Clarence Lodge (Great Yarmouth) Limited

Clarence Lodge

Inspection report

49-50 Clarence Road
Gorleston
Great Yarmouth
Norfolk
NR31 6DR

Tel: 01493662486

Date of inspection visit:
17 October 2019

Date of publication:
12 December 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Clarence Lodge is a residential home registered to provide accommodation and personal care to a maximum of 28 people. At the time of our inspection, 11 older people were living there, some of whom were living with dementia. The home accommodates people across a ground, first and second floor.

People's experience of using this service and what we found
Most of the people we spoke with were accepting of the service provided to them. Some told us the approach of staff could be improved, and that sometimes they had to wait for a response from staff when they needed support.

This is the fifth consecutive inspection that this service will be rated inadequate overall.

Risks to people were not always assessed and managed in a way which ensured people's safety. Actions had not always been taken to minimise risks. This put people at risk of injury or their health deteriorating.

There were not always sufficient staff with suitable skills, knowledge and experience deployed to meet the needs of people. The provider had not ensured that staff received the training they needed to be able to support people effectively, based on people's needs. Staff recruitment checks were still not sufficiently robust to ensure staff were suitable to work with vulnerable older people.

Each person had a care plan in place although there was not always sufficient detail to guide staff. Some care plans contained inaccuracies and contradictory information. Some areas of people's care hadn't been planned to reduce risk, such as risks associated with urinary tract infections and environmental risks.

The provider's systems for monitoring and improving the quality of the service had not been effective, because people were not always receiving a good quality of service and some risks had not been mitigated. This placed people at continued risk of harm.

There was a poor understanding of what constituted a safeguarding concern. Three incidents had not been reported to the local authority or CQC, which placed people at on-going risk of harm. This also meant there was no independent oversight to ensure people were fully protected.

Further improvements were still needed to ensure the views of relevant people were sought where people lacked capacity to consent. Though best interest decisions were in place for some people, not all aspects of their care were considered fully. For example, environmental risks.

There had been improvements in medicines management, but it was unclear whether the service could sustain these improvements, given only four staff were trained to administer medicines.

There was improved recording of people's participation in activities. However, we were still not assured that the provision of activity was meeting individual and specialist needs.

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 inadequate (published 7 October 2019) and there were multiple breaches of regulation. At this inspection we found that sufficient improvements had not been made, and the provider remained in breach of six regulations. We also found two new breaches in relation to reporting procedures and safeguarding people from the risk of abuse.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 21 August 2019. Breaches of legal requirements were found in relation to safe care and treatment, governance, nutrition and hydration, person centred care, recruitment, and staffing.

We undertook this focused inspection to check they had now met legal requirements. This report only covers our findings in relation to the key questions of safe, effective, responsive, and well-led which contain those requirements.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service is inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Clarence Lodge on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, reporting procedures, governance, staffing, nutrition and hydration, safeguarding people from the risk of abuse, and person-centred care.

CQC used its powers to keep people safe, and a Notice of Proposal to cancel the Registered Providers registration was sent to the Registered Provider on 11 December 2018. On 19 February 2019 the Notice of Decision was sent to the provider advising that we had decided to adopt the proposal to cancel registration.

The provider appealed against this decision to the First Tier Tribunal (Care Standards) under section 32 (1) (b) of the Health and Social Care Act 2008. The appeal hearing was held on 29, 30 and 31 October 2019, and the decision was made that CQC's action "was (and remains) lawful, fair, reasonable and proportionate." The appeal was dismissed by the tribunal judge. This means that the provider can no longer provide any regulated activities and the service is closed.

Just prior to the tribunal hearing the local authority took action to ensure that all people living in the service were supported to move to alternative accommodation.

This service is therefore no longer in operation.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not safe Details are in our safe findings below	**Inadequate**
Is the service effective? The service was not effective Details are in our effective findings below.	**Inadequate**
Is the service responsive? The service was not always responsive Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led Details are in our well-led findings below	**Inadequate**

Clarence Lodge

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
One inspector, one inspection manager, and one Expert by Experience carried out this inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

The service did not have a manager registered with the Care Quality Commission. Registered managers and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The service had a new manager who had been in post since July 2019. They had applied to be registered with the Care Quality Commission, and this was still in progress.

Clarence Lodge 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.

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 used all of this information to plan our inspection.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make.

We used all of this information to plan our inspection.

During the inspection
We spoke with 10 people who used the service, and one relative about their experience of the care provided. We carried out observations of people receiving support and staff interactions. We spoke with the manager, provider, and three members of care staff who worked at the service. We
looked at six care records in relation to people who used the service. This included medicines records. We also looked at three staff files, as well as records relating to the management of the service, and systems for monitoring quality.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We spoke with two professionals who regularly visit the service.

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 inadequate. At this inspection this key question has remained the same. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

At our last inspection the provider had failed to ensure that risks to people were managed effectively. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● The service was not managing actual and potential risks to people robustly. This related to risks associated with prevention of urinary tract infections, constipation, monitoring of blood pressures, environmental risks affecting residents, and physical altercations between residents.
● One person had recently been admitted to hospital for constipation. There was no risk assessment in relation to constipation. No medical advice had been sought when the person had not had a bowel movement for four days.
● Records showed that one person had got stuck between floors when using the passenger lift. The person had also grazed their hand on the door. The person had periods where they were confused and distressed, and therefore using the lift posed a significant risk. This risk had not been assessed despite two incidents occurring.
●There was no risk assessment in place for a person who had recurrent urine infections and this was also not referred to in their care plan. Their risk assessment for nutrition and hydration provided no detail about fluid intake targets and did not take into account the risk of urine infections.
● A district nurse had advised that one person should have their blood pressure monitored at least weekly. Their records showed this had not occurred despite the person suffering with high blood pressure and was at risk.
● Where incidents were recorded on 'behaviour' records, these were not always dated or timed, which helps to identify patterns, and inform external professionals of people's presentation and how best to support them.
● We observed that one person became unwell during our visit. Paramedics attended and concluded the person could remain in the service. When we checked on the person later in the day, we found their call bell to be out of reach, as well as their drink. Given the person had been unwell, it was very important they had access to their call bell to provide them with assurance that help was nearby if they became unwell again.

Staffing and recruitment
At our last inspection the provider had failed to ensure staffing levels were adequate to meet people's

needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● The provider had not ensured enough appropriately skilled staff were deployed at all times. 10 staff had not completed training in behaviour which challenged, and there were people living in the service who experienced regular periods of distress, which included physical violence.
● Four staff working in the service had left suddenly. One new staff member had only worked in the service for one week and was still on their induction but was counted as a member of staff on shift.
● Care staff on the late shift covered food preparation at tea time. The cook only worked until 2pm on some weeks and 4.30pm on others. This meant that care staff providing direct care to people was reduced whilst hot food was prepared.
● Monthly incident records stated that staff should observe people in the lounge and dining areas at all times. We saw this was not adhered to.
● People continued to tell us they had to wait for assistance. One person said, "They can be a bit slow in coming to help you when you call, but they do have a lot of other people to look after. I like to go to bed at 7pm and so I tell them I want to go at 6.30pm so I know they'll come for me then. I ring the bell in the morning and it's often a while before they come, but they do have a lot of people to get up". Another said, "If they're at the top of the house you have to wait for them. They do apologise when they're late."
● The layout of the building further impacted on staff's ability to respond promptly. A relative told us, "I come in every day in the morning and the evening. There are times in the evening when I've been here when there are no carers in the lounge because they're all upstairs helping people."

At our last inspection the provider had failed to ensure that robust recruitment checks were in place. This was a breach of regulation 19 (Fit and proper person's employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection, the provider remains in breach of regulation 19.

● We continued to identify gaps in employment histories, issues with reference checks, and documentation which showed a previous employer had not been declared in their work history which had not been picked up by the provider.
● Not having robust procedures in place when recruiting new staff posed a risk to people and some new staff were working night shifts, which would mean less oversight of their practice.

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 or CQC. This meant there was no independent oversight to ensure people were fully protected.
● The manager had failed to report three incidents which had occurred in the service. Incidents included unsafe repositioning of a person, unexplained bruising, and an altercation between two people.

This constituted a breach of regulation 13 (Safeguarding service users from risk of abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider had failed to ensure medicines were managed and administered safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although further improvement is needed, enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

● Medicines management had improved, and daily and weekly audits were in place. However, we found some errors with one person not receiving one medicine on three consecutive days, and not having topical cream applied on five occasions.
● The staff member responsible for medicines told us that errors occurred at the weekend when they were not around to check the medicines.
● There were only five staff members trained to administer medicines and no staff could administer medicines at night. There was an on call system in place at night, whereby a staff member was contacted to come in if needed. However, this arrangement could cause a delay in people receiving their medicines.

Learning lessons when things go wrong
● The provider had failed to ensure lessons were learnt and are subsequently still in breach of regulations. They had not ensured lessons were learnt following accidents and incidents to reduce the risk of recurrence.

Preventing and controlling infection
● Infection control was not reviewed during this inspection.

Inadequate

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 deteriorated to Inadequate.This meant there were shortfalls in people's care, support and outcomes.

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

At our last inspection the provider had failed to ensure people's nutritional and hydration needs were being met. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 14.

● People were still not receiving food in line with their assessed needs. Where care plans stated that people should receive a healthy balanced diet containing lots of fresh fruit and vegetables, food charts did not always evidence this was being adhered to. One person told us, "We don't get fresh vegetables. The food's alright, but it should be more varied."
● Snacks mainly consisted of cakes and biscuits, and in some cases there were long gaps between the tea time meal and breakfast. This could cause blood sugar levels to become unstable. We found this to be a concern at the previous inspection.
● Staff did not always ensure that people were offered nutritious food, for example, at approximately 11.30am we observed one person sitting in the dining room. We heard one carer ask another if they could make sure they had something to eat before returning to bed. We later looked at their food charts and the person had been given four biscuits.
● There was also no consideration as to suitable intervals between meals for those who had a late breakfast. One person was given breakfast late in the morning, they remained at the dining table until lunch was served when they were given sausages and mash. This was very soon after their breakfast and consequently they did not eat all of the meal.

Staff support: induction, training, skills and experience
● Our previous two inspection reports had identified concerns with staff completing training. On both occasions the provider had given assurances that this would be addressed, and staff would receive training. However, at this inspection we found that staff had not always received the required training to ensure people were cared for by a skilled workforce.
● The training matrix showed that 10 staff had not completed training in behaviour which challenged, and there were people living in the service who experienced regular periods of distress, which included physical violence. Eight staff were overdue their training in moving and handling, and six staff were overdue

safeguarding training. It was not clear if some staff had ever undertaken safeguarding training as the matrix was blank for three staff.
● For one person employed to cover night shifts there was no evidence of induction training. There was also no evidence of supervision being carried out post induction.
● Staff were still not receiving regular supervision sessions to ensure training needs were identified and that they were working effectively.

This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (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
● External professionals we spoke with were not always confident the service would follow guidance they had recommended. Where people were not always compliant with treatment, relevant professionals had not always been advised in a timely manner.
● We found evidence there was a lack of timely action seeking medical assistance when needed for one person who was experiencing blood in their urine, and the person had a history of urinary tract infections.
● People's oral health was assessed. Records listed people's oral healthcare needs, which included if they wore dentures, and how they liked their oral hygiene attended to.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were not always holistically assessed. For example, where people experienced urine infections or constipation, there was not always sufficient guidance in place to prevent the risks as far as possible.
● The service had not ensured guidance was being followed, for example, with people's dietary needs.

Adapting service, design, decoration to meet people's needs
● At our previous inspection in August 2019, we reported that improvements were required to ensure that good practice in dementia care was being followed, such as designing and decorating premises in a way that supports people. For example, doors, seats, and handrails being in a contrasting colour.
● We did not find any improvements in relation to this. Further, the provider did not consider the service to be in need of improvement. This demonstrates a lack of knowledge in relation to best practice guidance for people living with dementia or a visual impairment.

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.

● There was a mental capacity matrix' in place which recorded the number of DoLS applications which were pending and authorised. There was one authorised DoLS in place.

● At the last inspection we reported that best interests decisions were in place for several aspects of people's care, however, in most cases the decisions were made by the manager, care home consultant, and provider. We did not see any involvement from family members.

● At this inspection we saw the manager had added a page to say that the next of kin had given verbal consent by phone to support historical best interests decisions. However, there was no explanation as to which best interests decisions were discussed to ensure people's family members were included fully.

Requires Improvement

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 requires improvement. At this inspection this key question has remained the same. This meant people's needs were not always met.

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

At our last inspection we found the provider in breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 9.

● We reviewed care plans and found the issues identified at the August 2019 inspection persisted. This included a lack of guidance where risks existed, gaps in records, and inaccuracies in care plans and risk assessments.
● Care plans did not always cover people's needs in sufficient detail for staff to be able to deliver effective care. Some information was contradictory, for example, how often people should be weighed.
● Records did not always evidence that people's personal care needs were met. Records for one person showed a gap of six days when no bed bath had been carried out, and other gaps of three days.
● The recording of people's participation in activity had improved. However, we were still not assured that individual and specialist needs were being met.
● At 10 am there were seven people sitting in the lounge; one was playing cards with a carer; one was playing skittles and throwing balloons with the provider. Other people were watching television or sleeping. By 10.45am skittles and card games had finished and by 11am all people were asleep apart from one person who commented, "They're always asleep in here."
● In the afternoon a volunteer engaged with each person and all appeared to be enjoying the session. A person spoken with in the morning about the activities said, "We now have a man come in on Thursday and Friday to do music and bingo. I like it, it's a bit of fun." Another said, "I like playing skittles and I do love the bingo. I do get out sometimes, but not enough really."
● An activity schedule was still not displayed in the service so people knew what was happening each day.

End of life care and support
● People's end of life wishes were better reflected in some cases, and relatives had been sent these plans to complete. However, some people still had no preferences recorded, and had been living in the service for a significant period of time.

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 carers.

● People's care plans included a section on the most effective methods of communication. This took account of people's sensory needs, such as wearing glasses or hearing aids.

● Information in written form could be provided in large print if required for people with a visual impairment.

Improving care quality in response to complaints or concerns

● Specific complaints were not reviewed during this inspection. However, the service had a complaints procedure in place if people wished to raise a concern. One person told us, "If I had a problem I'd talk to [manager]."

● Members of the public had complained directly to the CQC about the poor quality of care, and their concerns for the welfare of people living at Clarence Lodge.

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 inadequate. At this inspection this key question has remained the same. 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; 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

At our last inspection we found the provider had been unable to make sufficient improvements to comply with Regulations and implement a robust governance system. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although systems were in place to improve governance of the service, not enough improvement had been made at this inspection and the provider remains in breach of regulation 17.

- Despite the issues being identified in August 2019 the provider had not resolved all of the breaches from the last inspection and new issues had also emerged. The systemic failings outlined in this report demonstrated the provider had failed to ensure people received a well-managed service which was safe and compassionate; placing people at risk of potential harm.
- Effective systems were not in operation to assess and improve the quality of the service and people continued to receive an unsafe service. Audits had been completed to monitor the quality of the service, but these had not identified and resolved the multiple shortfalls we found.
- A culture of high quality, person-centred care which valued and respected people was not embedded within the service. This was evident by the breaches of regulation identified during this inspection. This will be the fifth consecutive inspection with an overall rating of inadequate. The provider has never achieved a rating of 'Good'.
- Improvements that had been made, such as the management of people's medicines, was due to one staff member who had dedicated time to improving this. However, even they concluded that when they were not working in the service there was a risk of errors. We did not have confidence that the improvements would be sustained, and only five staff were trained in medicines management.
- People were not protected from the risk of abuse. As reported in the 'safe' section of this report, when allegations of abuse had been raised these had not been reported to the local authority or CQC. This meant there was no independent oversight to ensure people were fully protected.

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.

● The concerns in relation to poor reporting procedures were compounded by the fact that the provider and manager had not identified these incidents as safeguarding concerns. This demonstrated that the manager and provider did not have a sufficient understanding of regulatory requirements and their responsibilities as registered persons.
● The manager informed us during the inspection that a recent audit of the service was carried out by the local authority who informed them that they had made some improvements. We were later informed by the local authority that the outcome of their audit was 'poor'. This does not demonstrate an open and transparent approach.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People living at the service did not always benefit from a caring culture. For example, where people had come to harm, reduction of risk was not always explored.
● We asked people their views on the staff. One person said, "I think the staff are alright although there's been a lot who's left. The new ones talk to you properly. I need them to help me wash and they seem to know what they're doing. I prefer the male carers; they're more tender when they're helping you." Another said, "Best not to say; some are good, some are not."
● For those people living with dementia there was no evidence of the service sourcing regular feedback, for example, through the use of advocacy services.
● Four resident surveys were recently completed. Comments were now documented, and a timeline for actions, some of which we saw were completed.
● Staff we spoke with felt things were improving slowly. However, at least four staff had left the service recently and did not work their notice.

Continuous learning and improving care
● Effective systems were not in operation to support a culture of learning and improvement. The provider had not ensured that its workforce was adequately trained and skilled to work with vulnerable older people, many of whom were living with complex needs.

Working in partnership with others
● The service had worked with the local authority and healthcare professionals such as district nurses and dietitians.
● Feedback from external professionals about working with the provider and manager was negative. Some told us they found the new manager 'evasive' when they tried to arrange meetings to discuss people's needs.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified us in a timely manner of incidents that had occurred in the service. 18 (1) (e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment The provider had not reported, without delay, potential safeguarding concerns to the local authority or CQC 13 (1) (2)