Amber Care (East Anglia) Ltd

# Clann House Residential Home

## Inspection report

Clann House
Clann Lane, Lanivet
Bodmin
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13 September 2019

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

About the service
Clann House is a residential care home providing personal care and accommodation for up to 34 predominantly older people. At the time of the inspection 28 people were living at the service. Accommodation is spread over two floors. Clann House is an older style property on the outskirts of Lanivet village.

People's experience of using this service and what we found
The service had been short staffed and was heavily dependent on a number of agencies to help fill gaps in the rota. There had been several occasions during the weeks preceding the inspection when there had not been enough staff to meet people's needs. Although the service was fully staffed on the day of the inspection we found care was task based and staff had little time to spend talking to people or engaging them in activities. When staff were supporting people they were gentle and reassuring in their approach.

Systems for managing medicines and ensuring people were supported in line with advice and guidance from external healthcare professionals were not robust. When monitoring records completed by staff indicated people's health was deteriorating action was not taken to address the issues.

Accidents and incidents were not consistently recorded or escalated to the provider, the local authority or CQC.

People did not have access to meaningful occupation. We observed some people spent their day disengaged and asleep or withdrawn. There were limited opportunities to go out on trips or drives. These were restricted to people who were independently mobile.

Records showed people had limited opportunities for baths or showers and oral care was not regularly completed.

Staff told us they received training and supervision and were well supported. However, they said the staff shortages had been 'stressful' and had impacted on the quality of care they were able to provide.

People's needs were assessed when they started using the service. Ongoing reviews and assessments were not consistently completed.

There was limited information about people's preferences for end of life care. Only a few staff had received training in this area. We have made a recommendation about this in the report.

There had been a lack of oversight of the service. The provider was based in a different part of the country. They had five other locations which were also some distance away. This meant the registered manager did not have access to peer support from other managers in the organisation. They told us they were well

supported by the area manager who visited regularly.  However, the systems in place to monitor the service and drive improvement had failed to identify and address shortcomings.

Following our previous inspection we issued positive conditions requiring the service to provide CQC with monthly reports to evidence they had completed audits into specific areas and describe any actions taken as a result of those audits. The areas covered were medicines, including stock management, premises and staff training. While we found improvements had been made to the premises and staff training was mainly up to date we remained concerned about the management of medicines. Other areas of the service had deteriorated since the previous inspection.

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

Rating at last inspection and update
The last rating for this service was requires improvement (last report published in June 2019) and we issued a positive condition as that was the second consecutive time the service had been rated requires improvement. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
This inspection was planned to follow up on action we told the provider to take at the last inspection. The inspection was brought forward due to concerns received about the management of pressure sores and low staffing. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the full report.

Since the inspection the provider has made arrangements for more robust oversight of the service. The service is working with external healthcare professionals and other agencies to try and make the necessary improvements.

Enforcement
We have identified breaches in relation to the management of medicines, keeping people safe from identified risks, infection control, learning from poor experiences and events, reporting concerns outside of the organisation, systems for auditing and monitoring the service, staffing and a lack of effective oversight of the service.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

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|---|---|
| **Is the service safe?**<br>The service was not safe | **Inadequate** |
| **Is the service effective?**<br>The service was not entirely effective | **Requires Improvement** |
| **Is the service caring?**<br>The service was not caring | **Inadequate** |
| **Is the service responsive?**<br>The service was not responsive | **Inadequate** |
| **Is the service well-led?**<br>The service was not well-led | **Inadequate** |

# Clann House Residential Home

**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. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

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

Service and service type
Clann House is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We reviewed information of concern we had received from the local safeguarding authority. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information

about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with seven people who used the service and two relatives about their experience of the care provided. We spoke with nine members of staff including the area manager, registered manager, care workers and the cook.

We reviewed a range of records. This included seven people's care records, DoLS authorisations and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at policies and procedures and an action plan developed in response to feedback from the inspection. We spoke with seven relatives and friends of people who lived at Clann House.

Inadequate

# Is the service safe?

## Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely

At our last inspection we found the management of medicines was not robust. Medicine Administration Records (MAR) showed a significant number of medicines were not in stock. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had not been made and the provider was still in breach of regulation 12.

- Following our previous inspection we had asked the provider to complete monthly audits in relation to medicines. Despite this action, which had described good management of medicines, we found they remained unsafe. The audits had failed to be effective in identifying failings in the management of medicines.
- People did not always receive their medicines as prescribed. For example, some people's prescribed medicines were not available. One person's prescribed pain killer and a medicine used to help manage a health condition had not been in stock for a period of ten days. There was not a clear record of ordering or returning medicines to the pharmacy.
- Some people were prescribed 'as required' medicines (PRN). Care plans included protocols detailing the circumstances in which these medicines should be used. However, one person did not have a MAR sheet for their PRN medicines and there were no records of when this was last given.
- A medicines audit in July 2019 had identified concerns with medicines that required stricter controls, which had not been addressed. Stock held did not tally with the records.
- The temperature of a refrigerator used to store medicines was monitored and recorded. The records showed the temperature had been below the recommended limit for a period of 12 consecutive days. No action had been taken to address this.
- The monthly action plan provided to CQC in line with the imposed conditions stated; "All staff who are responsible for administration of medication are to have yearly competencies as per company policy." However we found staff with this responsibility, whilst they had received training in administering medicines, not all of them had undertaken medicine competency checks to enable the registered manager to assess their abilities in this area.

The failure to oversee the safe administration and management of medicines meant people were at risk of harm and there was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● People were not fully protected from the risk of harm. CQC had received concerns about the care of people who were at risk of developing, or had developed, pressure sores. We looked at monitoring records and found people were not consistently supported in line with advice given by district nurses. This had led to some people developing pressure areas and inappropriate action being taken when people's health had deteriorated.

● When monitoring records were used to identify risks to people, these were not always used effectively. For example, one person who was weighed monthly, had lost nine kilograms in one month. We discussed this with a member of staff and the registered manager who both told us this must be due to staff not using the scales properly. However, the records showed this weight had been recorded consistently over a period of three months. No action had been taken to address or investigate the apparent weight loss.

● Risk assessments were not always in place to indicate when people were at risk of harm. This was particularly in relation to people whose behaviour could be difficult for staff to manage.

● Where risk assessments were in place they did not always guide staff on the action they could take to mitigate the risk. For example, there was no information on how to support people when they were distressed. This placed them and others at risk of inappropriate care.

The failure to identify and manage risk meant people were at risk of harm and there was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Environmental risk assessments had been completed. Equipment and facilities were regularly checked to make sure they were safe to use.

Preventing and controlling infection

● People were at risk of cross infection. At our previous inspection we noted there were no sluice facilities for the emptying, cleaning and disinfecting of commodes. This remained the case at this inspection. A steam cleaner had been purchased to use to clean the commodes. Staff told us they emptied commodes in toilets and the commodes were then steam cleaned. There were no systems to ensure this was done safely and regularly. For example, there were no cleaning schedules in place. The area manager told us they were exploring options for installing a sluice room.

● On the second day of the inspection we were told one person was on barrier nursing as they had a suspected infection. The persons door was ajar and there was no sign on the door to indicate there was a potential risk. The door did not have a number or name on it to help visitors identify the room.

● Shared bathrooms were equipped with hand gel dispensers, three of these were empty. One bathroom had no toilet roll available.

The failure to initiate robust infection control processes meant people were at risk of harm. This contributed to the continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People's rooms and shared areas were clean and there were no unpleasant odours.

● Staff had access to aprons and gloves to use when carrying out personal care.

Learning lessons when things go wrong

● Despite support and guidance from external healthcare professionals, people had continued to develop pressure areas.
● There was no system to review safeguarding incidents when things went wrong.
● Accidents and incidents were not consistently recorded. This meant there were limited opportunities to quickly identify patterns and trends and mitigate risk.

The failure to learn from untoward events meant people were at risk of harm. This contributed to the continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were not protected from the risk of abuse. When allegations of abuse had been raised these had been investigated internally but not reported to the local safeguarding authority, the police or CQC. This meant there was no independent oversight to ensure people were fully protected.
● For example, one person's care daily records showed the person had sustained bruising to the wrist. No body map or incident report had been completed. There was no evidence any action had been taken to identify the cause of the bruising.

The failure to protect people from the risk of abuse was a breach of Regulation 13 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service held people's personal monies for them. There were clear records of any expenditures and regular audits were completed.

Staffing and recruitment

At our last inspection the provider had failed to ensure staff were adequately trained. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although improvements had been made to training arrangements, staffing shortages meant people's needs had not been met and the provider remained in breach of regulation 18.

● There were not enough staff to support people according to their needs and preferences. The service had been short staffed and relied heavily on agency staff to cover rotas. Rotas for the two weeks preceding the inspection showed there had been several occasions when gaps in the rota had not been covered.
● Staff told us the staff shortages had been "stressful" and they had not always been able to support people according to their preferences. For example, people had not had baths and showers as frequently as normal, or in line with their personal preferences.
● Relatives told us they had noted the service was short staffed. Comments included; "They are very short though. Been rushing about quite a bit." The registered manager agreed; "It was difficult, and it is difficult."

The failure to ensure there were enough staff to meet people's needs at all times was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Recruitment systems were not robust. Employment histories had not been completed meaning the registered manager was unable to check any gaps in employment as required. Some staff had received poor references. This had not been followed up or extra checks made to help ensure staff were suitable for working in the care sector.

Systems to check staff were suitable to work in the service were not robust. This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 when this is in their best interests and legally authorised under the MCA. 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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Some people lacked capacity to make certain decisions. Capacity assessments had been completed and DoLS applications had been made appropriately.
- Conditions attached to DoLS authorisations were not always being met. For example, one person's authorisation stated the person should be; "..supported to be engaged with meaningful activities….and encouraged to participate in activities in and outside of Clann House." Records showed the person had only been out on one occasion in August. There were no records to show they had been given the opportunity to go out more frequently.
- Some people had been assessed as lacking capacity and then been asked to sign to consent to their care plans. The registered manager told us this had been identified as an area for improvement and care records were being updated.
- Care plans recorded when there were Power of Attorney arrangements in place. It was not always specified if the arrangements were in respect of finance and property or health and welfare.

The principles of the MCA had not been consistently adhered to. This contributed to the breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

● People had their health needs assessed before moving into Clann House or spending time there for respite care. Ongoing assessments were not routinely completed to help ensure people's needs were known and could still be met.
● Care was not delivered in a way which met people's preferences or considered their emotional or social needs. Assessments did not guide staff on how to care for people to help ensure their emotional well-being was supported.
● There was limited use of technology. People had call bells in their bedroom, some people did not have access to a call bell in their bathroom. There were no portable call devices available to support people to be independent.

People were not supported in line with their needs and preferences, this was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Before the inspection we had received concerns that staff were not following advice given by external healthcare professionals.
● During the inspection we found monitoring records were still not being consistently completed in line with the advice given.
● There was no evidence to show people were encouraged to live healthy lives. Activities did not include any form of exercise. People told us they did not use the large garden. During the inspection we saw people were often sleeping or disengaged.
● The registered manager and area manager told us there had been confusion about how people should be monitored and this was being addressed. Arrangements had been made for staff to receive additional training about caring for people's skin from the local tissue viability nurse.
● People told us they saw the GP when necessary. One person commented; "They get the doctor if I need one."

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

At our last inspection the provider had failed to ensure facilities in the premises met people's needs. This was a breach of regulation 15 (Premises) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 15.

● There was signage and decoration around the premises to suit the needs of people living with dementia.
● Improvements to the heating and hot water systems had been made since our previous inspection. A wet room had been fitted on the first floor.
● There was a small outdoor courtyard where people could spend time. A large garden was well maintained and very pleasant. Although the weather was sunny and warm we did not see people using this area at all. There were no seating areas available. One person told us he was "fed up just walking round and round the 'rabbit' garden."

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff were adequately trained. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although improvements had been made to training arrangements, staffing shortages meant the provider was still in breach of regulation 18 (see the safe section of this report).

● Staff told us they had completed an induction when the started work at Clann House. This included some training and a period of shadowing more experienced staff.
● Staff had received training in various subjects. This included moving and handling, safeguarding, health and safety and food hygiene. Training in areas relevant to meeting people's psychological and emotional needs was less widespread.
● Staff received regular supervisions and told us the registered and deputy managers were supportive.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us the food was pleasant and they were given choices about what they ate. Comments included; "The food is OK with enough choice", "The food is good; there's enough of it. I can't fault it" and "There are plenty of drinks and snacks."

Inadequate

# 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.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate. This meant people were not treated with compassion and there were breaches of dignity.

Ensuring people are well treated and supported; respecting equality and diversity

- Staff had little time to spend with people and care was very task based. People did not always receive support in a caring and compassionate manner. Two people were seated in a lounge which was on the far side of the building away from the main lounge and dining area. We checked on these people at various points and did not see any staff engaging with them or checking on their well-being.
- A call bell in the room was positioned on the wall and was not accessible to either person. We had to alert staff when we noted one person's foot had fallen from the supportive cushion used to minimise the risk of developing pressure sores. Staff passed the room at times and looked in. However, one of the people was sitting round the corner and was not easy to see.
- In the afternoon tea and biscuits had been left for one person. However, the tea had gone cold and the cup was full indicating the person had not been supported to drink it.
- People were not treated equally. At our last inspection we noted the service had a mobility vehicle but the ramp had broken so people who used wheelchairs were unable to use it. At this inspection we found the ramp had not been repaired. This meant people with restricted mobility did not have the same opportunities as others to access the local community.
- There was no evidence to show people's diverse needs were considered. Care plans entitled 'Expressing sexuality' did not refer to people's sexuality. They recorded information about whether people liked their hair and make-up done.
- Records showed people were infrequently supported to have showers or baths. People were not regularly supported with oral care.

Respecting and promoting people's privacy, dignity and independence

- Care was not delivered in a way which protected people's dignity. Language used in care records was not always respectful. One person's care plan described them as; "grumpy."
- One person used a specific covering to protect part of the body. Their care plan directed staff to wash this on a daily basis. Staff told us; "We wash it if it is dirty, he can wet himself, so it will need washing then."
- Relatives told us the lack of staff had led to care being very task based. One commented; "They are understaffed. They do their best but can't cover everything. Mum wants the toilet and she has to wait. I had to take her once when I was there she waited so long, I got in to trouble for doing that. I have had to leave her to go home before now and she is still waiting to go to the toilet. They say it is not her time, they seem to have set times to take them, like when she goes to bed and that."
- Another relative told us they had visited their family member and found them wearing clothes which

didn't belong to them. They told us; "I did not recognise any of the clothes she had on or in her cupboards."

People were not supported in line with their needs and preferences, this contributed to the breach of Regulation 9 (Person-centred care) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

- Records were kept securely and people's confidential information was protected.
- When supporting people with personal care, staff were supportive and encouraging in their approach.

Supporting people to express their views and be involved in making decisions about their care
- People were not consistently supported to be involved in decisions about their care. One person told us they were not allowed to go into the main garden. We discussed this with the registered manager who told us this was not the case. However, the person's records did not show they had been supported to use the garden.
- People were asked for their views on some day to day events such as choosing meals.

Inadequate

# Is the service responsive?

## Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to inadequate: This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Most people had care plans in place to enable staff to meet their needs. One person had no care plan in place although they had been living at Clann House since June 2019.
- Other care plans were not consistently updated to reflect changes in people's needs. For example, one person's care plan stated they took a medicine 'as required' to help manage their anxieties. Since the care plan had been developed the prescription had changed and the person was now taking the medicine daily. When routines were important to people this was not recorded to help ensure consistent staff approaches.
- One person had mental health needs, their care plan did not guide staff on how best to support the person. Staff told us they had strategies to help calm the person but these were not always successful. The lack of guidance did not help ensure a consistent approach to supporting the person when they were distressed.
- Monitoring records were in place to show when people had received care. For example, records of oral care and turn charts to record when people were turned in line with advice to protect them from the risk of skin breakdown. These records were not consistently completed. Therefore we could not be sure people were receiving care and support in line with care plans and professionals advice.
- Daily records were kept to record the care people had received. These were very task based with little information about people's emotional well-being.

The failure to keep accurate and up to date records of people's individual needs and care received was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carer's.

- There was limited information about people's communication needs. What information there was had not been flagged to ensure it would be shared with other professionals when necessary. For example, hospital passports contained no details about people's communication needs.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

●There was very little evidence that people were meaningfully occupied. An activity co-ordinator was employed four days a week and was present on the first day of the inspection. They supported a few people to do some art and crafts.

● On both days of the inspection we saw some people who spent large periods of the day sitting alone, withdrawn or asleep with limited engagement from staff.

● One person's activity log had not been completed since 22 August 2019 when it stated; "Today we listened to some music."

● There was no evidence of any community links. The registered manager told us people rarely visited the nearby village. The drive down to the road was uneven and not suitable for people with restricted mobility. The shortage of staff and lack of suitable transport meant there were few opportunities to support people to go out.

People's interests and preferences were not taken into account when planning their care, this contributed to the breach of Regulation 9 (Person-centred care) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● The registered manager told us they were looking to recruit another activities co-ordinator to provide additional support.

Improving care quality in response to complaints or concerns

● Complaints were recorded. However, as noted in the safe section of this report action to follow up complaints was not effective.

End of life care and support

● Only a few staff had received training in end of life care.

● Information in care plans about how people wanted to be supported at this time of their lives was limited. There were no records to indicate any discussions had taken place with people or their loved ones to capture this information.

We recommend the provider seek advice and guidance on developing meaningful end of life care plans and supporting staff to deliver care during this time.

Inadequate

# 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.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● As reported in the 'safe' section of this report, the registered manager had failed to report significant events to either the local authority, the police or CQC. It is important CQC are notified of specific events to enable effective monitoring of services.

The failure to notify CQC of significant incidents was a breach of regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

At our last inspection we found quality and audit systems were not effective. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found improvements had not been made and the provider was still in breach of regulation 17.

● There was a lack of effective oversight from the provider. The provider was based in another part of the country and had limited contact with the service. The area manager visited monthly but this had not been sufficient to identify and address the problems identified in this report.
● Following our previous inspection we had imposed conditions on the provider requiring them to submit monthly reports to evidence they were regularly auditing the service. Although this had been adhered to the audits had not identified the issues raised in this report. For example, the providers action plan stated; "Manager has put in place a procedure to allow staff to check balances [of medicines] and ensure that any shortfalls are addressed quickly." We found one person had ran out of some medicines and another was about to run out. Although this had been identified no action had been taken to address the shortfall in a timely manner.
● The provider had not ensured they had fully understood their role and responsibilities as provider or taken sufficient action to monitor and improve the service. The provider had not always learned from experience to ensure the service improved. They had not monitored the culture of the service against any clearly defined aims or values.
● Systems to mitigate risk were not well established. For example, charts to show staff had checked pressure

mattresses were set appropriately were in place and had been completed. However, there was not always relevant information available about people's weights to ensure the checks were meaningful.
● The provider did not promote a positive person-centred culture. Care was task based and staff had little time to spend talking with people. During the inspection we saw people were not occupied and were sometimes distressed.
● One person approached us for reassurance and we alerted a member of staff. They were obviously pre-occupied with a task and told us; "Oh yes, that's what she does."
● Following the inspection the area manager told us they had arranged for various registered managers from one of the providers other locations to visit Clann House on a weekly basis to support the registered manager. However, given the distance between the services, the number of concerns identified and the lack of consistent managerial support we remain concerned about the arrangements for overseeing the service.

Continuous learning and improving care
● Audits and monitoring checks were completed by the registered manager and the area manager. However, these had not picked up all the issues raised in this report.
● When issues were highlighted it was not always clear what, if any, action had been taken to address them.
● This will be the third consecutive time the provider has been found to be in breach of the regulations. Following our previous inspection we imposed a condition requiring the provider to complete monthly audits. We are concerned the action taken has not supported an improvement in the service.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Although the service was situated just outside a village with a school and church there was no evidence of any community links.
● Communication between the staff team had not been effective. Staff were not always clear of the advice and guidance which had been given by external healthcare professionals.

Actions to assess, monitor and improve people's experiences of the service had not been effective, this was a continued breach of Regulation 17 (Good governance) of the Health and Social Care Act (Regulated Activities) Regulations 2014.

● Staff meetings took place and these were used as an opportunity to discuss individual concerns.
● People and relatives were asked for their views of the service in an annual survey. An occasional newsletter was produced to update stakeholders on any developments or news stories.

Working in partnership with others
● Concerns had been raised by external healthcare professionals about the risks to people's health and well-being. Despite guidance and support from external healthcare professionals, the risks were not being effectively managed.
● Since the concerns had been raised action was being taken by senior management, to help ensure the service worked closer with other agencies to improve people's experiences.
● Following our inspection the area manager provided an action plan to show how they intended to drive improvement.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager communicated with relatives and kept them informed when they had concerns.

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 18 Registration Regulations 2009 Notifications of other incidents<br><br>CQC had not been notified of all relevant incidents (1) |

**The enforcement action we took:**

We issued a notice of decision to remove the location from the providers registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>People's needs and preferences were not taken into account when planning and delivering care. (1)(a)(b)(c) |

**The enforcement action we took:**

We issued a notice of decision to remove the location from the providers registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>Risks were not assessed and action taken to mitigate risk. Systems for the management of medicines were not robust. Processes to protect people from the spread of infections were not sufficiently embedded. (1)(2) (a)(b)(f)(g)(h) |

**The enforcement action we took:**

We issued a notice of decision to remove the location from the providers registration.

| 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<br><br>Systems and processes were not established or operated effectively to protect people from the risk of abuse. (1)(2) |

**The enforcement action we took:**

We issued a notice of decision to remove the location from the providers registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>Systems to assess, monitor and improve the quality of the service were not robust. Auditing systems were ineffective. (1)(2) (a)(b) |

**The enforcement action we took:**

We issued a notice of decision to remove the location from the providers registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>Recruitment processes were not operated effectively. Information specified in Schedule 3 was not available for all staff. (1) (a) (3) (a) |

**The enforcement action we took:**

We issued a notice of decision to remove the location from the providers registration.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>There were not sufficient numbers of staff deployed. (1) |

**The enforcement action we took:**

We issued a notice of decision to remove the location from the providers registration.