps records of criminal convictions and tells services about people who are unsuitable to work with vulnerable adults. Staff files contained an application form, a record of the job interview with scores for the various aspects assessed, two references for each new staff member and photographic proof of identity. This meant that the service made sure the staff it recruited were safe to work with vulnerable people.

Requires Improvement

Is the service effective?

Our findings

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 make 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 MCA. The application procedure for this in care homes and hospitals is called Deprivation of Liberty Safeguards (DoLS).

Some of the people using the service were restricted by provisions under the Mental Health Act 1983 (amended in 2007) (MHA), such as Community Treatment Orders (CTO). CTOs enable people to live under supervision in the community.

We asked staff about their knowledge of the MCA and DoLS and found that it was mixed, even though 13 of the 18 regular support staff had attended Mental Capacity Act 2005 training within the previous two years. We asked staff who in the home was subject to DoLS; one support worker gave us two people's names, whereas another support worker gave us one other different name. A third support worker knew the names of people subject to DoLS and could explain how conditions attached to their DoLS affected them.

We checked the care records for people subject to DoLS authorisations who were living at Clifton House. One person's records showed that they were only allowed to leave the premises if they were escorted by a support worker. We saw on their file that a capacity assessment was recorded and a best interest decision made on their behalf. A DoLS application had been made for this and authorised for the person; but it had since expired and a subsequent application that had been made electronically to the local authority had also expired. This meant that if the person wished to leave the premises unescorted and the home's staff accompanied them anyway, they would be depriving the person of their liberty unlawfully. We discussed this person with the registered manager; he told us that the person's preferences had changed greatly since the original DoLS application was made in that they no longer wished to leave the premises often and if they did, they preferred to pop to the shops locally with staff. The registered manager also said that a meeting had been arranged with the person and their care coordinator to discuss the ongoing requirement for a DoLS.

We read in another person's file that they had a documented history of alcohol-related issues and were also subject to a CTO. The person's finances care plan dated December 2015 had been updated following an incident when the person had experienced an alcohol-related illness. The care plan stated that the registered manager had decided that the person was no longer allowed to have any alcohol or to manage their own money in case they bought alcohol with it. We saw that the person had signed their consent of this care plan, however, if the registered manager had made this decision in the best interests of the person because he felt that the person lacked the capacity to manage their alcohol intake and money, this should

have been done according the MCA, which it was not. In other words, no assessment of this person's mental capacity had been made. We discussed this person with the registered manager. He accepted that the decision, which had been made in the person's best interest, had not been made in the right way and said that a best interest meeting involving the relevant members of the person's care team had been arranged.

Staff we spoke with were also vague about the MHA and unclear as to which people at the home had a CTO in place, even though the training matrix showed that the majority of the regular staff had received mental health awareness training in the last two years. We saw in one person's file that they were subject to a CTO in 2014. When we spoke with the person they said that that was no longer the case, however, there was no discharge documentation on their file confirming this. We also found that none of the people subject to CTOs had a specific CTO care plan in their files to tell staff what the conditions or restrictions were and how they should be supported to meet them. This meant that support workers were unsure which people had conditions or restrictions in place and how these influenced the support they required.

We saw in the care files of two other people with CTOs that neither person was to be allowed to leave the premises unescorted due to concerns about their road safety. We could not find the reason or basis for either of these decisions as it did not appear to be a condition of their CTO and neither had a DoLS in place for this. We spoke to one of the people with this restriction; they told us that it stemmed from an incident that occurred a few years ago when they had been seen crossing a road without looking. The person felt that it had been blown out of all proportion. We discussed both people with the registered manager. He agreed that these were further examples of decisions made with people's best interests in mind, but in the wrong way.

We looked at the care files of five people subject to CTOs and found that each contained a form confirming that they had been informed about the reason for their CTO and their rights under the MHA. However, each of the forms had the same date printed on the top, 8 January 2016, and none were fully competed. People must be informed of their rights when restricted by a CTO. This meant that people's rights under the MHA were not fully protected.

The registered manager did not always act in accordance with the Mental Capacity Act 2005 or Mental Health Act 1983. This was a breach of Regulation 11 (1) (2) (3) (4) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people and their relatives if they thought the support workers were well trained. One person said, "They seem to know what they're doing", and a relative we spoke with told us, "Yes, they know what they're doing." The staff we spoke with talked positively about the training on offer at Clifton House. One support worker said they had some form of training monthly, another said, "They're dead good with the training, spot on."

We looked at the induction process used by the service for new staff. The home's documentation included the Care Certificate, which came into being in April 2015. The Care Certificate is a set of standards against which the competency of staff who are new to health and social care can be assessed. We spoke with the one of the directors who was visiting the home on behalf of the provider; they said that support workers who were new to care were not generally employed by the home, due to the specific needs of the people who used the service.

We spoke with a support worker about their induction. They told us that it involved shadowing a team leader for two weeks, being shown around and introduced to the people and other support staff. They also said that, "Induction was on the job, I was given policies and procedures, it was a lot to take in." We saw in

staff files that the induction process was documented correctly. This meant that staff received an induction to the service which included supernumerary shadowing of existing staff when they started work at the home.

We asked people what they thought about the food served at Clifton House. Feedback from the people was mixed. They told us, "The food is OK", "If we don't like what's on offer we can make a hand sandwich or there's pork pies in the fridge", "Some food is [swear word], some food is good", and, "The food is not always good although it was lovely yesterday." A member of our inspection team ate lunch with the people in the dining room on the first and second days of our inspection. They heard one person call out, "Where's that [cook's name]? These wedges are lovely." People's relatives also spoke about the food. One relative said, "[My relative] has always said it's all right", and, "It's good they get a balanced diet." Another relative said, "Yes it's OK [my relative] says", and a third told us, "[My relative] asks for salads when he wants them and they make a special meal for him", and, "[My relative] has never complained about the food."

We observed that the dining room furniture was tired and not always clean. Tables were set with plastic tablecloths, as well as salt, pepper and vinegar. Cordial was also available served in plastic cups. Two meal choices were on offer at lunchtime each day; on the second day of our inspection it was either burger with wedges and onion rings or quiche with salad. Yoghurt and fresh fruit was available as a dessert. This meant that people were offered a choice of foods at mealtimes.

We asked the cook how the menus and food options were decided. The cook said that the home had a four-weekly menu that the people living at the home were consulted on and the menu was changed twice a year. We saw the most recent food survey completed in September 2015 had involved support staff speaking with 17 people. Feedback included a request for more fresh vegetables, and desserts, such as sponge cake and custard and trifle. It concluded with the statement, "On the whole residents are happy with the food", and, "Well done chef". The cook said the feedback was sent to the provider and the menus were amended. This meant that the people were asked for their food preferences and menus were changed as a result of their feedback.

We observed that the cook made meals from scratch using good quality ingredients, including pies, soups and casseroles. The cook was able to describe the dietary needs of people living at the home, for example, those with diabetes. They also showed us a folder containing a breakdown of all the foods used in the kitchen stating the potential allergens they might contain; they used this information to make sure people with allergies were kept safe.

We saw in people's care files that they had access to a wide range of healthcare professionals and facilities. People were supported to make healthcare appointments such as with their GP, the optician, podiatrists, hospital outpatients, dentists and their mental health team. Those requiring or requesting assistance to attend appointments were accompanied by a member of support staff. All three family members we spoke with said that their relatives were supported to see other healthcare professionals. One relative said, "Staff will arrange appointments for [my relative] and even escort him." This meant that people were supported to meet their holistic health needs.

Good

Is the service caring?

Our findings

We asked the people using the service if they thought the support staff were caring. People told us, "It's the best place I've ever been. They really look after you", "Staff are very caring towards me", "Staff are very nice people, they listen and make time for me and care for me", and, "Staff are all right." We asked people's relatives if they thought the staff were caring. They told us, "Oh gosh yes", "Caring, oh yes", and, "Yes, I definitely get the feeling they're caring." Other feedback people gave us included, "I love it here", "It's the best place ever", "It feels great to live here", "I got some lovely Christmas presents from the service. I was very happy", 'I can talk to [the registered manager] about things bothering me', and, "I am looked after." A visitor we spoke with during the inspection told us that staff were always kind and helpful.

We asked the support workers about the people at Clifton House. Those that we spoke with saw each person as a unique individual with distinct needs, wishes and perspectives and could describe people's likes, dislikes and preferences. All of the members of the staff team could demonstrate how they made an effort to recognise people's diversity, including their gender, race, previous jobs, spiritual and religious beliefs, thoughts and opinions. It was clear to us from observing the support provided that all staff had developed caring yet professional relationships with each person as they knew people's personal histories, the activities they liked and who was important to them in terms of friends and family. This included the registered manager, who we observed interacting with people with banter and friendly humour which was reciprocated. Our observations showed us that residents seemed very comfortable with all of the staff at Clifton House and that their experiences when interacting with staff were positive.

One family member told us that their family member was an accomplished artist and described how the registered manager, with the person's permission, had hung the person's artwork around the home to encourage the person to continue painting. We saw the artwork during our inspection. We asked the family member how this had made their relative feel, they replied, "He loves it." This showed us that the home tried to provide people with encouragement and to bolster their self-esteem.

We saw that people's privacy and dignity was promoted by staff during our inspection. People's private information was stored securely and we noted that staff did not discuss individuals where other people could overhear them. The staff we spoke with described people using respectful language and this was also reflected in written records that we saw, even when the people described had displayed behaviours that might challenge others, or other problems had occurred. People we spoke with said that support staff always knocked on their bedroom doors if they wanted to speak with them and one relative told us, "They always knock on and never barge in." Our observations and people's feedback showed us that staff promoted people's privacy and dignity.

People's bedrooms were personalised with ornaments and pictures. People were supported by staff to clean and tidy their own rooms, called 'the room base' by the home. We noted that people had choice as to how tidy their rooms were kept. One family member described how their relative's level of tidiness could vary; they told us that support staff, "Allow [my relative] to run his room as he needs to." People without legal restrictions on their movements told us that they could come and go at will and each had a fob which

opened the front door as well as a key to lock their own bedroom door. One person said, "I can come and go as I please."

When we looked in people's care files we saw that they each had a one-to-one session with their name keyworker every week. Keyworkers at the home were senior support workers who had additional roles and responsibilities, including being the keyworker for four or five named people. During one-to-one sessions people were asked how they were or if they had any issues or problems and the conversation was documented. A member of support staff told us that if people raised issues that required a change in their care plan, then this would happen. One person told us, "I could tell the staff if I had any worries." A relative told us, "They go out of their way to make sure they have one-to-ones and listen to people." This showed us that the people had regular contact with a specific member of support staff who was interested in their well-being.

People using the service were provided with information regarding access to advocates if they wished. Posters promoting advocacy were displayed in all of the communal areas, including lounges and in the main corridor on the ground floor. None of the people we spoke with said that they had accessed an advocate as they had family members who did this for them. One member of support staff said that people were referred to advocates when they needed them and during our inspection one person described how a support worker had accompanied them to an appointment with a member of their mental health team and had advocated for them. This had resulted in a change to their support arrangements and medication, and the person told us they were very pleased with the result. This meant that people were made aware of advocacy services and that support staff advocated for the people on their behalf when they asked them to.

We noted that several people at the home had lived there for many years and clearly thought of the place as their permanent home. We therefore asked the registered manager if they already had or would ever provide end of life care to people who wished to die at the home. The registered manager stated that as yet, no person had died at the service but that this would be possible if they could be sure that the support staff could meet people's needs appropriately; he stated that, "This is their home." He also gave an example of speaking with an older person at the home about this issue in order to draw up an end of life care plan. This showed us that Clifton House would try to care for people at the end of their lives if their needs could be properly met.

Inadequate

Is the service responsive?

Our findings

In the Service User Guide for Clifton House it states that the main aim of the service is to, 'Improve your practical, social and psychological functioning to enable you to live as independently as possible within the community.' At our last inspection in September 2014 we found that the home was not supporting people to be independent, as care plans did not focus on recovery and rehabilitation or include people's goals and aspirations. It was also found that there were insufficient staff to support people with activities and re-enablement. At this inspection we looked in detail at eight people's care files to see what care plans were in place and whether they addressed people's identified support needs.

We found each care plan was standardised and incorporated 13 different areas where support was needed. These included mental health, physical health, nutrition, risks to self and others, relationships and finances. Each person had a risk assessment that informed their care and support plans; risk assessments were carried out by the clinical lead. Records showed that people's care plans had been reviewed every three months. According to the clinical lead, every three months people's care plans are discussed with them during a one-to-one session with their keyworker and any changes noted were made. We saw that people had signed their care plans and most had signed a form stating that they did not wish to be given copies of them. The care plans we saw contained a statement about the issue or aspect they required support with and then had a concise summary of how staff should support the person. There was then a form used to record each three-monthly review of the care plan. In each of the care plans we looked at for the eight people, the review of care plans form contained a standard statement for each review, which was 'care plan has been reviewed, client agreed to continue with care plan' or wording which was very similar. This did not allow us to understand how the care plans had been reviewed or what had been discussed with the person.

We also noted that none of the care plans contained any form of evaluation. Care plan evaluation is very important as it considers what support a person has received with respect to their agreed plan of care and evaluates the progress they have made towards any goals or outcomes. Care plan evaluation also analyses if care plans remain appropriate or require modification to improve them. Without this evaluation we could not tell if people were being supported according to their care plans or if they were making any progress.

We checked the daily records that support workers kept to see if people's care plans were evaluated there. The daily records were kept separately from people's care plans so support workers, who did not update care plans, would only know people's documented support needs if they looked in their care files. We found that the daily records were often very brief, comprising of a few sentences which focused on what a person had done or how they had acted that day. In one person's file we found a daily record sheet that had the person's name and daily records on one side and someone else's name and daily records on the other. The daily records were handwritten and we found that a significant proportion were either hard to read or illegible. We asked support workers if they read people's care plans to understand what support they needed. One support worker said they did and considered people's plans to be person-centred; another support worker said "I don't go in [people's] files anymore. I read them when they first come." An audit undertaken by the provider in December 2015 had rated the home as two out of five for the statement 'Evidence staff are reading all care plans.' This meant that support workers either did not know what was in

people's care plans or did not evaluate them in people's daily records.

The system of care planning in place was not comprehensive and did not meet all people's identified needs. For example, according to two people's care files they each had a learning disability. In one person's care plan it was described as a medical condition, which it is not. We could see no difference between these two people's care files and that of other people's in that information had not been produced in an 'easy read' format to help the person understand it, as is standard when supporting someone with a learning disability. In addition, neither person had a communication or health passport, which people with learning disabilities need when they move to other services or go to hospital. There was also no record of whether their learning disabilities affected their ability to consent to care and treatment. This meant that people with diagnosed learning disabilities were not assessed individually and supported according to their needs.

We noted in another person's care file that they experienced nocturnal incontinence. When we spoke with the person they told us that they found the problem very distressing. We saw that the person's care plan made reference to the incontinence, but there was no detail as to how staff should support the person or what incontinence products (if any) they required. We also saw that no referral had been made to the continence team so that the person could receive specialist support or advice. This meant that the person was not being supported to manage a health condition that had a detrimental impact on their quality of life.

The continuing lack of comprehensive care and support planning was a breach of Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The care of people living with enduring mental health conditions in care homes such as Clifton House should be coordinated by the Care Programme Approach (CPA) as described in the Mental Health Act 1983 Code of Practice. This involves a team of healthcare professionals who work with the person to identify their holistic care needs, including mental and physical health, social and housing needs and rehabilitation and recovery. This CPA care plan should then be used by the service supporting the person to understand the specific needs of the individual so that they can then plan to meet them. We looked at three people's care files to see if their CPA care plans had been used as the basis of their care plans; two care files did not contain copies of their CPA care plan so it was not possible for us to see if it had been used to inform the content of their care plans. We found in the third person's care file that their care plans did not plan to meet the needs identified in their CPA care plan. For example, the CPA care plan stated that support staff needed to monitor and record all aspects of the person's mental health and spend time exploring their symptoms with them, whereas the actions in the mental health care plan devised by Clifton House were for support staff to ensure the person adhered to their medication regime, offered one-to-one sessions and encouraged the person to maintain contact with their team of healthcare professionals. In this person's CPA care plan there was reference to recovery from substance misuse; this was also a condition of their Community Treatment Order (CTO). We found no reference to recovery from substance misuse in any of the service's care plans for this person, except in their financial care plan which placed restrictions on the person's ability to buy alcohol. This meant that the plans of care being developed for people by their team of healthcare professionals were not being transposed into care plans by Clifton House, so people's identified needs were not being met.

At our last inspection we found that people did not have aspirational care plans which set out their goals and ambitions in terms of rehabilitation and recovery or what the next step was in terms of accommodation and personal independence. At this inspection we found that this was still the case. None of the care plans we saw included people's longer term plans or wishes; they were focused on meeting people's health needs in the here and now. One person we spoke with said, "They should get people involved, they need to get people to move on." Another person told us that they felt bored and hopeless because of a lack of

structured routine and planned activities; we saw a letter referring to this person's CTO dated March 2015 which stated they should be supported to, 'Attend therapeutic activities as defined in your care plan up to a maximum of six hours a day.' From our observations during the inspection and by speaking with this person, we saw that this did not happen. This letter also noted that there had been a 'backward step' in terms of the person's level of functioning and recommended that Clifton House updated the person's care plans to try to facilitate a return to the previous level of functioning by providing clear anticipated outcomes and steps required to achieve these. We saw from the person's care file that this had not happened. In addition we found that the person had nine activities recorded in their activity log since March 2015, four of which were social. This meant that the home was not responsive and had not acted upon advice to modify care plans when a person's functioning had deteriorated.

By reading people's care files, speaking with people and making observations, we could see that a proportion of the people at Clifton House had issues with addiction, including cigarettes, alcohol and drugs. However, we could find no evidence in people's care files that they were supported to rehabilitate or recover. There were no care plans focused upon health promotion and rehabilitation and no evidence that mental health tools such as the 'recovery star' were used. The recovery star is a tool which can be used to assess and track people's rehabilitation and recovery from various issues.

Likewise, we could find no evidence in people's care files that they were being encouraged and supported to become independent with a view to moving on from the home eventually. One person told us that people cooked in one of the communal kitchens as an activity on Wednesdays and records showed that people were supported to clean their rooms and manage their laundry, but apart from that, activities focusing on promoting people's independence were lacking. We asked people what they did all day. One person replied, "I just watch the telly", and then said, "I used to cook a lot but I lost confidence. The staff don't encourage us to cook, they just say we can if we want to." Another person said, "I drink and eat, go outside, visit [a relative]. Sometimes do arts and crafts." A fourth resident on a CTO told us that their movements were restricted due to a lack of staff to accompany them on trips out; it also meant that they could not consistently attend a therapeutic work placement. This person told us that they could only go out on average for 15 minutes per day. We observed that at least half of the people living at Clifton House walked around on the ground floor for most of the day or congregated in the garden smoking area. We checked people's activity records to see what kind of activities they had taken part in during 2015 and found that they were sparse. For example, one person had four activities recorded since November 2015, however, three of these were visiting family. Another person had five activities recorded since November 2015, but again, four of these were visiting family. A third person had two activities recorded since November 2015 and one of these was visiting family. Our observations, feedback from people and records showed that no improvements had been made in terms of activities and engagement to stimulate people and promote their independence since our last inspection. This was backed up by a provider audit in December 2015 which rated the home as zero out of five for the statement, 'Evidence of residents making progress through supported activities.'

People and their relatives did tell us about other social activities that had been organised by the home. These included trips to Wales and Blackpool, which people had enjoyed, meals out to celebrate birthdays, arts and crafts sessions, drinks in the pub, coffee at a local café and support when going out shopping. One family member said of their relative, "[Name] occasionally goes out for a pint," and another said, "They took [my relative] on holiday to Wales, which he really enjoyed. They didn't have to do that." This meant that the people had some opportunities to take part in social activities.

We discussed this lack of progress since the last inspection in this area with one of the directors visiting on behalf of the provider in the absence of the registered manager during the third day of this inspection. They

agreed that activities were lacking and stated that this had been one of the outcomes noted in the audit of the home in December 2015. The director also said, "Not giving people activities allows them to focus on their issues." The director then explained the role of the 'recovery team' which had been recruited in October 2015. The team consisted of an occupational therapist and two assistants and its aim was promote people's recovery and rehabilitation by incorporating aspects such as activities, health promotion, addiction support and promotion of people's independence in order to help them move forwards. We spoke with the occupational therapist, who was very enthusiastic, about the plans to use functional assessments (assessments of people's ability to perform tasks) and the recovery star to track progress. The director informed us that the provider was trialling the recovery team approach and that the team of three would be supporting two other services owned by the provider in the local area in addition to Clifton House. We asked how three people supporting three services would be effective; the director said that they would train the support workers in each service in how to support the people with their individualised recovery needs and we saw that initial training had already taken place. However, during this inspection our observations and feedback showed that the current level of staffing at the home did not allow staff sufficient time to support people with activities. How support staff would have time to provide the activities and support detailed in each person's individualised plan devised by the recovery team was not certain.

The fundamental purpose of Clifton House was to support people to recover, rehabilitate and become independent. The continuing lack of action to meet people's identified needs was a breach of Regulation 9 (1) (a) (b) (c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had a complaints policy and procedure and system for reporting and responding to complaints and concerns was place at Clifton House. We saw that the complaints procedure was clearly displayed in the main reception area and included in the service user guide, which was also available in the reception area. We checked the complaints file and noted that only one written complaint had been made since our last inspection and this had been made by a member of staff against a person living at the home. We saw that complaints were kept in a 'complaints and compliments' file which also contained a piece of positive feedback from a person's social worker, praising a member of support staff who had accompanied the person during a hospital visit in 2015. None of the people we spoke with at the home or their relatives said they had made a formal complaint. One relative told us, "I've never complained about anything", and another said, "I've never made a formal complaint. I raised concerns to the manager once which he took seriously and sorted out."

Inadequate

Is the service well-led?

Our findings

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

We asked people, their relatives and staff what they thought of Clifton House and the way it was run. All of the people we spoke with described the registered manager as approachable and supportive. One person said, "I feel better living here, they have helped me", another person said, "It's the best place I've ever been," and a third person said of the registered manager, "[Name] is marvellous. A bit strict sometimes but he's approachable." One relative we spoke with described the home as, "Overall a good place", and another said, "The manager certainly knows what he's doing." A third relative said, "The manager is fantastic. I can't speak highly enough of him." We asked healthcare professionals involved with the service what they thought of it. One healthcare professional told us, "In my experience they have worked well with a complex and challenging client group."

As part of this inspection we checked the accidents and incidents that had been recorded at Clifton House. Certain accidents or incidents must be reported to the local authority and to the Care Quality Commission (CQC). When we checked the records of accidents and incidents that had occurred since the beginning of August 2015 (including safeguarding incidents), we found that of the seven incidents that had occurred and should have been notified to CQC, six were not. This meant that CQC had not been notified about the majority of incidents. We spoke with one of the directors about the issue of inconsistent reporting and they said they would make sure the reporting procedures at the home were reviewed and improved.

We checked the supervision records for three members of support staff; the last documented supervision on file for each of these staff was dated 2013. We were unsure if this was an issue with filing rather than a lack of supervision so we asked to be shown all the supervision and appraisal records for support staff. At first these records could not be located but within a few days we were sent records which showed that seven staff had supervision in 2015. Four of these staff had received one supervision in 2015 and three had received two. This meant that of the 17 regular support workers at Clifton House (not including the registered manager), only seven support workers had supervision in 2015. No records of staff appraisals could be located and we could only find one appraisal dated 2011 in the staff files we inspected.

We spoke to support workers about supervision and appraisal. One member of staff said they had one supervision with the registered manager in 2015 but had not received any notes from it. Another member of staff told us they had supervision a maximum of once a year, they said, "[The registered manager] is supposed to do it a minimum of once every three months but it doesn't happen." Another support worker told us that they had supervision with the registered manager monthly and a fourth said that supervisions were held regularly but they were just not documented. We saw that an audit of the home undertaken by the provider in December 2015 had rated the home as two out of five for two-monthly staff supervision and zero

out of five for annual appraisal (where five was the highest rating), suggesting that staff supervision was not regular and staff appraisal was not done. This meant that staff supervision and appraisal was not undertaken according to the home's policy and procedure; staff were therefore not receiving the support from the registered manager that they needed to do their jobs.

We wanted to find out how the service involved people in developing and improving the service so we asked for the results of the most recent residents' survey. We were told there had been a recent survey but the results could not be located during our inspection; all of the people we spoke with said they could not recall receiving a survey. We saw that there were suggestion boxes located around the building so people could leave anonymous feedback if they wished; however the registered manager said that although they had been up for about two years, no suggestions had ever been received in that way. When we asked people how they fed back their opinions on the service they told us they did this at the regular residents' meetings. We saw the minutes of two of these meetings held in 2015; they were attended by seven people each were and chaired by the registered manager. Items discussed included a trip to Wales and the arrangements at Christmas. We asked people's relatives if they had ever received a survey about the home or been invited to a relatives' meeting; they said they had not. However, each person and relative said that they would speak to the registered manager directly if they had a problem. This meant that although people were not surveyed for feedback, they could attend house meetings or use the suggestion boxes if they wished; however, their relatives were not asked for feedback at all.

At our last inspection in September 2014 we found there were issues with audit and quality assurance at the home so we asked for audit records during this inspection. We spoke with a director visiting from the provider about audits at the home. They told us that it was part of their role to support the registered manager with audit quarterly, and that they had completed a comprehensive audit of the home in December 2015. They also added that due to other commitments, their last audit prior to this was over a year earlier. The director told us that managers should audit various aspects of a home on a monthly basis and showed us a new comprehensive audit tool that was being trialled. We saw that the December 2015 audit by this director rated the registered manager as two out of five for the statement 'Managers are completing monthly audits.' Our findings at this inspection that audit was not regular or comprehensive supported this.

According to the home's current infection control policy and procedure, each registered manager should complete a fortnightly audit of various aspects of the home. A tool was included for use in the policy. We saw that this tool had been completed relatively regularly in 2014 but had only been done once in 2015, in March. Actions relating to the issues with dirty and damaged flooring were identified at this audit. This meant that regular infection control audits had not been undertaken at the home for over 10 months.

We saw that that medication audits were being undertaken, although the method for doing so was somewhat complex and not recorded together in the same place. Checks included stock taking, reviewing medicine administration records and observing members of staff when administering medicines to people. This meant that that the home had a regular medicine audit in place that worked for them.

Issues with the quality and content of care plans were highlighted by the provider's comprehensive audit in December 2015. It has been noted elsewhere in this report the issues we identified in terms of people's care plans. We asked the registered manager if he audited people's care files to ensure that care plans were fit for purpose and met people's needs; he told us that this role had been delegated to another member of staff. This meant that the registered manager had not retained oversight of the content and quality of people's care documentation.

We saw that the provider was involved with the audit of incidents and accidents. Each week, the registered manager sent a report to the directors detailing any issues with aspects such as care, staffing or safeguarding, and then every month, the directors discussed incidents and accidents in an analysis meeting. Any actions that were required were then provided to a named member of staff at the home for them to carry out. We looked at the actions from the November 2015 analysis meeting. We saw that one person had displayed behaviours that challenged others and the directors had recommended that the person's risk assessment was to be updated. When we checked the person's risk assessment we saw that it was dated September 2015 so this had therefore not been done. We asked a director visiting from the provider if the action plans from the analysis meetings were followed up by the directors and they said they were not. This meant that incident audit and analysis was taking place but actions were not always carried out or followed up.

The home did not report certain incidents to CQC as is required, support workers did not receive regular supervision or appraisal, and effective systems to monitor and assess the safety and suitability of care provision were still not in place. These issues stemmed from a lack of leadership and governance at the home and reflected the registered manager's focus on supporting the people directly, rather than on the management aspect of his role. In addition, the registered manager was not supported adequately by the provider.

This was a breach of Regulation 17 (1) and (2) (a) (b) (e) (f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

As noted earlier in this report, support staff were not receiving regular supervision so we wanted to find out how they were kept up to date with changes at the service and involved with its development. We found that staff meetings were infrequent and not well attended. According to the minutes we saw, in 2015, out of 17 permanent staff at the home, five attended a meeting in November 2015 and seven attended two other staff meetings, both held in June 2015. There had been one meeting so far in 2016. Topics discussed at the 2015 meetings included lateness, staff conduct, breaks, care plans and night staff pay; our inspection had been the subject of the meeting in January 2016. One staff member told us, "Team meetings should be once a month, don't really happen that much", another staff member said, "Yes we have team meetings regularly, we had one the other day", however when we asked the date of the last one, they said, "It was a while ago, yes they could take place more regularly." This meant that staff meetings not held regularly and focused on human resource issues rather than on the people living at Clifton House.

During the inspection we observed how the registered manager and other senior staff interacted with the people at the home. We saw that the registered manager and other staff were based in an office near the main entrance and were visible and accessible to the people. Interactions we observed were friendly and it was clear that the people found the staff approachable and the staff knew the people well. Family members told us they were happy with the way the home communicated with them about their relatives who lived there. They said the registered manager or clinical lead were always available to speak with them on the phone if they had any concerns. One relative said, "If I'm concerned about [my relative] I can just phone up and they go straightaway to check on [them]. They ask if I want to speak to [my relative] and I can." Another family member described how the registered manager would arrange to be at the home when they visited their relative; this was important to the relative because they travelled a distance. We noted that the registered manager was often to focus of people's attention and requests, and that he could not walk far down a corridor without being asked for something by a person or engaged by them in conversation. From this we could see that the registered manager was very much part of the team providing support directly to the people.

We spoke with the registered manager about their oversight of the home and raised some issues we had found that concerned us. Examples included a lack of action taken over a person's decline in health and a fire enforcement notice issued by the Fire and Rescue Service in 2013 that did not appear to have been actioned. In each case the registered manager was able to describe in detail what actions had been taken to address or resolve the issues; these actions had just not been written down. The registered manager admitted to us that he was most passionate about supporting the people and less focused on the administrative aspect of his role. However, during the inspection a decision was made with the registered manager and the provider of the home that the registered manager was to move to a separate office in the home so that he could have protected time to concentrate on his duties and he told us that he was committed to improving his oversight of the home.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The premises used to provide the service were not clean and the facilities were poorly maintained. Regulation 15 (1) (a) and (e)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care There was a lack of comprehensive care and support planning and action to meet people's identified needs. Regulation 9 (1) (a) (b) (c)

The enforcement action we took:

We have served a warning notice on the Provider and the Registered Manager. They were told they must become compliant with the Regulation by 30 April 2016

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The home was not fully compliant with the Mental Capacity Act 2005 and Mental Health Act 1983. Regulation 11 (1)

The enforcement action we took:

We have served a warning notice on the Provider and the Registered Manager. They were told they must become compliant with the Regulation by 30 April 2016

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Support staff had not received the right training to care for people safely. Regulation 12 (1) and (2) (c) Equipment was in use at the home that had been deemed to be unsafe. Other equipment and facilities had been broken for long periods of time. Regulation 12 (1) and (2) (e)

The enforcement action we took:

We have served a warning notice on the Provider and the Registered Manager. They were told they must become compliant with the Regulation by 30 April 2016

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a continuing failure to assess, monitor and improve the safety and suitability of the service. Regulation 17 (1) and (2) (a) (b) (f)

The enforcement action we took:

We have served a warning notice on the Provider and the Registered Manager. They were told they must become compliant with the Regulation by 30 April 2016