Clover Residents Limited

Clover Residents - 2 Dorchester Drive

Inspection report

2 Dorchester Drive
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Tel: 02088931123

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 16 January 2017 and was unannounced.

The last inspection took place on 14 January 2015, when we found no breaches of Regulation.

Clover Residents - 2 Dorchester Drive is a care home for up to three people. At the time of our inspection three people were living at the service. Two were adults under the age of 65 years who had learning disabilities. The third person was an older person living with the experience of dementia. People living at the service had limited communication skills because of their disability or condition. In addition one person did not speak English as their first language. The service was managed by Clover Residents Limited, a private organisation who ran two other care homes in North West London.

The registered manager left the organisation in August 2016. There was a new manager in post but they had not applied to be registered with the Care Quality Commission at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

People were not always cared for in a safe way. For example, the staff used restraint on one person. This had not been appropriately planned for and the person had been injured during some incidents of restraint. The manager and staff were not aware that these incidents were reportable under safeguarding procedures and had not recorded any incidents of restraint or why they had happened. Therefore these had not been appropriately investigated.

People were placed at risk because the staff worked long hours without sufficient breaks and time off work.

The risk assessments and care plan for one person were not up to date and information about how to support the person was not always clearly recorded. Therefore their current needs were not clear and they were at risk of receiving inappropriate care and treatment. The information for other people was up to date, but was not always recorded in a clear way. In addition information from other professionals had not been incorporated into the support plan for one person.

The provider had not always acted in accordance with the requirements of the Mental Capacity Act 2005. In particular people's freedom was restricted without proper authorisation.

People were not always being supported in a way which met their needs and reflected their preferences. For example, they did not have opportunities to access the community, for social and leisure engagement or to meet their sensory needs.

There was not a positive or open culture at the service.

The provider had not operated effective systems to provide a quality service because they had failed to identify and mitigate risks to the health and wellbeing of people who lived at the service.

The provider had not notified the Care Quality Commission of significant events as required by Regulation.

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

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

People were cared for by kind, polite and considerate staff. They had good relationships with the staff and relatives gave positive feedback about this aspect of the service.

People were offered enough to eat and were able to make choices about what they ate. All food was freshly prepared and reflected their individual tastes and preferences.

People's health needs were monitored and they had access to healthcare professionals when they needed this.

The relatives of people told us they knew how to make a complaint and felt able to do this.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were placed at risk of unlawful restraint, abuse and harm from this.

The staff worked long hours without sufficient breaks and time off work and this placed people at risk.

Information about managing risks and supporting people had not always been reviewed and did not reflect current risks or practice.

People received their medicines as prescribed but these were not stored safely and this put people at risk.□

Is the service effective?

Requires Improvement

The service was not always effective.

The provider had placed restrictions on people's freedom without proper assessment or authorisation.

People were offered a choice of freshly prepared meals.

The staff were appropriately trained and had regular meetings where they could discuss their work.

People's health was monitored and their health care needs were met.

Is the service caring?

Good

The service was caring.

People were supported by kind, caring and polite staff.

People's privacy and dignity were respected.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always supported in a way which met their needs and reflected their preferences.

The representatives of people knew how to make a complaint if they were not happy.

Is the service well-led?

Requires Improvement

The culture of the service was not open, transparent or inclusive.

There was no registered manager in post.

The provider had not always notified the Care Quality Commission of significant events.

The staff carried out audits and checks on different aspects of the service. However, the provider failed to have systems in place to assess, monitor and improve the quality and safety of the service.

Clover Residents - 2 Dorchester Drive

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 16 January 2017 and was unannounced.

The inspection visit was carried out by one inspector.

Before the inspection visit we looked at all the information we held about the service. This included notifications of significant events and the last inspection report.

During the inspection visit we met and spoke with all three people who lived there. They were not able to give us feedback about how they felt about the service because of their disabilities. Therefore we observed how they were cared for and supported. We spoke with one visiting relative. We also spoke with the manager and three other members of staff. Following the inspection visit we had telephone feedback from two relatives of people who lived at the home, three social workers and a healthcare professional who worked with one person. We also received an anonymous telephone call from a member of staff.

At the visit we looked at the care plans and records for all three people, records of staff recruitment, support and training for four members of staff, records of complaints, accidents, incidents and other records the provider used for monitoring and managing the service. We also looked at the environment and how medicines were managed and stored.

Inadequate

Is the service safe?

Our findings

People living at the service were placed at risk from staff interventions which were not lawful and did not follow approved guidance. During the inspection we were informed by staff and a relative that one person was regularly restrained by the staff holding their wrists to prevent them from causing injury to themselves or others whilst certain personal and healthcare interventions were taking place. In addition there was evidence in an accident report that they had been injured during one such restraint. The relative of the person told us that the restraint had caused bruising to the person's wrists on other occasions. The care plan for this person did not describe any approved restraint techniques. In addition, the staff had not received training in order to ensure they understood how to safely restrain people and when this intervention was appropriate. The incidents where restraint had been used had not been recorded so that they could be monitored. There were no checks to ensure that when restraint had been used this had been done so appropriately, with minimal force and as a last resort. There was no record of bruising caused by these incidents and there was no evidence that the incident where the person had been scratched had been investigated. Therefore people living at the service were at risk of unlawful restraint and injury from this.

The manager and staff were not aware that the use of restraining techniques or injuries as a result of this were notifiable under safeguarding procedures and had not made the appropriate notifications to the local authority or Care Quality Commission. Following the inspection visit we notified the local authority about what we had been told.

The above is a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living at the service were at risk because the staff were not deployed in a safe way. The staff regularly worked long hours without sufficient breaks. For example, the rotas showed that for one week in December one member of staff had worked from 5pm on the Monday until 10am on the following Saturday without any time off. They had undertaken four sleeping in duties (10pm until 7am) at the home during this time and one waking night duty. In addition they returned to the service at 9pm on the Saturday to undertake a waking night duty and remained at the service until the following Monday. The staff told us that sleeping in duties involved the member of staff sleeping on the sofa in the lounge and being called upon by the waking night staff if needed. The lounge was positioned between two of the bedrooms and the bathroom. The staff told us they were disturbed during their sleeping in duties. A member of staff had anonymously raised concerns about the arrangements for night cover with the local authority, claiming that staff regularly worked waking hours at the service for over 24 hours. The local authority were investigating this claim and the manager was aware of the concerns around this. However, on the week of the inspection the planned rota for staff hours showed that on 21 January 2017 one member of staff was due to start work at 9am and was scheduled to work a waking shift until 11am on Sunday 22 January 2017. The rotas showed that the staff regularly worked from 7am until 10pm followed by a sleep in duty and a shift the next day from 7am until 10pm. The rota stated, ''15 minute recoded break to be taken by all staff each shift.'' There was a risk that staff working these long hours without sufficient breaks and time off were not fit to safely care for people and meet their needs.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

The arrangements for ensuring that people living at the home and staff were kept safe in event of a fire were not sufficient. During the inspection we saw that some doors were being held open with wedges which prevented them from closing in event of a fire. There were no personal emergency evacuation plans for people to explain how the staff needed to support them in event of a fire. One person's mobility was reduced. The staff explained that they could walk very short distances (from a chair to a bed) with the assistance of two members of staff. The staff explained the person would not be able to walk out of the building even with two members of staff supporting them. The records of an incident in September 2016 where the fire alarm had been activated by burnt food showed that another person had refused to leave the building and a member of staff had remained with them in the home whilst the incident was happening. A fire drill practice which took place in December 2016 recorded that it took eight minutes for everyone to evacuate and the fire drill practice in November 2016 stated that one person had refused to leave the home. There was no recorded plan to explain how the staff should respond to these incidents and risk assessments had not been updated following these events where people had not been safely evacuated. Therefore people were at risk in event of a fire.

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

One person was at risk because information about how to care for them safely and manage risks was out of date. For example, the risks to this person's safety had last been assessed in November 2015. The assessments included a plan about how the person should be supported to use the toilet. Since this time the person's needs had significantly increased. However, this had not been recorded and there had been no review or update to the risk assessments to inform the staff about changes in this person's need and the way they should be supported to manage any risks.

This was also a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, the risk assessments and plans to manage the risks for two other people who lived at the service had been reviewed and updated in 2016. These plans included risks associated with physical aggression and challenges, safety in and outside of the home.

People received their medicines as prescribed. However, the medicines were stored in a cupboard which was positioned over a tumble dryer. The walls inside the cabinet were wet. This could have affected the property and potency of the medicines. In addition the area was very warm. The staff recorded the temperature of the cabinet each day but we saw that the thermometer had broken and staff had been recording the same temperature without appearing to notice this. High temperatures could also have affected medicines and people were at risk because of this. We told the provider of our findings so that they could take immediate action to store the medicines safely.

Medicine administration records were completed accurately and the staff counted and checked medicine stocks at each changeover of staff. There were some protocols for the use of PRN (as required) medicines. These were appropriately detailed. However, these had not been completed for all of the people and for all PRN medicines. Therefore the staff did not always have the information they needed to help them decide if administration of these ''as required'' medicines was needed.

This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All three relatives we spoke with told us they thought the home was a safe place. One relative said, ''I do not like to see [my relative] frightened, and [they] are not at this home, it is secluded and quiet.''

The staff recruitment records we looked at showed that the provider had made the necessary checks on staff suitability to work with vulnerable people. For example, they had asked the staff to complete an application form with their employment history, they had carried out checks on their criminal records, they had received references from previous employers and they had checked their identity and eligibility to work in the United Kingdom.

Requires Improvement

Is the service effective?

Our findings

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Two people received their medicines hidden in food. We saw approval from the GP to administer medicines in this way for one person but not for the other. The staff told us that there was an approval in place. However, there were no capacity assessments in relation to the decision to administer medicines covertly. In addition, the decision had not been made as part of a best interest process for the individuals.

The door to the kitchen was locked. The staff reported that this was because one person entered the kitchen and ate or damaged food in there. They also said there had been an incident where they had placed themselves and others at risk by attempting to pull a refrigerator over. However, the decision to the lock the door resulted in restricting access to this area for the other two people as well. There were no capacity assessments relating to this and there was no evidence this restriction had been imposed as part of a best interest decision.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that an assessment regarding a DoLS had taken place for one person. One of the other people had a DoLS in place but this has expired in June 2016 and there was no evidence that an application to renew this had been made. We could not find evidence of a DoLS for the third person. The manager told us that they thought all three people had an up to date DoLS. We requested evidence of this to be sent to us following the visit. No further evidence was received. In addition, care providers are required to notify us when DoLS authorisations have been made. The last such notification we received was in July 2012.

This was a further breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were able to make choices about the food they ate. The staff prepared food from fresh ingredients and each person was able to choose their own individual meals.

The staff told us they had received a range of training. This included classroom based training and a computer course. Two members of staff who we spoke with had been employed in 2016. They were able to describe their induction into the service and the training they had received. We saw evidence of staff inductions. The staff told us they felt they had the information they needed to care for people and meet their needs.

The staff told us they had regular opportunities for individual and team meetings with their line manager.

These were recorded and we saw that regular meetings were planned for. The staff used verbal handovers of information and written communication books to update each other with changes. We saw that these were appropriately used.

People's healthcare needs were being met. They had regular consultations with healthcare professionals and these were recorded. There was recorded information about their health needs. The staff monitored people's health on a daily basis and had responded appropriately when people had become unwell and following accidents.

Good

Is the service caring?

Our findings

People living at the service did not have the communication skills to be able to tell us how they felt about the staff who supported them. However, we observed that the staff were kind, gentle and patient with people. People appeared relaxed in the company of staff. The staff were polite when addressing people, smiling and approaching people in a calm and friendly way.

The relatives who we spoke with told us they felt the service was caring. Their comments included, ''[My relative] is happy, the staff have always been attentive to [their] needs'', ''The carers are fantastic with [my relative] day to day'', ''[The staff] have really bonded with [my relative]'', ''Every move [my relative] has had has been difficult but [they] have settled so well at this home and so quickly'', ''We are happy with all the efforts of the staff'' and ''The carers are good and relaxed.''

One relative mentioned a particular member of staff, telling us how they had researched the type of food their relative liked and made an effort to prepare this in the way the person wanted. The relative told us they thought this was particularly caring and thoughtful.

One of the professionals who we spoke with told us, ''The client is doing well and they have made good efforts to meet [their] cultural needs. They seem supportive and caring. ''

One person spoke did not have English as a first language. The provider had employed one member of staff from the same cultural background who could speak in the person's first language with them. The member of staff also supported the family by providing translation when they communicated with the provider.

The relatives we spoke with told us people's privacy was respected. We also observed this. The staff provided care behind closed doors and were discrete and sensitive to people's needs.

Requires Improvement

Is the service responsive?

Our findings

Some relatives felt that people's needs were not always being met. One relative said, ''I am very worried that [my relative] has put on so much weight, the staff just give [them] snacks all the time and [my relative] never goes out or has any exercise.'' Another relative said, ''The staff never take [my relative] out, we are not happy about this or the support.'' However, one relative told us they were happy with the support at the service, telling us, ''We are happy [our relative]'s needs are catered to. [Our relative] is clean and cared for. The staff ring us if anything happens.''

The professionals who we spoke with told us they would like there to be more opportunities for people to go out and do more things. One professional said, ''[The person] does not go out. We wanted more activities and we worked with [another external professional] to put a plan in place but the provider told us they did not need this and they had their own plan. Unfortunately this has meant [the person] does not have any structure each day because there was no plan as far as we could see.'' Another professional said, ''The staff are supposed to use objects of reference to support communication with [the person] but they do not do this.'' A third professional said, ''I am unclear on [the person]'s day activities but I think the staff do their best.''

People's needs were not always being met. For example, people did not have opportunities to access the community, leave the home or take part in a wide range of activities which reflected their needs and interests. During our inspection visit the television was left on for the duration of the morning. None of the people who lived at the service showed any interest in this. However, we noted that for some of the time the staff sat and watched the television. One person spent time seated in their bedroom. The staff told us they always did this. Some of the time a member of staff sat and talked to this person. The two other people spent time in either the lounge or their bedrooms and walking between the two areas. They were not offered any activity or anything to do. During the inspection one person was visited by a relative who they spent some time with and another person was taken to visit their relatives later in the day. Apart from this they did not take part in any other activity. When people walked around the room they were asked to sit down by the staff. We also noted that when people became agitated the staff offered them bowls of crisps and other snacks, asking them to sit down and eat these. The staff did not offer any other stimulation or support to help reduce anxiety and agitation.

We looked at the records of activity provision for the two weeks preceding our inspection. One person had left the home once for a ''walk to the shops'' on one day and once to visit their family on another day. The other two people had not left the home. One person was in their nineties and frail and their family member confirmed that they did not want to go out. But the other two people were younger adults. Professionals working with these people and their families said that they would benefit from community activities. The records of activities for one person over a two week period included four days where the recorded activity was ''walking around the home'' and ''Watching the television''. The staff had recorded personal care as an activity on three of the days. All other recorded activities for the two weeks were either, ''Watching TV'', ''Playing with toys'', ''Relaxing'' or ''Watching a movie.'' The other younger adult's recorded activities for the two week period were recorded as either games, watching the television, chores, exercises and one entry of

''sensory.'' As part of the care plans for two of the people living at the home they are supposed to make use of a ''sensory box'' made specifically for them with a collection of objects to meet their sensory needs. We asked the staff where these boxes were. They told us they were locked away because otherwise people took the things out of the boxes. No one was offered any items from their sensory boxes during our inspection, despite the fact one person became agitated at times and neither person was taking part in any other activity.

Therefore the service was failing to care for and support people in a way which reflected their preferences and met their needs.

The staff had created support plans for each person. However, these varied in quality and clarity of information. The support plans had not always been reviewed and were not all up to date. In addition information from professionals working with people had not been incorporated into their support plans. For example, one professional had developed plans to help the staff support the person when they became agitated or physically challenging. This information was not recorded in the care plan for the person and therefore staff did not have easy access to this information. The staff were not aware of these plans and therefore did not support people appropriately when they became agitated.

One person was at risk because they had a very low weight. They had not been weighed since April 2016 and therefore the staff were unable to monitor whether the risks for them had increased further. In addition they had a poor appetite and ate very little. They had been prescribed supplement milkshakes and the staff were providing these. The staff were aware of some of the risks associated with low weight. But there was not a record of this. The staff had not carried out regular assessments of the person's nutritional needs and there was not a clear care plan to describe how the person should be cared for in relation to this. Another person's weight had increased significantly with a weight gain of more than 10kg in one month. Their relative told us they were concerned about this.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was an appropriate procedure for making complaints. Relatives of people who lived at the home said they knew who to raise a complaint with.

Requires Improvement

Is the service well-led?

Our findings

The culture of the home was not open or transparent. The ownership of the organisation and the manager of the service changed in September 2016. The relatives of the people who lived at the service told us they had not yet met with the new owners. One relative told us they had met the new manager ''in passing'' but that they had not introduced themselves formally. The other two relatives told us they had not met the new manager. One relative said, ''I haven't got used to the new people yet.'' Another relative said, ''The new manager and owners have not contacted us to introduce themselves.'' The professionals working with the service told us they had not received formal information about the change of ownership or manager. One professional said, ''I am very confused about the situation the manager first told me [they were] one of the owners and then said [they were] the manager not the owner, I really do not know what the situation is.'' Another professional told us, ''I contacted the new manager to arrange a meeting but they did not turn up on the day of the meeting, I tried to arrange a second meeting and they did not turn up to this either.''

The manager responded to these comments by writing to tell us, ''As the manager, the service is visited on regular basis each week to ensure the residents are receiving the best possible care and to monitor the service, some unannounced to meet with the staff and assist in any issues and to ensure they are supported face to face. I interact with the residents, know about their likes and dislikes. Assisted in providing birthday celebrations for one resident whose family came, organised a birthday gathering for another service user, spend quality time with all service users and have sat with one family for over two hours after introducing myself and ensure they are well each time they visit their family member.''

One relative told us that the manager had given notice to their relative without consulting them or informing them. They told us they were upset that they had not had any contact from the manager about this. One professional who was involved with supporting this person said that they felt the decision had been communicated poorly and the manager had not involved them or consulted with them in the way they would expect. The manager told us, ''We acted upon advice from the local authority. We wanted to work in partnership therefore we did what we were asked to do by the local authority.''

The staff on duty told us they had ''Not had a lot of contact from the new manager or owners'.'' In addition we received a whistle blowing concern shortly after the inspection visit from an anonymous member of staff who told us they did not feel supported by the organisation. One professional told us, ''I think it is very difficult for the staff.'' The manager responded by telling us, ''We support whistle blowing and are advocates of the policy.''

The new manager had not submitted an application to be registered with the Care Quality Commission (CQC) at the time of the inspection. The previous registered manager left the organisation in August 2016 and cancelled their registration with CQC in October 2016. The service is required to have a registered manager in post. The new manager provided us with evidence that they had started the process of making this application.

The provider is required to notify the Care Quality Commission of certain significant events. We found

records of incidents which had happened where the provider had failed to make the appropriate notifications. For example, one person had been injured whilst they were being supported by a visiting health care professional and another person had injured their head, resulting in a hospital admission whilst they were having a seizure.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Registration) Regulations 2009.

The staff undertook a number of audits each day, including checking medicine records and stock, checking the temperature of food storage and served food and checking the health and safety of the environment. There were regular tests of fire fighting and detecting equipment. However, as evidenced in the safe and effective domains, the provider's auditing systems failed to adequately assess, monitor and improve the quality of the service.

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

The provider had introduced some new record keeping systems in order to better organise how information was recorded and monitored.

Since the inspection visit the local authority had been working closely with the service to review the needs of people who live there. They had also worked with the provider to look at some of the issues we identified at the inspection visit, for example appropriately staffing arrangements and safeguarding people. The local healthcare behavioural support team had been giving the staff advice and support about how to help people express their needs in a safe way.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person had not notified the Care Quality Commission without delay of the incidents specified in the Regulation. Regulation 18(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered person did not always ensure that the care and treatment of service users were appropriate, met their needs and reflected their preferences. Regulation 9 (3) (b) The registered person had not always carried out an assessment of the needs and preferences of service users or designed care to ensure these needs were met. Regulation 9 (3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person did not safeguard service users from abuse and improper treatment Reg 13 (1)

	Service users were deprived of their liberty without lawful authorisation Reg 13 (5) Systems and processes were not operated effectively to prevent or investigate abuse. Reg 13 (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not assess, monitor and improve the quality and safety of the service. Regulation 17(2)(a) The registered person did not assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. Regulation 17(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had not deployed sufficient numbers of competent or skilled staff. Regulation 18(1)

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 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure that care and treatment was provided in a safe way to service users because they had not: -assessed the risks to the health and safety of service users Reg 12 (2) (a) - done all that is reasonably practical to mitigate risks to service users Reg 12 (2) (b) - ensured the safe and proper management of medicines. Reg 12 (2) (g)

The enforcement action we took:

We have issued a warning notice to the provider telling them they must make improvements by 10 March 2017