Cephas Care Limited

Clarence House Care Home

Inspection report

40 Sea View Road
Mundesley
Norwich
Norfolk
NR11 8DJ

Tel: 01263721490

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Clarence House Care Home is a residential care home providing personal care to up to 41 older people, some of who are living with dementia. There were 21 people living at the service at the time of the inspection visit.

People's experience of using this service and what we found
People were not receiving consistently safe standards of care, from sufficient levels of staff with the necessary skills and attributes to provide good care. The condition of the care environment was poor, people were not being protected from accessing risk items and areas of risk within the service, and we identified areas of concern in relation to infection prevention and control practices. People were raising concerns with staff and members of the management team for example in relation to their medicines, and these were not being acted on. People raised concerns with inspectors, which resulted in onward referrals being made to the local authority safeguarding team. We received some additional concerns from speaking with people's relatives.

Timely action was not being taken to address risks, concerns and shortfalls identified through checks and audits completed by members of the management team. This did not ensure people were protected from harm, or that they were receiving consistent standards of care and support. In the absence of a registered manager at the service, the registered provider holds accountability for the safe running of the service.

Rating at last inspection (and update)
The last rating for this service was Inadequate with breaches of regulation relating to safe care and treatment, staffing and the governance and oversight of the service including in the submission of notifications to CQC. (Published 26 November 2020). At this inspection enough improvement had not been made and the provider was still in breach of regulations and remained placed in special measures.

Why we inspected
We carried out an unannounced focused inspection of this service on 01 October 2020. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, staffing, good governance and submission of notifications to CQC.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe 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 has changed remained 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 House Care Home on our website at www.cqc.org.uk.
We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified repeated breaches in relation to safe care and treatment, staffing and the governance and oversight of the service. We also identified a breach in relation to protecting people from risks abuse and harm at this inspection.

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

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The overall rating for this service remains 'Inadequate' and the service remains 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.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Clarence House Care 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.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
Consisted of two inspectors.

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

The service had a manager in post, but they were not registered with the Care Quality Commission. For the purposes of the report, they will be referred to as the manager. This means that the provider is 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
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 took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about. We liaised with third party stakeholders, including local social care services before the inspection site visit. We used all this information to plan our inspection.

During the inspection
We spoke with five people living at the service, the regional manager and manager, a contractor, head of maintenance and a member of the housekeeping team. We observed care and support provided in communal areas. We looked at six people's care and support records and six people's medicine records, as well as a sample of medicines. We looked at staff files as well as records relating to the management of the service, recruitment, policies, training and systems for monitoring quality.

After the inspection
We completed telephone interviews with five people's relatives and nine members of care and domestic staff. We liaised with the local health and social care services including a social care professional. We also requested further information and clarification from the provider. Final inspection feedback was provided virtually on 25 March 2021. This meeting was attended by the manager, regional manager and members of the provider team, including the nominated individual.

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 we found the provider failed to assess the risk to the health and safety of service users. They had failed to do all that was reasonably practical to mitigate risks. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider remained in breach of regulation 12.

- The gaps and inconsistencies we found in some people's care records meant we could not be confident they received the care they needed to keep them safe. For example, there were gaps in people's repositioning charts putting them at risk of developing pressure ulcers. Choking risk assessments were not fully completed impacting on the overall risk scores. Inconsistencies in the recording of people's dietary needs meant staff did not have accurate and consistent information to provide the safe and appropriate care people needed. This put people at risk of harm.
- The provider's records identified concerns with the compatibility of beds and safety rails in place, and we identified a recent incident where a person had experienced a skin injury linked to bed equipment. Insufficient action was being taken to address these risks to maintain people's safety once identified.
- The provider had not overseen the standards of legionella water safety checks being completed across the home, with a lack of de-scaling noted on taps in people's bedrooms, the corresponding documentation didn't include checks of de-scaling.
- The provider had not carried out a fire drill since November 2020, when concerns around staff performance and response times had been identified. There had been no further drills completed, this did not ensure staff knew how to support people in the event of an emergency such as a fire.
- Inspectors found unlocked bedrooms not in use, that were full of large items of unsecured furniture, which posed a risk to people and staff safety. Most communal bathrooms were not accessible due to being full of pieces of equipment.
- Inspectors found many doors with signs asking staff to ensure the doors were kept closed to prevent access to risk items such as very hot water and cleaning chemicals. These doors were unlocked across all three floors of the service, giving people access to recognised risks. Staff also left unsecured risk items such as teeth cleaning tablets in communal bathrooms and one person's own bedroom, with no risk management plans in place.

Risks relating to the health and welfare of people were not fully assessed and managed. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008

(Regulated Activities) Regulations 2014.

● After the inspection site visit, the provider gave written assurances that rooms were now locked and risk assessed. They had also implemented designated equipment rooms.

Using medicines safely

At our last inspection we found the provider did not ensure the proper and safe management of medicines. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider remained in breach of regulation 12.

● Staff had left unsecured, prescribed creams in most people's bedrooms and bathrooms. The provider sent us a generic risk assessment; however, this did not address our concerns as these items needed to be individually risk assessed and where appropriate, locked away. These items posed a particular risk of ingestion to those people living with dementia placing them at risk of harm.
● Where people applied their own creams, corresponding risk assessments were not in place to ensure this was completed safely, with oversight from staff. For people supported with skin creams, staff were not consistently completing their records.
● One person was regularly refusing medicines, and the manager gave assurances that they sourced advice and guidance from the GP. However, the guidance sourced was not reflected in the person's medicines management care plan, which had not been reviewed since December 2020.
● An incident form identified staff gave one person their medicine, the person refused to take the tablet then refused to give it back to the staff member. Staff were unsure if the person had taken the tablet or not. This posed a risk as this medicine was unaccounted for. The person's care plan lacked guidance on what staff needed to do if this happened again.
● Staff completed individual conversations with people to source their feedback on care provision, for one person they told staff the week before our inspection that their time specific medicines were often late. This feedback was also given to inspectors, therefore did not assure us action was being taken to address this risk, even when the person had brought this to the attention of staff.
● One person told inspectors staff had refused to give them pain relief when requested. This concern was referred to the local authority safeguarding team for further investigation.
● Staff had not followed guidance in medicine risk assessments, to check the temperature of the storage of medications in people's bedrooms twice a day. There was also no guidance on an acceptable temperature range to prevent damage to the efficacy of medicines.

Risks relating to safe storage and administration of medicines were not fully assessed and managed. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

At our last inspection we found the provider had failed to ensure sufficient numbers of suitably qualified staff to enable them to meet the needs of people who use the service at all times and other regulatory requirements. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider remained in breach of regulation 18.

● Three relatives and four staff raised concerns about staffing levels, and their abilities to meet people's needs when there were limited numbers on shift and working across the three floors of the home. Relatives gave examples of call bells and the office telephone ringing repeatedly and not being answered.
● People's bedrooms were across all three floors of the service, impacting on staff coverage and ease of monitoring people. The manager's weekly reports identified people were experiencing unwitnessed falls. There was a recent fall where a neighbouring person had heard a noise and alerted staff to the fact someone had fallen.
● The provider had implemented a new dependency tool, and the manager confirmed staffing levels in place during the day and overnight, they also explained that the activity co-ordinator was available to support at meal times. However, from reviewing staffing rotas, we identified unexplained variations in staffing levels, a recent night shift that had only been covered by two members of staff. This was not sufficient staff on shift to safely meet people's needs and risks, and did not allow any flexibility for staff to respond to an emergency situation or access regular breaks.
● The manager told us there were 11 people who required assistance from two staff to complete aspects of their care. There were insufficient staff on at night-time to respond to people's assessed needs. Staff told us there were not always enough staff on shift to meet people's needs and spend time have meaningful interactions with people.
● The provider had not ensured that all staff had the necessary skills and competency to keep people safe. Training records demonstrated that not all staff had received safeguarding vulnerable adults training and infection control training. Staff did not always follow guidance around use of personal protective equipment.
● Staff told us where they had tried to challenge the performance of other staff, and raised their concerns to managers, but this feedback was not consistently acted on or addressed to improve staff performance and cohesion.

Risks remained, relating to staffing levels and skill mix. This was a continued breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● One person's relative raised concerns about the standards of care being provided, and about staff not ensuring the person had access to items brought in by their family, to improve their overall quality of life.
● Three people gave examples of where staff had been unkind to them, for example refusing to give a person pain relief and telling them to go back to sleep, and two people telling us staff had told them off for being incontinent or needing to use their call bell regularly to ask to use the toilet. CQC reported these safeguarding concerns to the local authority safeguarding team for further investigation
● The management team told us meetings had been held with all people living at the service and that no concerns were identified. However, resident feedback forms, and resident meeting minutes identified concerns being raised by some of the same people we received concerns from, which demonstrated a lack of action being taken by staff to ensure people felt safe.
● At the time of the last inspection, the local authority were investigating multiple safeguarding concerns. The lack of response to concerns being raised by people during the inspection did not demonstrate lessons have been learnt from these safeguarding incidents. We also identified staff were not being kept updated with safeguarding outcomes as recent meeting minutes just advised staff the cases had been closed.
● People's confidential information was not being stored securely, particularly when they had stopped living at the service. We were therefore not assured people's privacy was being safeguarded in line with data

protection principles.
● The provider had not learnt lessons following the last inspection visit, as there continued to be significant concerns and risks identified, and a lack of mitigation in place to ensure people's safety.
● One person's care records contained written instructions telling staff "Not to swear or retaliate" if this person was verbally aggressive towards staff. We were concerned that staff needed to be reminded of acceptable standards of behaviour, to safeguard people from verbal abuse by staff.

Measures were not in place to protect people from risk of harm and abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection
● We were not assured that the provider was preventing visitors from catching and spreading infections. Staff were not working in line with the provider's policy when visitors arrived, to ensure they asked visitors about their health and presence of any COVID-19 symptoms. Staff were also not checking results when offered for visitors completing regular testing in line with their own visitor policy. Waste bins within the service did not all have lids, and we identified a broken pedal bin affecting hygienic use. Guidance information for visitors was on the outer door of the service, making it unclear if visitors could enter the inner lobby or not.
● We were not assured that the provider was using personal protective equipment (PPE) effectively and safely. We observed some staff to be wearing fabric masks rather than use of disposable in line with government guidelines. Not all staff wore a uniform, risking that their clothing could not be washed at high temperatures, in line with government guidelines. Staff did not have designated donning and doffing areas, and we found used PPE inappropriately discarded. Staff told us they carried used PPE to the sluice room on each floor, from checking in bins, PPE was not consistently being bagged up to prevent the spread of infection.
● We were not assured that the provider was promoting safety through the layout and hygiene practices of the premises. Areas of the home had damaged surfaces, such as damaged bathroom tiles, unsealed flooring and exposed areas of wall plaster. These impacted on the ability to keep surfaces clean and hygienic.
●We were assured that the provider's infection prevention and control policy was up to date. However, policy guidance and risk assessments on display at the service were found to be out of date.

Measures were not in place to prevent the risk of the spread of infection. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

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 now 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.

Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection we found the provider failed to have an effective system in place to assess, monitor and improve the quality and safety of the service and the risks relating to the health, safety and welfare of people. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider remained in breach of regulation 17.

- The provider had not learnt lessons from the last inspection and overall service improvement was still in progress, with changes not fully embedded. Further deterioration and breaches of regulation were identified at this inspection. Infection prevention and control concerns were identified at this inspection that had not been found during the last inspection, demonstrating further deterioration in the care being provided.
- As an outcome of accident and incident analysis, the provider had not considered the deployment of staff or the layout of the service as possible contributory factors relating to unwitnessed falls.
- The provider's audits identified risks needing to be addressed, such as ensuring staff knew what pressure setting to have mattresses and cushions set on to maintain people's skin and prevent developing sores, yet the management team had given themselves over a month to rectify this risk. We discussed this matter with the provider during high level feedback who told us they were experiencing difficulties gaining guidance from healthcare professionals.
- The provider's audits identified issues which remained an ongoing risk when we inspected. There was a lack of action being taken to address staff performance issues and shortfalls. We received feedback from staff raising concerns regarding bullying within the staff team, and a lack of a response by the management team when they voiced concerns.
- The provider had support from an external auditor. The external auditor gave the provider a service improvement plan. However, many of the original points remained uncompleted approximately a year on. Findings from the external auditor continued to be found during our inspection. Therefore, demonstrating whether issues were identified internally or externally mitigation was not being implemented to address shortfalls.
- The manager's premises audits did not check the same things each month, including risk areas such as bed rails. From inspection findings, when compared with the premises audits, we identified that the

condition of laundry was not being checked, with bedding and duvets in use visually stained. Premises audits also did not check issues found during the previous audit to ensure these issues had been rectified.
● We identified that the manager did not have oversight of checks and audits being completed by the maintenance team.

The service continued to have poor governance arrangements in place to drive improvement at the service. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider gave an update during our high level feedback meeting to confirm measures were now in place to improve oversight of works completed by the maintenance team.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At our last inspection we found the provider failed to have an effective system in place to assess, monitor and improve the quality and safety of the service and the risks relating to the health, safety and welfare of people. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had not been made at this inspection and the provider remained in breach of regulation 17.

● Staff gave examples of where they tried to raise concerns about other staff poor practice with the management team. For example, with a person declining lunch, then telling another staff member they were hungry and that staff member telling us they had to argue with another staff member to ensure the person was fed.
● People raised concerns with staff, that had not been acted on. When we spoke about these with the manager, they had not been made aware of any concerns by the staff. Therefore, a need to improve communication within the staff team was identified.
● There was a sign on the doors leading out onto the decked seating area outside the main lounge, stating that the decking had been out of use since August 2020. We spoke with staff who confirmed this to be correct. Whilst people had an alternative fire exit to use to leave the building, this did not offer people easy outside access to fresh air during the pandemic.
●The provider completed questionnaires with people in January 2021. We noted that a staff member had filled these forms out with people, therefore not offering the option to give anonymous feedback. Some people had raised concerns regarding staff politeness and courtesy, respecting their privacy and dignity. However, when we raised safeguarding concerns with the manager and regional manager, they told us everyone had been happy with the care provided when the questionnaires were completed.
● The provider had only completed one recent care plan audit in the last 4 months (since the regional manager started in post). This reviewed three records and did not demonstrate fully what action was being taken to address shortfalls or the rationale for not checking other records for themes and trends. This did not ensure people's care records were consistently person-centred. It also supported the shortfalls we identified in aspects of people's care records.
● Action points on the provider's audits were rolling from month to month with no changes or improvements noted, such as an issue with the fit of fire doors reported in the last 3 months of fire checks, and a missing window restrictor identified in the last two months of audits. This did not ensure best outcomes were achieved for people and placed people at risk of harm.

The service continued to have poor governance arrangements in place to drive improvement through acting on feedback and audit findings. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

At our last inspection we found the provider failed to notify the Care Quality Commission (CQC) of incidents that should be reported to CQC. This is a breach of regulation 18 (Notification of other incidents) Care Quality Commission (Registration) Regulations 2009

Enough improvement had been made at this inspection and the provider was no longer in breach of registration regulation 18.

● The service was submitting notifications to CQC in line with their own policies and procedures, recognising their own regulatory responsibilities. The new manager was building relationships with external stakeholders including the local authority and community health teams to ensure consistency of reporting.

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; Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People's feedback was being asked during resident meetings and through use of feedback questionnaires, but from inspection findings and speaking with people, this information was not being acted on, as issues remained outstanding during inspection.

● In the absence of a registered manager, the provider holds overall legal responsibility to ensure the safe running of the service. Standards had not been maintained, and service improvement remained ongoing based on inspection findings.

● The manager's knowledge and understanding of people's assessed risks and needs was an area of concern. When asked, the level of risk we were told was less when compared against information held in people's care records. We were therefore concerned that the manager did not fully recognise their own professional accountability.

● The service was receiving regular support from the local authority since the last inspection but based on inspection findings had not implemented aspects of this guidance into practice to drive service improvement.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The care provider did not ensure that people and the care environment were consistently kept safe. Risks to people were not always well managed, including with medicines management and infection, prevention and control. Regulation 12 (1) (2) (a) (b) (g) (h)

The enforcement action we took:

Conditions imposed on the provider's registration at this location.

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 care provider did not ensure people were always protected from risks of harm and abuse. Regulation 13 (1) (2) (3)

The enforcement action we took:

Conditions imposed on the provider's registration at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The care provider did not have good governance processes and procedures in place. Audits and quality checks were not identifying risks and concerns found during the inspection, or mitigating and addressing and areas of poor practice. Regulation 17 (1) (2) (a) (b)

The enforcement action we took:

Conditions imposed on the provider's registration at this location.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The care provider did not ensure there were sufficient levels of suitably trained and competent staff on each shift to meet people's care and support needs. Regulation 18 (1)

The enforcement action we took:

Conditions imposed on the provider's registration at this location.