Aegis Residential Care Homes Limited

The Clough Care Home

Inspection report

Chorley New Road
Bolton
Lancashire
BL1 5BB

Tel: 01204492488
Website: www.pearlcare.co.uk

Date of inspection visit:
08 August 2018
09 August 2018

Date of publication:
18 September 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection tool place on 8 and 9 August 2018. Our visit on 8 August was unannounced.

During the last inspection of The Clough in July 2017 we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because environmental risks had not always been identified and standards of infection control did not effectively prevent the spread of infection. Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key questions 'is the service safe?' and 'is the service well led?' to at least good. At this inspection we found improvements in these areas but we found further breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014, relating to servicing records and poor medicines administration. You can see what action we told the provider to take at the back of the full version of the report.

The Clough Care home provides accommodation and personal care for up to 32 older people in a residential area of Bolton. At the time of our inspection there were 30 people living in the home.

Following the retirement of the previous registered manager the service had appointed a new manager who was in the process of applying to the Care Quality Commission (CQC) to become the registered manager. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe at The Clough, and the staff we spoke with demonstrated a good understanding of safeguarding and whistleblowing procedures. There were few incidents of alleged abuse but where these had been raised there was appropriate recording and follow up action taken.

There were enough staff on duty and staff were encouraged to spend time with the people who used the service. Staff were well trained and had access to refresher training to ensure that their knowledge was up to date and in line with current best practice. The service made appropriate checks during the recruitment process to ensure that new staff had the right attributes and character to work with vulnerable people. All new staff received a full induction and systems were in place to provide supervisions for staff. However not all staff had had a recent supervision although the manager was addressing this at the time of our inspection.

We saw risks were considered, including generic and environmental risks. Where identified, appropriate action was taken to minimise the risks. There was consideration of people's needs prior to and immediately following people's admission to The Clough and plans of care were regularly reviewed to ensure that changing needs were identified. Care records showed that the service worked in partnership with social workers and health care professionals and that people had access to healthcare services, including general

practitioners (GPs), district nurses, and dieticians as necessary.

People told us that they enjoyed the food provided. The cooks understood the needs and preferences of people who used the service, and were aware of any specific dietary requirements. Where necessary, food and drink intake was monitored, and we saw hot and cold drinks were provided throughout the day.

The staff we spoke with demonstrated a good understanding of consent and choice. Where people lacked the capacity to consent to their care and treatment the appropriate authorisation to carry out their care had been sought and agreed by the relevant authority.

Staff communicated well with each other during their shifts, and any issues of concern were recorded and passed on at handover between shifts to ensure that needs were not overlooked and to allow consistent delivery of care.

People told us that they were supported by considerate and caring staff and throughout our inspection we saw staff demonstrate a caring attitude and a willingness to go above and beyond what would normally be expected from their caring role. People were not overlooked, and staff were vigilant to their needs, treating people with respect. They recognised the need for both privacy and confidentiality; information held about people was stored securely when not in use. This care extended to support for people at the end of their life, and we saw a number of thank you cards from relatives complimenting the staff for the end of life care and support provided.

Care plans provided appropriate information about individuals to enable care staff to meet their needs, but they were not always written in a way which reflected the person-centred way we saw care was delivered.

Although the service did not employ an activity co-ordinator we saw some evidence of organised group activities, and throughout our inspection we saw people enjoyed the attention of care staff either in one to one or small group conversations. People had formed friendships within the service, and staff demonstrated a good understanding of people's hobbies and interests. The service provided a kind and caring environment considerate of the needs and wishes of the people who lived at The Clough.

Staff understood their roles and responsibilities, and those we spoke with told us that they felt well supported and well managed. We saw that there were systems of quality assurance, including audits and regular feedback from people who used the service, which was used to improve the quality of service delivery.

We saw that there was good support from the provider, and evidence of partnership working with the local authority and across other homes within the group.

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.

Systems to check medicines were given safely were not always effective.

Environmental risks were assessed but the service had allowed the gas safety certificate to lapse.

There were enough staff who had been safely recruited and knew how to protect people from harm.

Appropriate measures were in place to prevent the spread of infection.

Is the service effective?

Good

The service was effective.

People told us the staff knew them well and we saw that staff receive training to maintain and develop their skills to meet people's needs.

The management and staff demonstrated their understanding of the Mental Capacity Act 2005 (MCA) and deprivation of Liberty Safeguards (DoLS).

People enjoyed the food provided.

Is the service caring?

Good

The service was caring.

Staff treated people in a caring and compassionate manner and spoke affectionately about the people they supported.

People's privacy and dignity was respected.

Staff were attentive to need and showed a good understanding of people's likes and dislikes.

Is the service responsive?

Good

The service was responsive.

Care plans reflected people's needs and wishes.

There was a complaints procedure for people to voice their concerns and people were encouraged to raise any issues.

How people wished to be supported at the end of their life was considered.

Is the service well-led?

Requires Improvement

The service was not always well led.

Audits and checks did not always identify action needed to improve the service.

The provider had recently appointed a new manager, who had applied to register with the Care Quality Commission (CQC).

Management information and feedback from people and other parties was used to improve the quality of service delivery.

The Clough Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 8 and 9 August 2018 and was unannounced. The inspection team consisted of one adult social care inspector and one assistant inspector.

Prior to our inspection we asked the provider to complete a Provider Information Return. This is a form which asks the provider to give us some key information about the service, what the service does well and improvements they would like to make. We also reviewed the information we held about The Clough, including any statutory notifications submitted by the provider or other information received by members of the public. A statutory notification is information about important events which the provider is required to send to us by law.

During our visit we spoke with the manager, a deputy manager and two area directors. We spoke with three care workers, the maintenance officer, a cook and a domestic assistant. We observed how staff interacted with people and spoke with six people who used the service and four visiting relatives.

We looked around the building, including all the communal areas, toilets, bathrooms, the kitchen, and the garden. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us to understand the experience of people who cannot talk with us. We observed how staff cared for and supported people, and looked at food provision.

We reviewed the care records for four people, three staff personnel files, and other documents related to the management of the home, such as maintenance records and service invoices. We also checked 15 medicine administration records.

Prior to our inspection we reviewed the information we held about the service, and contacted the local authority safeguarding and commissioning teams to obtain their views about the service.

Requires Improvement

Is the service safe?

Our findings

When we looked at the systems in place for the safe management of medicines we found that people using the service were not always fully protected against associated risks, as medicines were not fully accounted for. We saw that medicines received from the pharmacy were checked, signed for, countersigned and recorded when received and disposed of. However, when we checked we found that the number of medicines available did not always match the records kept. For example, records showed that one person had received 44 tablets in total, and there ought to have been 4 remaining according to their MAR. When we checked, we found that there were only three. Moreover, the MAR chart indicated that two tablets had been taken on the morning of our inspection, but we were informed that the person had only taken one, as the person did not want to take both as they made them sleepy. This meant the record was inaccurate, and did not reflect the amount of medicine taken.

We also found errors in recording the administration of controlled drugs (CDs). Controlled drugs are medicines named under Misuse of Drugs legislation, which restricts how such medicines are stored and recorded. The home used some of these prescribed medicines and we saw they were stored in a further locked cabinet, and the controlled drug register was countersigned when administered. However, when we checked the balance of controlled drugs we found them to be incorrect. For example, the register for one person who was prescribed a patch for pain relief showed that five patches had been received, two had been signed out, but the box contained only two patches meaning one was missing. When we informed the deputy manager she believed the error occurred when documenting the number of patches received. It should have stated four and not five. Therefore, with two patches signed out there would be two patches remaining. This error had not been picked up when the new patches were signed in, nor on the subsequent counts when the two patches were taken.

Systems for recording administration of controlled drugs was not clear. When drugs were not required, an X was recorded on the persons MAR chart, but on one sheet we looked at the administration of a patch had also been recorded using an X, leading to confusion about whether the patch had been given or not. Moreover, the CD register was confusing, as different pages were used to record when medicines had been administered with no clear follow on from page to page.

When we toured the building we found in one bedroom a partly use tube of skin cream which had been prescribed for a person in another room. When we inquired about this we were told that the person to whom the cream had been prescribed no longer required it and it should have been returned to the pharmacy for destruction, but the service could not explain why it was in a different person's room.

The service was in breach of Regulation 12 (1) (2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as medicines were not managed properly or safely.

A locked medicines room was used to store the medication trolley and all other medicines for the service. Refrigerator temperatures were checked daily and a record of temperatures was kept, to ensure medicines were stored at the correct temperature. If medicines are stored at the wrong temperature they can lose their

potency and become ineffective. Medicines were provided using a monitored dosage system. This minimised the risk of giving the wrong dose to people and provided an efficient system of storing and accounting for medicines.

We looked at maintenance records and safety certificates relating to the upkeep and safety of the premises. We saw documentation which showed recent servicing of fire equipment, lifting hoist, platform lift, stairlift and a bath hoist had occurred. This meant that this equipment was safe for staff and people who used the service. However, we saw a stand aid in the hallway by the dining room. There was no documentation available to show that this piece of equipment had been serviced. There was also some confusion between staff as to whether the stand aid was owned by the home, a person who had used the service, or if it was on loan. When we toured the building we found a large amount of old equipment such as zimmer frames and a hoist, but it was not clear to whom this equipment belonged.

A yearly gas safety inspection had been carried out on 14 March 2017 and we saw documentation to show that work had been carried out as recommended. However, there was no documentation to show that a gas safety check had been carried out since. This meant that gas safety could not be guaranteed.

This was a breach of Regulation 12 (1) (2)(d)(e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A recent legionella inspection stated that all water samples which had been taken were clear. The maintenance officer told us that they carried out monthly temperature and water checks, and checked and cleaned shower heads on a quarterly basis. Records indicated that this had been completed in January, April and July 2018. In addition, the maintenance officer conducted annual portable appliance testing (PAT). This was last completed in October 2017. All equipment tested was itemised and recorded.

A five year hardwire check carried out in January 2018 identified concerns about the electrical wiring. This led to a full rewire of the whole building which had been carried out between May and July 2018. Following this, a fire risk assessment was carried out, and the service was awaiting the report at the time of our inspection.

People told us that they believed they were safe at The Clough. One person remarked, "I am very, very happy here, so glad I came. There is always someone around so I feel safe. I've no worries at all". Visitors agreed; one relative we spoke with told us, "[My relative] is well cared for. I can leave here knowing all is well, and [my relative] is in safe hands."

The building was secure. There were no restrictions on people's movements with the only exceptions being to areas where it may not be safe, such as the laundry and kitchen. The main entrance was through a door on the side of the building, but at the time of our inspection this was closed off as a leak in the guttering made the entrance lobby unsafe. Instead, visitors were asked to use a back entrance which was kept locked, with access via a secure key code. This would help to ensure that unauthorised people would have difficulty entering the home, and a visitor's book ensured that staff were aware of who was in the building at any time. The front entrance led onto a conservatory and external patio area which was used by people who used the service, and meals were served there on pleasant days. When we last inspected The Clough we noticed that this this area had open access to the car park and road outside. However, the service had since erected lockable gates and assigned a member of staff to oversee the garden area to prevent unauthorised access or exit from the building.

A safeguarding policy was in place and protocols and procedures were in line with the local authority

guidelines. Where safeguarding allegations had been raised, we saw that appropriate action had been taken, with protective measures in place and investigations carried out.

When we spoke with staff they told us that they received training around the protection of vulnerable adults with regular refresher training and updates. They showed a good understanding of how to protect people from harm, and could tell us what they would do if they suspected a person was at risk of abuse. They told us how they recognised people's vulnerability and were vigilant to signs of abuse. They also told us that they understood the organisation's whistle blowing policy. Whistle blowing is the disclosure of information which relates to suspected wrongdoing or dangers at work. One care assistant told us that if they witnessed any person doing something inappropriate, "I wouldn't be able to go home and sleep. I wouldn't wait, I would inform [the manager] right away."

As we toured the building we saw that day to day risks were well managed. Where cleaning was in progress, the domestic staff placed signs warning people of wet floors. Environmental risks had been assessed and appropriate action taken. Weekly 'Walk the floor' checks undertaken by the manager, maintenance officer or regional manager would identify any new or emerging risks, and check any issues regarding lighting, heating or flooring which might indicate trip hazards. Walkways and corridors were clear and free of any clutter. We saw that the service had recently requested a fire safety inspection, and was awaiting the report. Regular fire drills and tests were undertaken, and everyone living at The Clough had a personal evacuation escape plan (PEEP). These explain how each person would be evacuated from the building in the event of an emergency.

We looked at four care records, which showed that risks to people's health and well-being had been identified. These involved risks such as mobility, eating and drinking, nutrition and hydration, communication and hygiene. Risks identified had corresponding care plans to help reduce or eliminate the identified risks, which were reviewed on a regular basis. When we looked around the home, we saw measures were in place to prevent injury or harm. For example, where people were at risk of falls during the night infra-red beams across their rooms would alert night staff to any movement, so if a person were to get out of bed the risk of injury would be reduced. Call bells were accessible to allow people who used the service to summon help.

The recruitment procedures in place gave clear guidance on how staff were to be properly and safely recruited. We looked at three staff files. These included proof of identity, an application form that documented a full employment history and accounted for any gaps in employment, interview notes, a job description, and two references. Checks were carried out with the Disclosure and Barring Service (DBS) before any member of staff began work, and these checks were updated every three years. The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. This meant that checks had been completed to reduce the risk of unsuitable staffing being employed at The Clough.

We saw that there enough staff to meet the needs of the people who used the service and the care staff we spoke with agreed. One care assistant told us, "There are certain things we need to do during the day, but we also have some quality time with the [people who use the service]". The regional manager informed us that they used a dependency tool to determine how many staff would be required. The staff rota showed that there were three care staff on duty during the day with two waking night staff. There was some flexibility should needs change, for example, if more staff were needed due to people who used the service becoming ill or needing end of life care. Gaps in the rota, for example to cover annual leave or sickness, were covered by regular staff so the service did not have to rely on agency workers. This meant care and support was consistently delivered by care staff who knew the people living at The Clough well. There was a low staff turnover, and many of the care and domiciliary staff had worked at The Clough for more than ten years.

When we last inspected The Clough we found that standards of infection control were not maintained. Following that inspection the service sent us an action plan to show how this issue would be addressed and we found at this inspection that improvements had been made. The service employed three domestic assistants which meant that a cleaner was on site each day, and a cleaning schedule ensured that no areas were missed. Staff we spoke with understood the importance of infection control measures, such as the use of colour coded cleaning equipment and the use of personal protective equipment such as tabards, vinyl gloves and other protective measures when handling food or completing personal care tasks and cleaning. Wearing such clothing protects staff and people using the service from the risk of cross infection during the delivery of care.

Staff had attended infection prevention and control training. One domestic assistant we spoke with demonstrated a sound knowledge of control of substances hazardous to health guidelines (COSHH), and we saw that where dangerous or hazardous equipment was stored, doors displayed warning signs and 'keep locked notices'. When we tried to open these doors, we found that they were locked. Communal bathrooms were clean and hygienic. We saw that toilets had posters detailing safe hand washing techniques, and that soap; paper towels, disposable aprons and hand gel were available, further reducing the risk of cross contamination. In the laundry, we saw that soiled items were appropriately washed separately from other items of clothing, preventing the risk of cross contamination.

We checked the kitchen and saw that it was clean, and that kitchen staff regularly monitored the fridge temperatures and stored food safely to prevent any risks of cross contamination or food wastage. The kitchen was awarded the highest food hygiene rating from the Food Standards Agency.

When we spoke with the regional manager they informed us that they encouraged staff to report any errors or mistakes, and we saw that accidents and incidents were reported and investigated. They also checked with other similar agencies to ensure mistakes made elsewhere were not repeated at The Clough, for example they told us that following a recent food poisoning outbreak at a similar home, they had completed a thorough check of food stores at the Clough, ensuring that food was stored appropriately and used in rotation, with the correct labelling, storage and dating of any opened food items.

Good

Is the service effective?

Our findings

Prior to their admission into The Clough, people received a full assessment of their needs by either the manager or a deputy manager with consideration of how their needs and wishes could be met. When we looked at care records we saw that they included the views of other people who may have been involved in care and support; records included any assessments completed by health and social care professionals such as social workers or occupational therapists. This information was then used to form an interim care plan so staff would understand the needs and wishes of the person and how best to meet these needs from the moment of admission. During our inspection one new person was admitted to the home. Staff took time to greet this person, introduce them to other people who used the service and orientate them to their new surroundings. We saw important information, such as dietary requirements, were passed to the appropriate staff to ensure their needs were met.

People who used the service received effective care and support from well trained and well supported staff. Discussions with the manager, observations and conversations with staff showed they had an in-depth knowledge and understanding of the needs of the people they were looking after.

Prior to working with people who used the service staff told us that they received training in essential aspects of the job, such as moving and handling, infection control, first aid, and food hygiene. They would then spend time working alongside a more experienced member of staff before they were allowed to work on their own. This enabled them to meet the people who used the service, understand their specific needs, and how best to respond. Staff new to care would undertake the care certificate. This is a nationally recognised qualification for people working in the caring sector which provides the essential knowledge to ensure new care workers have the required competence to care for people safely and effectively. At the time of our inspection nine care staff had completed this and a further fourteen staff had achieved a nationally recognised qualification in care.

Staff were expected to complete refresher training in all necessary aspects of their role on a yearly basis. This meant that they were aware of any changes to legislation and best practice, to ensure people received the safest possible care. Some of this training, including moving and handling, was completed face to face, but the majority of the training was though an e-learning system called e-learning for you (eLFY). This was designed to thoroughly test the knowledge of each member of staff. If staff failed their coursework twice, the manager was alerted and would follow this up through supervision and appropriate action. All staff received mandatory equality and diversity training renewed yearly to capture any updates in legislation, and to ensure they were aware of how best to meet religious, sexual or social needs in a way which reflected people's culture and beliefs.

We saw staff files included copies of certificates to demonstrate that they had attended any external training such as the local authority safeguarding awareness training, and included evidence of any training completed prior to starting work at The Clough, such as National Vocational Qualifications (NVQ) or Health and Social Care accredited qualifications.

Supervision meetings enable managers to formally feedback and record performance, and allow staff opportunity to speak in private about their training and support needs as well as being able to discuss any issues in relation to their work. The deputy managers provided regular 'on the job' oversight for care staff, but we saw that most staff members had not had a formal supervision session in the past year. However, we accepted that the manager was new in post, and they informed us that they were working through supervision for all staff. Since June 2018 eleven people had had a formal supervision meeting with the manager, and we saw notes which showed these included questions for staff to test knowledge and gather their opinion.

Prior to becoming a care home The Clough was a private mansion built by a mill owner and set in its own large gardens. Many of the original features remained, and the house was decorated in a style which matched the building and surrounding area. Old photographs of the building were on display in lounges, and the manager told us that she had asked relatives to bring in old photographs which could be enlarged and framed for display throughout the home. The structure of the building, however, reflected its age, and was in need of some repair. An electrical rewiring of the whole of the property had recently been completed; guttering and external fascia and window frames required attention. The carpet was in poor condition throughout the property. Some of this could be attributed to the recent electrical work where the carpets have been pulled up and then put back down with tape and nails. The manager informed us that the owner was aware of these issues which would be addressed. She showed us an action plan dealing with major repairs and ongoing maintenance work.

When we toured the building, we found that the design and adaptations suited the needs of the people who lived there. People's rooms were decorated and furnished to reflect their tastes and preferences, with personal belongings, including furniture and pictures. People were supported to choose their own decorations, curtains and bedding.

Two separate lounges, a dining room and a conservatory allowed for change of aspect and people were free to settle where they chose. The main lounge had been thoughtfully partitioned using furniture to make good use of space, avoid an 'institutionalised look' and allow for small private conversations or larger group activities. Appropriate signage was discreetly displayed to assist people with orientation around the building or to direct them to fire exits. New dementia friendly lighting had been fitted throughout all communal areas. We noticed that some bedrooms had a small poppy placed on the inside of their door. When we asked the manager about these we were told that this indicated to staff and any visiting health care professionals that the person had a DNAR in place. A DNAR form (do not attempt resuscitation) is a document issued and signed by a doctor, after discussion and agreement with the person or their representative, which advises medical teams not to attempt cardiopulmonary resuscitation.

The dining room was set in keeping with the environment and there was ample space to seat all the people who used it, either in tables of four or a larger table seating eight. We observed the lunch-time meal. Tables were nicely laid, with cups and saucers, condiments, and each displayed a menu of the day's choice of food. Lunchtime was a sociable, relaxed and happy occasion, with staff engaging well with residents. Meals were plated in the kitchen and served under cloches individually to each person.

All the people we spoke with told us they enjoyed the food provided. Comments included, "I particularly like the food," and, "The food is always very nice." One person told us they were partial to potato cakes, and informed us that they were always available at breakfast.

Attention was paid to diet and people were supported to eat and drink in a way that met their needs. Care records included an eating and drinking care plan and recorded that people were weighed monthly. We saw

that attention was paid to people's food and drink and people received a nutritionally balanced diet. The kitchen displayed information about specific dietary needs and the cooks understood the specific requirements needs and preferences of people living at The Clough. At the time of our inspection nobody required a diet in accordance with cultural or religious requirements. Where necessary, food and drink intake was monitored, and we saw hot and cold drinks were provided throughout the day. A 'bolero' machine, which dispensed fresh cold drinks, was available for people to help themselves to a cold drink to ensure that they remained well hydrated.

People had good access to healthcare and staff monitored their physical and mental health needs. Evidence in the case notes we reviewed showed liaison with district nurses, regular health checks and GP visits for example, to monitor skin integrity. We saw in care plans that people had regular access to other treatment such as dentist, optician and chiropody appointments. This meant that people were receiving care and support to access additional health care services to meet their specific health needs. One visiting relative told us that the staff were "on the ball" with healthcare, and were vigilant to any changes in a person's outlook.

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. The service had a detailed MCA policy and staff had been provided with training in this legislation and were able to feedback how they put it in practice.

When we spoke to staff, they were able to explain the best interests process. They were able to give examples of where they made decisions for people and where people were supported to make their own decisions. They were aware of the importance of asking people for consent before undertaking any care delivery.

We saw that people's care records had been signed by people who used the service where possible. The care files we looked at had individual capacity assessments for people's needs and this was reflected in people's care plans.

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 procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The service had an effective system for monitoring any applications and authorisations to ensure they were reviewed appropriately. When we inspected The Clough eight people were subject to authorised deprivations, and the registered manager kept a record of when the authorisations had been applied for, and when the service might need to seek renewal.

Capacity assessments were held on people's care files to demonstrate that a formal capacity assessment had been carried out before the DoLS application was made. Best interest meetings had been held to support the decision-making process for people who could not make decisions for themselves.

Good

Is the service caring?

Our findings

"I am very well looked after here," one person remarked. Other people told us, "The staff are very kind", and "all the staff are nice and helpful." One visiting relative said to us, "The staff are lovely, they really look after [my relative] Whatever they do, they do their upmost for [my relative]."

Throughout our inspection, we saw that people were treated with care and compassion by all the staff, who were without exception warm, friendly and open. We saw the maintenance officer and domestic assistants would stop and talk with people who used the service, showing patience and kindness, and staff had time to sit and talk with people who used the service. One told us, "This is what I like about my job, I have the chance to talk and listen to what people have to say." When giving people their medicines we observed staff were courteous and patient. As they offered medicines the senior care worker would sit with the person, explaining what the tablets were, and offering a drink to help wash them down. There were enough people on duty and staff were encouraged to spend time with the people who used the service. The regional manager showed us an electronic system being introduced to the service. This would enable staff to record information more efficiently and would then free staff up to spend more time on a one to one basis with the people they supported. When assistance was required we observed that people did not have to wait for long. Carers gave positive encouragement and support when assisting people to mobilise.

We observed care workers sitting quietly with people, making eye contact and chatting quietly, or sitting with groups and supporting conversations. All showed positive regard for people who used the service. We saw they responded to people's anxieties in a calm and measured fashion, helping to put them at their ease. For example, one person who was living with dementia became agitated. They said that they needed to get home, but a care worker reassured the person, letting them know their family knew where they were, and, "Besides, you wouldn't want to go out in this weather would you? Look, it's pouring down!" The person was reassured and responded, "Ooh, I'm glad you said that; I'll stop a bit longer."

Staff reflected a visible person-centred culture. A visiting relative observed that staff, "Treat all [people who use the service] as individuals; they know each and every one, and what they like or don't like". We saw staff respected people's wishes, beliefs and cultural needs, which were noted in care records. People told us that they were fully involved in the delivery of their care and support. One person told us, "Today I got up late; I fancied a lie in. They always give me a choice and leave me in peace if that's what I want."

We found examples where staff would go beyond what would normally be expected. For example, we saw the deputy manager had gone out to buy two bras for a person who used the service before coming to work. The person was 'happy that the trip was successful' and was pleased that the deputy had done this. A person new to the care home had stated to the maintenance officer that they would prefer a wooden toilet seat in their en-suite bathroom. Later that day we observed a new wooden seat had been fitted.

Relatives we spoke with also told us that they were made welcome when visiting the home. They told us that they could visit at any time. One visitor told us, "I like the feel of the place. The staff are always approachable and willing to help". We saw that staff knew people's relatives, addressed them by their preferred name and

were always welcoming.

We saw that people's personal belongings were treated with respect, and privacy was respected. For example, staff would knock on people's doors or ask for permission before they entered bedrooms. When one person moved into a new room the furniture was rearranged to allow greater privacy for when the door was open.

Information held about people, including all care records were securely stored in locked offices when not in use. This helped to protect the personal information held about people who used the service. Staff had access to the notes and we saw that they regularly consulted care plans and assessments to ensure that they were providing appropriate care and support.

Good

Is the service responsive?

Our findings

People told us that staff responded to their needs and provided them with support when they required it. One person said, "They leave me in peace but are always there when I need them. They're great; I love them all." The service supported people to maintain their lifestyle and considered their wishes. For example, one person had always enjoyed a glass of sherry in the afternoon and a whisky in the evening, but when a change in pain relief medication affected this habit, the service liaised with the person's general practitioner to amend the way pain relief was administered so that they could continue to enjoy their customary practice.

People told us that they were supported in the way they had agreed and that the staff knew what they liked and disliked. We saw they were asked about how they liked their care to be delivered and care plans documented any conversations with family members. The care records we looked at showed that people and their relatives had been consulted in drawing up and reviewing care plans.

Care records provided enough information about individuals to enable care staff to meet their needs. They reflected people's age, gender, sexuality and disability, recording any specific cultural or spiritual needs. Plans clearly documented what support people required with day to day living tasks such as eating meals or with personal care. When we spoke with one care worker, they told us that in conversation with people they might find out information about their past interests or hobbies, and that this would be added to their care records. However, plans of care were not always written in a way which reflected the person-centred way we saw care was delivered. The new manager acknowledged this, and informed us that the planned introduction of a new computerised system would allow for care records to be written in a way which put the person at the centre of their care and support.

Care plans were kept up to date and reviewed on a monthly basis. A social profile had been completed on admission which gathered background information and interests, and as new information was obtained about the person this was added to the social profile.

All the people who lived at The Clough had care and support needs, but staff recognised that this did not make them totally dependent and people were encouraged to do as much for themselves as they could. One care worker told us, "We are here to support, not to do for them." Abilities were acknowledged, and personal choice respected. Staff understood when people wanted assistance and were sensitive to each person's individual needs.

Visitors told us that the care staff had worked effectively to ensure their relatives' well-being. They told us that the staff were mindful of their needs, and vigilant to any changes in mood or appearance. We saw a compliment card which read, "My [relative] was resistant and in poor health when she came to The Clough. Your daily love, care and patience changed all that".

We asked people about any activities. One person told us, "We play a lot of games, I really enjoy those". Although the service did not employ an activity co-ordinator we saw some evidence of organised and

spontaneous group activities. A garden party had been planned for later in the month and an activities chart documented any planned activities. On the first day of our inspection we observed a care worker engaging with people who used the service and arranging a game of 'Family Fortunes'. This went down well with a high level of participation, and stimulated conversation and reminiscence. People told us that there was enough to do, and they were allowed to spend time in their own way. One person told us that they enjoyed sitting in the conservatory where it was quiet, and they could read a book, and another that they enjoyed looking onto the garden. They told us, "I like to sit by the window and look out at the garden. It's pretty. There are very nice flowers there." Another person who had been a keen gardener all their life was encouraged to help with the gardening. If people wanted, they could order a daily newspaper which would be delivered to them each morning.

Throughout our inspection we saw people enjoyed the attention of care staff either in one to one or small group conversations. People had formed friendships within the service, and staff demonstrated a good understanding of people's hobbies and interests.

People understood who they could go to if they had a complaint or were unhappy about something. A visiting relative said, "I have no complaints. I could approach anyone if I had a problem", and a person who lived at The Clough told us, "I can complain if needed. It's part of life. I have a leaflet about complaints". We saw the complaints policy was on display in the main entrance and a copy was left in each person's room. This told people how to complain, who to complain to and the timescales the service would respond to any concerns. This procedure included the contact details of other organisations including the local authority.

The manager maintained a monthly log of complaints which showed that there had been no complaints made between January and May, but two complaints had been made in June. The regional manager told us that following an audit of complaints in May they noted that no complaints had been received, so they publicised the complaint procedure. This then led to the new complaints being received. They told us that they viewed complaints as a positive opportunity to improve the quality of service delivery. We saw both complaints had been investigated, and appropriate action taken to remedy faults with a full response and apology as necessary to the complainant.

There was evidence that people's wishes for their end of life care had been considered. When we looked at care plans we saw that they included some information about how people would like to be supported at this time. Where appropriate a 'do not attempt resuscitation' form (DNAR) signed by the person's GP was kept at the front of the person's file.

We saw a number of thank you messages from relatives of people who had passed away at The Clough. One read, "Thanks to you… [our relative] was able to pass away peacefully and with us by their side", and another spoke of the support not only given to the person but to their family: "Thanks so much for being with me at [my relative's] end. It was a great comfort to me to remember the love and attention you gave not only to [my relative] but also to me".

Requires Improvement

Is the service well-led?

Our findings

It is a requirement under The Health and Social Care Act that the manager of a service like The Clough is registered with the Care Quality Commission. However when we visited the manager had only recently been appointed. An application to register with the CQC had been made in May 2018 and the registration process was underway.

When we asked, staff expressed confidence in the manager. They told us that she was approachable and would "Listen to what we have to say, take on board our issues and act on them".

The Clough had a statement of purpose and a vision statement which read "[We] put the residents at the heart of our service". We saw the service lived up to this claim, and offered a caring and supportive environment to the people who lived at the Clough. We read one recent compliment which stated, "[Our relative] settled into what was her home for ten years… The Clough is a family who have never let our family down". The service provided a peaceful environment where people appeared content, well cared for and never rushed.

There were systems in place to monitor the quality of the service. The provider and regional manager conducted regular audits and checks to look at the quality of care. During weekly 'Walk the Floor' checks they would speak to people who used the service, visiting relatives, and staff. Checks were made on environmental concerns, infection control, deployment of staff, and any other issues which might need addressing. Any concerns or issues were noted for action (for example, "Soiled pads in yellow bin: instructed staff to ensure bins are emptied after use"), and good practice was recorded: "[Relative] particularly thankful for support offered by all staff due to mother being end of life".

Regular Health and Safety audits conducted by the manager and maintenance officer checked the safety of the environment. Where issues were identified appropriate action was put in place. However, these had failed to identify that gas appliances had not been serviced for over a year.

Three monthly audits were undertaken by the manager on twelve separate areas of service delivery including falls, accidents and incidents, safeguarding concerns, pressure relief and medicines. These were checked by the regional manager, and action identified to improve the quality of the service. We saw that audits of medicines had highlighted errors in recording the administration of medicines, but during our inspection we found further repeat errors. We raised this issue with the manager and regional manager who agreed that further action would be taken to instruct staff on the safe administration and recording of medicines.

People using the service and their representatives were given the opportunity to give feedback. Each month six people would be asked to give feedback various aspects of their care and support, and the results analysed, with a 'You said we did' action plan to implement any changes.

The service had a business continuity plan which contained details of what needed to be done in the event

of an emergency or incident occurring such as a fire or utility failures. We saw the registered manager reported any incidents that affected the running of the service or involved people who used the service in line with our regulations.

We were informed that the home had recently successfully applied for a transformation grant from the local authority to improve the quality of the garden area.

The service had signed up to the Bolton Care Excellence scheme. This is a programme aimed at improving the quality of care for people who use the service by building on best practice and providing training opportunities for members to improve their knowledge and share best practice. The manager also worked closely with other care homes owned by the provider, and attended regular meetings within the region.

It is a requirement that each service registered with the CQC displays their current rating. We saw The Clough had displayed their rating in the main entrance to the home and the service displayed their rating in the home and on their website.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (1) (2)(g) : medicines were not managed properly or safely. Regulation 12 (1) (2) (d)(e) appliances and equipment had not always been serviced.