Clough House Residential Home Limited

Clough House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service:
Clough House is in a residential area of Leyland, close to the town centre and on the outskirts of Preston. The home provides accommodation for up to 14 people who need support with personal care needs, including those who are living with dementia. Accommodation is provided in single rooms, although one double room is available for those who wish to share facilities. The upper floor is served by two stair lifts, one at either end of the premises. There are communal areas available, including lounges and a dining area. Car parking facilities and outdoor seating is provided. At the time of our inspection there were 12 people living at the home.

People's experience of using this service:
The views of people we spoke with varied. We received some positive feedback about the service provided. However, some people thought improvements could be made. The provider had systems to act on allegations of abuse and people felt they or their loved ones were safe living at Clough House. However, new staff were not recruited safely.

A system was in place for the reporting and recording of accidents and incidents, although medical advice had not always been sought when required. Relevant information had not been recorded. We made a recommendation about this.

The provider lacked oversight of the service, as they failed to carry out robust checks to ensure people received care and support in accordance with their wishes. The premises needed upgrading and modernising and some areas of the home needed a thorough clean.

The management of medicines was satisfactory. However, some creams were not stored safely.

Plans of care were detailed and person-centred. They reflected people's assessed needs well and had been consistently reviewed. Any changes in need had been recorded. People thought the provision of activities was satisfactory.

People's needs and choices were assessed before they moved into Clough House and the policies of the home indicated they were given choices, with their wishes being respected. However, we found people were not supported to have maximum choice and control of their lives and restrictions were imposed in some aspects of daily life. This did not promote choice, independence and respect.

Although people's views varied in relation to the number of staff on duty, we found assistance was provided in a timely manner and therefore staffing levels were satisfactory at the time of our inspection. New staff received an in-depth induction programme and a broad range of training had been completed by staff, who were regularly supervised and observed at work. However, annual appraisals had not been introduced at the time of our inspection.

The provider had policies for the management of complaints and systems for recording complaints had been introduced. Feedback had been obtained from those who used the service and their relatives. Team meetings had been held for those who lived at the home and the staff team. Staff members said they felt able to approach the managers with any concerns, should they need to do so.

Rating at the last inspection:
This service was rated as good at the last inspection (published 21 December 2016).

Why we inspected:
This was a scheduled inspection based on the previous rating. However, we were aware of several recent safeguarding concerns in relation to restricted choice, lack of dignity, institutional practices and poor recruitment practices.

Enforcement:
We have identified breaches in relation to safe care and treatment, premises and equipment and good governance. Please see the action we have told the provider to take at the end of this report.

Follow up:
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will monitor the progress of the improvements, working alongside the provider and local authority. We will return to visit as per our re-inspection programme. If any concerning information is received, we may inspect sooner.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Clough House

Detailed findings

Background to this inspection

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

Inspection team:
The inspection was undertaken by two adult social care inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
Clough House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
This inspection was unannounced, which meant they did not know we were coming.

What we did:
Before the inspection, we looked at all the information we held about the service. This included any safeguarding investigations, incidents and feedback about the service provided. We looked at any statutory notifications that the provider is required to send to us by law. We also looked at the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also contacted six community health and social care professionals to request their feedback about the quality of service provided. We received three responses. We used a planning tool to collate all this evidence and

information prior to visiting the service.

During the inspection we spoke with six people who lived at Clough House and one family member. We also spoke with six staff members, the registered manager and the nominated individual, who acted on behalf of the provider. We looked at a variety of records, which included the care files of four people who lived at the home and six staff files. We also reviewed records relating to the operation and monitoring of the service. These included, audits, surveys, training records, minutes of meetings, duty rotas and safety checks.

Following our inspection, we met with the nominated individual and registered manager. They provided us with a detailed action plan and gave us assurances they had addressed or were in the process of addressing the issues we had raised as concerns during our inspection.

Requires Improvement

Is the service safe?

Our findings

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

Some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed. Regulations may or may not have been met.

Systems and processes to safeguard people from the risk of abuse

- Everyone said they felt safe living at Clough House. People also said they would be happy to tell a staff member if they felt unsafe in any way. One person commented, "The staff are very good and look after you. They're very nice with me."
- Although information was available for staff in relation to safeguarding people from abuse, the provider had failed to follow policies by not making referrals under safeguarding procedures, when this was needed.
- Staff members said they would know what to do if they thought someone who lived at the home was being abused. However, not all staff members were aware of the whistle-blowing policies of the home.

Recruitment

- The provider had failed to ensure robust recruitment practices had been adopted by the home. Police checks had not always been conducted before people were employed. This was not in accordance with the recruitment policies of the home, which stated, 'People who use the service benefit from staff who are only allowed to start work after a full Disclosure and Barring Service (DBS) check has been received. Evidence was not always available to demonstrate interviews had taken place for prospective employees. This meant assurances were not in place to confirm staff members were fit to work with vulnerable people.
- There was no evidence available to show that the provider had repeated police checks periodically to ensure staff members remained suitable to work with those who lived at the home.

Assessing risk, safety monitoring and management

- People's safety was not always promoted because the management of risks was not robust. Although a range of risk assessments had been conducted, these were not always effective.
- We saw one person sitting on a chair inappropriate for their needs. We were told this was due to space in the persons room. Risk assessments had not been conducted and strategies had not been implemented to reduce the possibility of injury.
- Personal Emergency Evacuation Plans (PEEPs) in place. However, some did not contain enough detail and failed to provide guidance about how to safely manage people's individual needs in the event of an emergency.
- Missing persons protocols were in place. Although these provided a physical description of the individual a photograph was not always available on these documents. The provider had failed to identify this as part of the care file audits.
- The provider had not always sought medical advice when needed. Where concerns had been identified for two people requiring urgent medical attention, staff had not acted on these in a timely manner. This potentially had a serious impact on those concerned.

Preventing and controlling infection

● People were not protected from the risks of infection. Effective infection control practices were not followed. The provider had failed to implement Isolation techniques to help prevent cross infection.

● The provider had also failed to ensure soiled linen was disposed of correctly and staff failed to ensure personal protective equipment was used when needed. Safe cleaning procedure for continence equipment was not followed and appropriate sluice facilities were not available on the washing machine to ensure linen was washed appropriately. Although the home was superficially clean areas such as under beds, pipes in bathrooms and the kitchen required a deep clean.

The above findings found that the provider had failed to adequately assess risk and monitor safety at the service. This was a breach of regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Safe care and treatment.

● As a result of feedback form the first day of our inspection the provide took immediate action, organised team meetings, arranged for supervisions with the staff and commenced a thorough clean.

● The provider had failed to ensure safety measures were implemented to protect those who lived at Clough House. We noted a slide lock was fitted on the external facing of a toilet door, some hot water pipes were exposed, a radiator guard was loose, a wooden box for covering pipework was broken, a bannister rail was loose and a curtain prevented a fire door closing properly on activation of the fire alarm. We discussed our findings in these areas with the registered manager and nominated individual at the time of our inspection who took immediate action to address these areas and therefore the level of risk was mitigated.

We recommend the provider consults Public Health England website for guidance in relation to a safe environment, so that any areas of risk are identified and addressed in a timely manner.

● Systems and equipment within the home had been serviced in accordance with manufacturers' recommendations and accident and incident reports had been completed, although action taken was not always clear.

We recommend the provider ensures accident and incident records include actions taken.

● The provider had fire policies and procedures, which provided people with clear guidance about the action staff needed to take in the event of a fire. Fire drills were conducted periodically and internal fire checks were done regularly, which highlighted any faults and action needed. A fire risk assessment had been conducted.

Staffing

● Comments about staffing levels varied. Some people felt there were enough staff on duty, whilst others felt more staff would be helpful, as when staff were busy people had to wait a while for assistance. One person told us, "It can depend on how busy they are as to whether people have to wait. Sometimes they do, but it's not really a problem, I don't think." Another said, "If I use the call bell the staff come like a bullet out of a gun." At the time of our inspection we noted assistance was provided within acceptable timeframes and therefore enough staff were on duty to meet people's needs.

Using medicines safely

● People told us they were happy with how they received their medicines. However, the provider had not ensured medicines were always managed safely.

● We found some creams were not stored safely and some bottles and tubes of medicines were not dated

on opening to ensure their shelf life had not expired.

We recommended creams be stored safely and medicines not in blister packs be dated on opening.

● The room temperatures where medicines were stored were recorded daily. However, a number of recordings showed the room temperature was above the guidance recommended. This could affect the composition of the medications. However, the provider had recently taken action to address this by installing a extractor fan, which had resolved the problem.

Learning lessons when things go wrong

● The provider had not demonstrated lessons had been learned when things went wrong, such as following accidents and safeguarding incidents. Following our inspection staff meetings had taken place to discuss our findings and to highlight how lessons should be learned, to reduce the possibility of re-occurring incidents.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

The effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent. Regulations may or may not have been met.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

Ensuring consent to care and treatment in line with law and guidance

- The provider had failed to ensure one person was not being unlawfully deprived of their liberty. The registered manager told us this person would not be allowed to leave the building unescorted, if they wished to do so. However, relevant assessments and DoLS applications had not been completed and submitted appropriately. Because of the inspection the appropriate application was submitted to the assessing authority. An audit of this person's care file had not identified missing information or that a DoLS application was needed.
- A mental capacity assessment for one person showed they were able to understand simple questions but were not able to retain complex information. However, they had signed consent for GDPR (General Data Protection Regulations) that had not been written in simple terms to support their understanding. This is a regulation which governs the protection of personal information. The registered manager failed to demonstrate a good understanding of the MCA, DoLS, consent, lasting power of attorney or best interest decision making.
- Although the registered manager had obtained consent in a range of areas she had not ensured this had been properly obtained or that decisions had been made in people's best interests.

The provider had failed to ensure consent had been properly obtained in line with the Mental Capacity Act 2005. This was a breach of regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Need for consent.

Supporting people to eat and drink enough to maintain a balanced diet

● We received some concerning information before our inspection in relation to restricted meal time practices. This was substantiated by staff, the registered manager and a number of those who lived at the home, who confirmed that they could not have a pudding at meal time unless they ate their main course. One person said, "If people don't eat their main course, they don't get pudding. And I was once told that if I didn't eat a specific thing on my plate I couldn't have pudding, so I got up and left the dining room." The registered manager told us this was advice from the nutritionist. However, there was no recorded evidence to show this advice had been given. One care plan we saw instructed staff to withhold puddings unless the person ate their main course. Records showed this person had significant weight loss and therefore their nutritional needs were not being met. This was unacceptable practice, as it supported institutional practices and did not promote independence or choice. We raised our concerns with the nominated individual, who stopped this practice with immediate effect.
● At lunch-time we noted nobody was asked if they would like anymore when plates were being cleared away. People were able to tell us what time meals were served. When we asked if they could have a meal at an alternative time no-one responded, except one person, who laughed and said, "You'd be on a diet", indicating there was no flexibility in meal times.

The provider had failed to ensure people's nutritional requirements were being met, in accordance with their needs and choices. This was a breach of regulation 14 of the Health and Social Care Act (Regulated Activities) Regulations 2014 Meeting nutritional and hydration needs.

● The menu of the day was displayed in the dining room and dining tables were laid attractively with cutlery, cups and salt and pepper at hand. A choice of cold beverages was offered at lunch time. The food served was hot and the quantity of food appeared sufficient for those who lived at the home, although everyone was served their meal on a small plate, without any alternative being offered. Comments about the food at lunch-time included, "Very nice; very tasty indeed" and "I enjoyed that very much."

Staff support: induction, training, skills and experience
● The registered manager had ensured new staff were assisted through a varied induction programme and following this were regularly supervised and observed on an individual basis. This helped to ensure the staff team were supported to carry out their individual roles. However, we did not see evidence of annual appraisals taking place.

It is recommended that the provider introduces annual appraisals for the staff team, so that staff members are able to discuss any concerns, as well as performance and training needs with their line managers.

● Staff training records showed a wide range of learning modules had been completed, which helped to ensure the staff team were kept up to date with any changes in legislation or good practice guidelines. Staff members told us about training they had completed and felt this was sufficient to meet their needs.
● People felt their needs were met by a competent and knowledgeable staff team.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● The provider had ensured people's needs were assessed before a place at the home was arranged. This helped to ensure the staff team could provide the care and support people needed.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● The provider had ensured that a range of community professionals were involved in the care and support of those who lived at Clough House. However, external professional advice had not always been sought in a

timely manner, as identified under the safe domain of this report.

Adapting service, design, decoration to meet people's needs

● The premises throughout looked worn, in need of upgrading and modernising. The home did not have a passenger lift for easy access to different floor levels. However, stair-lifts had been installed. The provider had a refurbishment plan for 2019, which outlined work to be done within set timescales. This would help to enhance the surroundings for people to live in.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People did not always feel well-supported, cared for or treated with dignity and respect. Regulations may or may not have been met.

Ensuring people are well treated and supported; respecting equality and diversity
● We had received some information before our inspection in relation to the allocation of chairs in the communal lounge. This was confirmed during our inspection by the registered manager and through our observations. We noted there to be an insufficient number of chairs to seat everyone in the television lounge. We were told everyone had their own chairs and therefore those most recently admitted to the home had to sit in the quiet lounge, which was without a television or in their bedrooms. This did not promote choice, independence and equality. We discussed this with the registered manager and nominated individual, who advised they would look at a more suitable seating arrangements, so everyone could access this area of the home of their choosing.

Supporting people to express their views and be involved in making decisions about their care
● People told us they were able to have a shower or bath once a week but did not know if they would be able to have one more often, should they wish to do so. One person told us, "I have a shower on my shower day. The staff help me" and another said, "We have a shower once a week; I think it's enough because I need such a lot of help."
● People were able to make some choices, such as choosing their own wallpaper for their bedrooms. However, one person said, "They [the staff] know me and I'd tell them if there was something I didn't want them to do. I can get about without any help. I go to my own room when I'm allowed, but occasionally I'm not [allowed]. I'm not sure why."

Respecting and promoting people's privacy, dignity and independence
● The registered manager had introduced some restrictive practices, which did not allow people the right to choose and did not promote freedom of choice.

We recommend the provider assesses and monitors daily life for those who live at the home to ensure people are at liberty to make choices in everything they do.

● When people were asked if they were respected by the staff team, responses included, "I'll go 50:50 on that. You can sometimes feel like a school child"; "The staff are not bad at all. Some won't listen, but it's me probably; they can get a bit 'short" and "Most of them are all right." Others provided us with positive comments about the staff team. One person said, "Staff are pretty fair to everyone; they're kind to me. They take their time, especially when they're helping me to get up and go to bed. They say not to worry about holding them up."
● Staff were pleasant towards those who lived at Clough House, but little interaction was observed. One

member of staff told us, "This is a happy home. It's cosy and I am happy working here." We were told that staff respected people's privacy by knocking on doors before entering and by closed bedroom curtains during personal care.

● People were able to have their bedroom doors locked, if they chose to do so. This helped to promote privacy and dignity. We saw people being able to walk into town, if they wished and were able to do so without support. One person told us, "I come and go as I like, but I always let the staff now where I'm going, if I'm going out I take my mobile so they can contact me."

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

People's needs were not always met. Regulations may or may not have been met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control

● People's likes and dislikes were recorded and a document was available to tell staff all about them. This helped the staff team to familiarise themselves with individual preferences and past interests. People told us they had been involved in the planning of their care. However, the provider had not always ensured people were offered choices and control of their daily living experiences, particularly in relation to the meal service, provision of personal care and community lounge arrangements. This was discussed with the registered manager and nominated individual at the time of the inspection, who assured us these areas would be addressed without delay.

● Staff had conducted a dependency rating scale to show the level of care and support required by each person and a record of daily events was maintained.

● The registered manager was in the process of introducing new care documentation. The care plans were informative and these were supported by a summary, which provided staff with a good overview of individual needs. Regular reviews of the plans of care had been conducted. This helped to ensure they were up to date and provided current guidance for the staff team.

● The provider had introduced some computerised systems for the management of policies and procedures, staff training and monitoring records.

● An activity co-ordinator was employed four mornings each week. People said they were satisfied with the activities provided. One community professional was positive in feedback about the activities provided.

● We noted that community professionals were involved in the care and treatment of those who lived at the home. The feedback from them was positive about the support people received.

Improving care quality in response to complaints or concerns

● The provider had a complaints policy and a system was in place for recording complaints received. One recorded complaint was a police matter, but this had not been reported on instructions from the family and reportedly in agreement with the individual concerned, although this had not been recorded.

We recommend the provider ensures any requests from people who live at the home are clearly recorded to ensure their wishes are respected.

● We saw a range of thank you cards and messages, which provided positive feedback about peoples' experiences of Clough House.

End of life care and support

● The provider had considered people's needs in relation to their end of life care wishes and where appropriated family involvement was evident.

Requires Improvement

Is the service well-led?

Our findings

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

Service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care. Some regulations may or may not have been met.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The provider had failed to ensure robust monitoring of the service. A range of recent internal audits had been conducted. However, these were not always effective, as many showed results of 100% in areas where we found significant gaps and shortfalls.
- The registered manager had ensured a kitchen and dining experience audit had been conducted each month. This showed an achievement of 100% during the previous three months. However, we found significant shortfalls and inaccuracies in their findings.

The provider had failed to ensure systems had been introduced which effectively assessed and monitored the quality of service provided. This was a breach of regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014, Good governance.

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

- We saw surveys completed by staff members. These showed staff meetings were held, despite some feedback we received stating that these did not take place. We saw the minutes of staff meetings and the nominated individual confirmed two staff meetings were held, so that the staff team were aware of the findings from our inspection.
- One member of staff told us, "I really, really love it here. [Registered manager] is a beautiful boss. You can talk to her. She is really supportive and treats everybody the same" and "I love it here; I feel comfortable, and feel that people are very, very well looked after and cared for, like a little family." Feedback about the registered manager from a community professional was positive.
- The provider had also held meetings for those who lived at the home and had obtained feedback from them in the form of surveys. All those we saw provided positive comments about the services and facilities available at Clough House.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility

- A range of information was available, which provided any interested parties with details about the home, including the facilities and services available.
- The provider had ensured the planning of people's care was person-centre by ensuring individual likes and dislikes had been recorded. This provided guidance for the staff team about people's needs and wishes.

Continuous learning and improving care

● At the end of day one of our inspection we provided the registered manager and nominated individual with both written and verbal feedback about our findings and the concerns we had identified. The nominated individual produced a detailed action plan immediately as well as updates on the actions taken throughout the inspection process. During our meeting following the inspection the registered manager and nominated individual provided some assurances that our concerns would be addressed promptly and people would be kept safe and allowed freedom of choice.

Working in partnership with others

● The provider had developed good working relationships with other community professionals and organisations, which helped to promote partnership working. This was confirmed by people we spoke with who were not directly connected with Clough House.

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 11 HSCA RA Regulations 2014 Need for consent The provider had failed to ensure consent had been properly obtained in line with the Mental Capacity Act 2005.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to adequately assess risk and monitor safety at the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider had failed to ensure people's nutritional requirements were being met, in accordance with their needs and choices.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure systems had been introduced which effectively assessed and monitored the quality of service provided.