SHC Clemsfold Group Limited

Clemsfold House

Inspection report

Guildford Road
Broadbridge Heath
Horsham
West Sussex
RH12 3PW

Tel: 01403790312
Website: www.sussexhealthcare.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection took place on 8, 9 and 18 October 2018 and was unannounced.

Services operated by the provider had been subject to a period of increased monitoring and support by commissioners. As a result of concerns raised, the provider is currently subject to a police investigation. The investigation is on-going and no conclusions have been made. We used the information of concern raised by partner agencies to plan what areas we would inspect and to judge the safety and quality of the service at the time of the inspection. Between May 2017 and October 2018, we have inspected a number of Sussex Health Care locations in relation to concerns about variation in quality and safety across their services and will report on what we find.

Clemsfold House is a care home which provides residential care. People in care homes receive accommodation and personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided and both were looked at during this inspection.

Clemsfold House provides accommodation and personal care for up to 48 older people. At the time of our inspection there were 19 older people living at Clemsfold House. Most people were living with dementia. People had their own bedrooms and shared communal areas such as a lounge and dining area.

There was no registered manager at the time of this inspection. The service is required by a condition of its registration to have a registered manager. A registered manager is a person who registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A manager and deputy manager had started their employment in August 2018 and were in day to day management of the home. The home had been without a registered manager since March 2018. The manager, present at this inspection, had applied to register with the Commission. A regional operations director also joined the inspection over the three days.

At the last inspection in November 2017, the service was found to be in breach of legal requirements and was given a rating of 'Requires Improvement'. The provider wrote to us after the inspection to inform us the actions they were taking. At this inspection we found that the quality and safety of care provided to people had deteriorated further and we identified seven breaches of the Regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection, the provider told us they had planned to close the home temporarily to address maintenance and environmental issues. The provider informed people, their relatives and the local authority of this after our inspection had been completed.

At the last inspection, systems to assess and monitor the service were in place but these were not sufficiently

robust as they had not ensured the delivery of consistently good quality and safe care across the service. At this inspection we found the provider had failed to ensure the necessary improvements had been made to improve the quality and safety of care provided.

We observed poor examples of care and treatment over the three days of the inspection. This included unsafe moving and handling techniques and a lack of appropriate support for people assessed as needing a pureed and/or a specialist diet, which placed them at risk from harm.

People who experienced weight loss had not always been referred to the appropriate health professionals to seek their expertise. Care records did not always demonstrate people's health needs were being met.

Consent was not always sought from people by staff before carrying out personal care. The Mental Capacity Act was not consistently applied to protect people's rights.

A caring culture had not been promoted consistently across the service and activities and occupation were not consistently person-centred.

Staff had received safeguarding adults training. However, they failed to demonstrate their competence and understanding of this in practice as people had not always been protected from harm. Incidents were not always escalated and investigated to ensure actions were taken and lessons learnt to keep people safe in the future.

Medicines were not always managed safely. DNACPR status records were contradictory which meant there was a risk of the incorrect action being taken if a person became significantly unwell.

Recruitment practices for permanent staff remained safe however the provider was highly reliant on agency care support. Premises were not always adapted to meet the needs of people to ensure they could enjoy the outside area of the home.

We identified gaps in training and competencies. When training had been provided, staff had not always implemented the learning when supporting people.

The provider asked people and their relatives views on the care they received using various methods including satisfaction surveys. Infection control measures were in place to mitigate the risk of cross infection.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not, enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from

operating this service. This will lead to cancelling their registration or to varying the terms of their 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.

We imposed conditions on the provider's registration. The conditions are therefore imposed at each service operated by the provider. CQC imposed the conditions due to repeated and significant concerns about the quality and safety of care at a number of services operated by the provider. The conditions mean that the provider must send to the CQC, monthly information about incidents and accidents, unplanned hospital admissions and staffing. We will use this information to help us review and monitor the provider's services and actions to improve, and to inform our inspections.

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

To service was not safe.

Known risks to people had not been mitigated, this included people at risk of choking, skin integrity and weight loss.

There were not enough skilled and competent staff deployed to meet people's needs as we observed poor moving and handling practices.

People were not always protected from harm as incidents were not always escalated and investigated to ensure actions were taken and lessons learnt to keep people safe in the future.

Medicines were not always managed safely.

Recruitment practices for permanent staff remained safe however the provider was highly reliant on agency care support.

Infection control measures were in place to mitigate the risk of cross infection.

Is the service effective?

Inadequate

The service was not effective.

The service was not meeting the requirements of the Mental Capacity Act legislation as mental capacity assessments were generic and consent was not always sought by staff before providing care.

We identified gaps in essential training and learning received was not always implemented by staff in practice when supporting people.

People were not always supported to eat and drink in accordance with their assessed needs.

Referrals had not always been made on behalf of people to health professionals when a need had been assessed such as significant weight loss.

Premises were not always adapted to meet the needs of people to ensure they could enjoy the outside area of the home.

Is the service caring?

Inadequate

The service was not caring.

People's needs were not always considered appropriately, this included a lack of respect and staff had failed to consistently promote people's dignity.

People were not always given the choice to be involved in their own care on a day to day basis.

Independence was not consistently encouraged.

Despite our observations, positive feedback was received from relatives about caring approaches used by staff.

Is the service responsive?

Requires Improvement

The service wasn't consistently responsive.

Personalised care was not always delivered to people.

Improvements were needed to the activities and occupation provided to people.

DNACPR status records were contradictory which meant there was a risk of the incorrect action being taken against a person's wishes if they became significantly unwell.

Information provided, which included care plans, were not consistently in an accessible format to aid people's understanding.

We received positive feedback from relatives regarding how complaints were managed.

Is the service well-led?

Inadequate

The service was not well-led.

Leadership was poor. The service did not have a registered manager. Known, serious risks to people had not been reduced across a range of areas.

Auditing and oversight had been ineffective since the last

inspection and had failed to improve.

Staff culture had deteriorated and inappropriate and unsafe actions were going unchecked and unchallenged.

The provider had failed to promote effective partner agency working to improve the quality and safety of the care people received.

Opportunities were given to relative's to feedback to the provider their views on the care received through satisfaction surveys. The written responses we read were positive.

Clemsfold House

Detailed findings

Background to this inspection

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

This inspection took place on 8, 9 and 18 October 2018. The first day was unannounced and the inspection team consisted of three inspectors, a specialist medicine's advisor 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. Their area of expertise included services for older people living with dementia. The second and third day of inspection consisted of three inspectors.

Prior to the inspection, we reviewed the information we held about the service. This included information from other agencies and statutory notifications sent to us by the manager about events that had occurred at the service. A notification is information about important events which the provider is required to tell us about by law. The provider had also completed a Provider Information Pack (PIR) since the last inspection. This shared what they had been doing since the last inspection to support people living at the home. We used this information to decide which areas to focus on during our inspection.

We spoke with five people who lived at the home to gain their views of the care they received. We also spoke with two people's relatives. Due to the nature of some people's complex needs, we were not always able to ask people direct questions about the care they received. To obtain these, we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spent time observing the care and support that people received during the morning, at lunchtime and during the afternoon over the course of the inspection.

During the inspection we spoke with the deputy manager, the manager and the regional operation's director. We also spoke with three agency care staff two permanent care staff, the activities coordinator and the chef. We provided feedback throughout the inspection and at the end of the inspection to the providers' nominated individual and the operations director.

During the inspection, we observed medicines being administered to people. We reviewed a range of records about people's care which included seven care plans. We also looked at three care staff records which included information about their training, support and recruitment records. We reviewed audits, minutes of meetings with people and staff, policies and procedures, accident and incident reports, Medication Administration Records (MAR) and other documents relating to the management of the home such as quality audits and checks.

Inadequate

Is the service safe?

Our findings

The service was not safe in a number of areas. Although people and relatives reported feeling safe and secure, our findings showed that people were exposed to risks which had not been properly assessed or minimised placing them at risk from harm.

At our last inspection, risks to people from falls and poor moving and handling practices had not been properly minimised. At this inspection we observed six incidences of very unsafe practice by staff when people were being supported to move. Inspectors had to intervene to prevent people being hurt by staff actions. Agency care staff used inappropriate and dangerous techniques to transfer people from chairs to wheelchairs. They did so by placing their hands under people's armpits and dragging them forward and by gripping people's upper arms and by pulling people back into wheelchair seats from behind by putting their hands under the person's armpits. Two people were observed to be very unsteady on their feet while being transferred. They were not given appropriate levels of support by care staff, which placed them at risk of falling.

Brakes were not always put on wheelchairs when people were transferred into them; and two people landed awkwardly into the wheelchairs because of this. Some people's feet were not placed onto footplates before being pushed along by staff in wheelchairs, so their feet dragged on the floor and were pulled backwards underneath it in one case. None of these methods of supporting people was in line with national guidance about safe moving and handling; and people had been placed at risk of harm. We made the manager immediately aware of our serious concerns, and they witnessed two agency staff supporting a person in a particularly unsafe way. The manager asked the agency staff if they had received training about moving and handling. They replied that they had, to which the manager said, "You know it's wrong then-you can't move someone by holding them like that". The management team told us that staff concerned had been supplied by the same agency, and that they would not be used in future. We referred our concerns to the local safeguarding authority.

Care plans and risk assessments did not contain sufficient detail to make sure all staff knew how to support people to move safely. One person's care plan had not been updated to show that they were no longer independently mobile and needed to use a wheelchair. As a result, there was no step by step guidance for staff to follow when supporting the person from an armchair to a wheelchair, for example. Another person's care plan had not been updated to reflect their increased risk of falling, after a number of incidents where they had actually fallen. Given the high level of agency staff working in the service, this lack of detailed or accurate information significantly increased risks to people.

Risks to people from choking had not been appropriately assessed or reduced. One person's care plan about nutrition stated that they needed a pureed diet because they did not wish to wear their dentures and was, 'Unable to chew normal food'. On the first day of our inspection, this person was given dry biscuits and left alone to eat them. We made the manager aware of this because biscuits may present a choking risk, given that the person had no teeth to chew them before swallowing. We received assurances that the risk of choking for this person would be assessed and minimised as a priority. However, on the second day of our

inspection, the same person was given dry, crumbly biscuits again by staff. The person was not wearing dentures and began eating a piece of the biscuit and started coughing. We made the deputy manager immediately aware that this person was again attempting to eat dry biscuits without their teeth in. They were also hooking some pieces of biscuit out of their mouth which suggested they may not be able to swallow them.

The manager said, that following our feedback the day before, they had told staff that this person must not be left unsupervised with biscuits. They said that staff had told them that the person dipped biscuits into their tea before eating them. This was not our observation on either day of the inspection, when they ate a dry biscuit. The manager said she had told staff that they could not be sure that the person was dipping the biscuits unless they were constantly observing them on each occasion she was given them. Staff had continued to give the person dry biscuits despite the manager's direct instruction about this, placing them at continuing risk of choking. This person was referred by the manager during the inspection to speech and language therapy for a full assessment of their swallowing.

The care plans for three other people referred to the special diets they required in relation to risks associated with swallowing. The deputy manager and five agency staff told us they were not aware of any person at risk of choking. Following the second day of our inspection we contacted the provider and sought assurances about how people would be protected from choking risks. They told us that special placemats had been introduced for those people at risk. These placemats held a photo of the person and information about the consistency of their meals and any supervision needed, with biscuits for example. However, on the third day of our inspection, only one person had their placemat with them. This was face down on the person's lap so could not be read by staff. Two other people had no placemats throughout the morning and lunchtime. When we prompted staff, they found the placemat for one person on a bookshelf, but the third persons could not be located during our inspection. Despite the lack of placemats, all three people did receive meals of the correct texture, but the system put in place by the nominated individual had not been properly used in practice to protect people. We referred our concerns to the local safeguarding authority.

Risks associated with weight loss had not been appropriately reduced to protect people from deteriorating health. One person's care plan about nutrition stated they should be weighed monthly and any pattern of significant weight loss/gain should be reported and investigated. Although this person had been weighed monthly, they had lost 12kgs since January 2018, with losses documented almost every month. The manager told us that no dietetic input had been sought for this person but made a referral to the GP after we raised the issue.

Another person's care plan about nutrition said their weight was currently within normal limits but that it would be unwise for them to lose significant weight. They had lost 10% of their original weight between January and October 2018. Again, no referral for dietician input had been made. A letter from speech and language therapy dated May 2018 stated that the person's weight should be 'Monitored closely, consider supplements and dietetic referral if weight loss persists'. The manager was unable to provide evidence that this had happened.

Weights audits showed that two further people had lost 10.5kgs since and 8.2kgs respectively since January 2018. The manager told us that following our initial feedback, three people had been referred for dietetic input. They also said that others were within, "normal Body Mass Index ranges". This was not accurate because of the significant weight losses. BMI is a tool for cross-checking a person's height against their weight to see if it is within normal ranges. Staff were completing Malnutrition Universal Scoring Tools (MUST) for each person. This is a method for applying a combined score to a person's BMI, weight losses and medical conditions to see if they are at risk of malnutrition. In all of the MUST records we read, every person

had been scored as '0' for weight loss. This was incorrect on many occasions and staff had failed to include the appropriate score of '1' or '2' when people had lost between 5 and 10% of their bodyweight. This meant they were not highlighted as a risk on the MUST document. The manager told us that they were not using MUST but based their decisions about people's weight loss solely on their BMI. There was a risk that people could lose significant weight due to an underlying health problem, which would not be picked up if the person's BMI remained within 'normal' ranges.

Following the inspection some people were referred to the GP about weight loss. However, the need to consider whether people should be assessed by a GP or referred for professional dietetic advice had not happened until inspectors drew attention to the large number of service users who had lost weight. Medicines had not been safely managed. Agency staff were observed leaving the medicines round on two occasions to carry out other tasks. Although they were wearing a red tabard with 'Do not disturb' printed on it, the staff member was interrupted during the round, which created the opportunity for mistakes to happen. On one of these occasions, agency staff left a medicine, about which there are special legal requirements, unattended in a pot on top of the medicines trolley. This was situated in the middle of the dining area, with people who were living with dementia. It was unsafe practice to leave a medicine where it could be taken by the wrong person.

Another person's medicine had been signed as administered on the medicines chart but it was found to be still in the dispensing pod for that day. The manager later told us that the person had received their medicine but that staff had taken it from the pod relating to a different day. This was unsafe practice because it caused confusion over whether the person had received it or not. Another person had missed three days of a blood pressure medicine and staff were unable to say why this had happened. The timing of some people's medicines doses was not in line with prescriber's directions. One person was due their dose at 'Noon' but an inspector had to make staff aware that the person had not received it by 1:30pm. Staff said that people did not always receive one specific medicine before food, despite dispensing instructions which stated that this should happen.

Reconciliation checks of boxed medicines found that there were discrepancies between the number of tablets that remained and those recorded as 'in stock'. This was of concern because in some instances there were less medicines in the boxes than there should have been, which might indicate people had been given more of the tablets than had been required. The service had a supply of over the counter medicines which could be used to treat people's minor ailments. These are known as 'homely remedies'. The GP had provided a list of approved medicines for general use but there were three items in use which did not feature on the GP's list. Paracetamol which had been prescribed for a person who had passed away had also been included in the over the counter stock. The provider's policy stated that these medicines 'must be purchased by the home or the individual involved' so it was inappropriate for the prescribed pain relief of a deceased person to be used by others.

Records showed that body charts were not always used when people had medicines prescribed in patch form. The application site of patches needs to be regularly rotated to prevent skin irritation, and body charts help to ensure this happens. There were no body charts used to show staff where and how often to apply people's prescribed creams. Staff had not acted in line with the provider's policy when making handwritten entries onto medicines administration records. This stated that two staff should sign any additions; which helps to make sure all the information is double-checked and correct. Where people had regularly refused to take medicines, this had not been referred to the GP as per the provider's policy; to make sure the person's health did not deteriorate as a result.

After raising our concerns about medicines management, we received assurances that medicines rounds

would be overseen by a team leader to make sure staff were administering safely and competently. Although this had happened on most days, this had not continued over the weekend between our inspections. We were told this was because there was no team leader available to carry out this task. We referred our concerns to the local safeguarding authority.

Measures had not been implemented to reduce known risks to some people's skin One person's care plan stated that they did not like to sit in a comfortable chair and preferred to sit in a wheelchair. Their care record said, however, [Person's name] should be transferred on comfy chair for a few hours before lunch and need to elevate feet and legs'. This person was observed to be sat in their wheelchair for most of the three days of our inspection. At no point were they transferred to a comfortable chair and neither were their legs raised. We made the manager aware that the person's feet were on the floor and not on the footplates of the wheelchair while they sat for long periods in the dining room. One of the straps on the footplates was broken so could not hold the foot in place. Senior staff told us, "It's very difficult with [Named person], they shout and swear and we don't know what to do with them". However, no input had been sought from community mental health teams to offer advice or support for this person.

Another person's care plan about skin, highlighted that they were at high risk of developing pressure wounds. One of the minimising actions documented was that the person should sit on a pressure-relieving cushion in their armchair. On the first morning of our inspection we made the manager aware that there was no cushion beneath the person. By the afternoon, the person was still not sitting on the pressure -relieving equipment. This situation had not improved on the second day of our inspection, when the person was observed seated on an armchair without the cushion again. Whilst staff told us they were not suffering with any damage to their skin, as failure to work in accordance with this assessed need may have increased the risk of this happening.

The failure to properly mitigate risks and safely manage medicines is a continuing breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Information about people's allergies was clearly documented and there was guidance for staff about medicines to be given on an 'as required' basis. The medicines storage room and trollies were clean and tidy. The temperature of the medicines fridge had been tested daily and was within correct limits. Staff said that urine samples were occasionally stored in the medicines fridge. This is an infection control issue which we discussed with the provider.

People and relatives had no concerns about medicines safety. One person said, "I get all the medication I require and when I need it" and "They seem to be good at giving it". A relative told us "[Named person] only gets some paracetamol for arthritis pain and they are controlling it well".

At our last inspection, appropriate action had not always taken place in the event of possible safeguarding matters, and this may have placed people at risk of unsafe care. At this inspection we continued to have concerns about this. We found staff had received safeguarding adults training and could share with inspectors the value of its importance. However, one person had a very large bruise on their leg but the manager was unaware of it. Daily checklists completed by staff had been ticked to show that this person's skin had been looked over and any issues raised with senior staff. We spoke with the agency care staff who had completed the checklist. They confirmed that they had noticed the bruise that morning and the day before while giving personal care. They said they had reported this to senior care staff, but that staff denied having been made aware of it. Processes designed to keep people safe by involving senior staff, had been ineffective and created the risk that safeguarding matters may not be investigated appropriately.

We also read incident reports which failed to demonstrate whether people had been protected from further harm. For example, one incident described a physical assault incident from one person living at the home to another. Records failed to include the actions taken by the staff team at the time to ensure people were protected. The incident had occurred prior to the new manager being in post so we were unable to ascertain whether the incident had been escalated to the local authority safeguarding team for their independent review.

After the inspection, we wrote to the providers safeguarding lead for any further information they may have about the incident. They confirmed the incident had not been escalated to the local authority for their review at the time. They shared information they had about the incident retrospectively with both the local authority safeguarding team and the Commission after the inspection.
Our review of medicines found that a person had been given their medicine covertly, meaning without their knowledge or consent. This had happened without the correct assessment and decision-making processes. Although this had been picked up by the manager before our inspection, no referral had been made to the local safeguarding authority. As the giving of medicines covertly without the proper systems and documentation can be a form of abuse, the safeguarding authority should have been made aware so that they could consider an independent investigation. We raised our concerns with the local safeguarding authority following the inspection.

The provider failed to ensure systems and processes enabled appropriate investigation of potential safeguarding issues, which placed people at risk of abuse. This was a continued breach of Regulation 13 of the Health and Social Care Act 2014.

We received mixed views about staffing arrangements. One person said, "There aren't enough permanent staff" and another commented, "At most times they are short of staff. Other people and relatives disagreed. One person said, "On the whole, there are enough staff working" and "When I call for help, they come quickly, they are good at that", while a relative said "Yes, there are enough staff here".

At our last inspection we recommended that the provider reviewed the deployment of staff. At this inspection there were not enough skilled, competent and experienced staff on duty to meet people's needs. There was a very high reliance on agency staff to work in the service. For example, on all three days of the inspection there were more agency care staff working than permanent care staff. The manager told us they did not always know which agency staff would be covering each shift until the day. They said they used agency profiles to guide them as to what training the agency staff member had achieved. Despite an agency induction being provided there were no checks on the competencies of the agency staff used prior to them covering shifts.

Throughout the inspection, agency staff were unable to tell us people's names or accurately describe their care needs. Agency staff carried out unsafe and inappropriate moving and handling techniques, which placed people at risk of injury and distress. Permanent staff did not know what conditions people's medicines had been prescribed for, even though they were giving them to people.

The failure to deploy skilled, competent and experienced staff is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite this, people and their relatives told us they had experienced safe care and treatment from the provider. One person told us "Oh yes, I definitely feel safe here, I think it's a wonderful place and there are always people around". Another person told us, "I've felt very safe here" and nothing worries me-attention to security is very good".

The service was generally clean and tidy. One person said, "They keep the place very clean" and a relative remarked, "Everywhere looks tidy and clean and her room is always well aired". Staff wore gloves and aprons for any personal care tasks.

Staff were only able to start employment once the provider had made suitable recruitment checks. This included; two satisfactory reference checks with previous employers and a Disclosure and Barring Service (DBS) check. This process ensured as far as possible, that permanent staff were of good character and had the skills and experience to meet people's needs prior to commencing their role.

We checked records for equipment, such as standing aids and wheelchairs and these had been serviced correctly. Gas and electrical safety was reviewed by contractors to ensure risks were identified and addressed promptly. Records confirmed that maintenance staff attended when contacted by staff to repair damage, which ensured people were protected from environmental risks. Service checks such as legionella checks were managed effectively through prompt and regular servicing. Fire equipment such as emergency lighting, extinguishers and alarms were tested by the provider's maintenance engineer.

Inadequate

Is the service effective?

Our findings

At our last inspection, the provider and staff had not acted in accordance with the Mental Capacity Act 2005 and its code of practice to protect people's rights and ensure lawful consent was obtained. The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 make decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). Restrictions could include, for example, bed rails, lap belts, stair gates, restrictions about leaving the service and continuous supervision inside and outside of the service.

At this inspection, MCA assessments continued to be general and covered several aspects of care such as, personal safety, care and welfare, medicines and finances, rather than being individual and decision-specific. Decision specific capacity assessments must be made only, as people may have capacity to make some decisions about their own care but lack capacity to make others. A 'blanket' approach to assessing people's capacity was used by the provider which was not in accordance with MCA guidance and principles. The manager said that MCA assessments were a working progress but we found people's rights and choices had not been properly considered. Risk assessments about the use of bed rails had been completed, but there were no associated MCA assessments or records of best interest decisions to show that the least restrictive option had been discussed and agreed.

The front door of the service was locked with key code entry and exit. The manager told us that two people would be safe to leave the service alone, but they had not been proactively given the door code. The manager said this had "not been hidden from them" and that a picture was being produced with the door code concealed within it for those two people to use when they wished to leave the service. Some DoLS applications had been authorised with no conditions and others had been applied for and were awaiting assessment by the local authority.

In practice, we observed that staff did not always seek people's consent before carrying out tasks. For example, food protectors were placed around people's necks or items were removed from people without asking them first. The impact of this was that some people became agitated and upset when they were not consulted or pre-warned about actions staff were taking. One agency staff member told us that they promised people who were living with dementia that they would arrange for them to go out, as a method of calming them when agitated. They confirmed that they did not actually make these arrangements or take people out, but the method worked because people had forgotten the promise by the next day. They also said that this did not work with all people and that with those they had to be, "More sincere".

The failure to act within the principles of the MCA is a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all staff had received appropriate training to work with the people living at Clemsfold House. One person told us, "The permanent staff work very well together here but the temporary ones are not as well trained". Information compiled by the agencies who provided temporary staff to work in the service, showed that only one agency care staff had received training about MCA and DoLS. Although this training was listed as mandatory for permanent staff, three care and one activities staff did not receive it until after our inspection. This training is important for ensuring that all staff understand about people's rights and choices, that they act lawfully and they seek people's consent where possible. The manager confirmed that there had been no competency checks carried out to make sure staff were knowledgeable in this area. This had led to people's rights to choose being consistently overlooked.

Nine care staff including activity staff and one senior had not received mandatory training about dementia awareness. Most people were living with varying stages of this condition and it was important that all staff understood how to support people appropriately. No staff had any training about diabetes, even though staff told us at least one person was living with the condition.

All staff, including agency workers had received training about how to safely support people to move. However, observations showed that agency staff in particular were not competent to do so. There had been no effective supervision or competency of staff practice to make sure that their actions were in line with national guidance.

Some staff had been taking and recording people's pulse rates before giving them a heart medicine. We asked if they had been trained to do this effectively and they said they had not received any training but had previously worked as a nurse in another country. Daily notes made by other staff sometimes recorded clinical observations, such as oxygen saturation levels and blood pressure readings. The manager said they did not know why staff were doing so, as the service is not registered for nursing care. They told us that staff had not been trained by the provider to complete these checks, but that some staff had previously worked abroad as nurses. There was no guidance for staff about how to interpret the clinical readings they took and this created a risk that people's health could deteriorate without medical intervention being sought. We established GP's visited the home on a weekly basis and spoke with staff about any concerns they had. However, one person's notes recorded an oxygen saturation level and pulse rate that were not within normal ranges, but there was no information to suggest that a doctor had been made aware of this at the time. We spoke to the management team about our concerns.

The failure to provide appropriate training and supervision is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had a choice of meals, but no picture menus were used to support people to show staff their preferences when they may not have been able to verbally discuss this. The kitchen staff kept a list of people who needed special diets. This had not been recently updated and included the names of two people who had passed away in recent months. One person was supposed to have a plate guard, but this was not provided to them during the inspection. They were observed spilling cream and fruit on their clothes.

Pureed meals were presented with each component separately pureed, and people received reasonable portions of food at mealtimes. However, people did not always receive the support they needed with their meals. One person's care plan said they needed encouragement with their meals and may eat slowly, so staff should take account of this. Our observations showed that this person did not receive any encouragement from staff with their lunch, although their meal was changed quickly for an alternative when they said they did not like it. However, their meal they had chosen was taken away by staff after the person had eaten only a mouthful or two. Another person needed staff to prompt them to eat but staff only spoke

to the person once and very briefly during the lunchtime meal. The person had been asleep with their spoon in their hand and fell straight back to sleep after staff spoke with them. They ate very little of their meal and it was removed by staff and replaced with pudding.

People's care plans referred to them receiving 'fortified diets'. Kitchen staff said that they enriched food by adding milk and cream and by making a calorific milkshake for people. They said that enriched milk was left out for care staff to give to those people who needed it. They were unable to tell us which people required the 'special milk'. One agency care staff did not understand what we meant when we asked about which people needed to have the enriched milk and a permanent staff member said it was the kitchen staffs' job to ensure the correct people received fortified meals. Food intake records were in 'tick box' format with no details about the content of meals or snacks, so it was not possible to see from them whether people had received consistently nutritionally balanced food. There was no information on these charts to show whether food had been fortified. We have discussed concerns we raised about the management of people's weight in the Safe section of this report.
The failure to provide adequate support to meet people's nutritional needs is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were able to speak with us gave positive feedback about the food on offer. One person said, "The meals are lovely" and "Good meal choices". Another person added, "The food, in many ways, is very good, they always make sure I have a drink." A relative told us "The food here is wonderful". Tea or coffee and biscuits/cakes were delivered to people in the morning and afternoon. Drinks were available on request all day and were evident in bedrooms.

The provider told us they wanted to close the home temporarily due to extensive maintenance works required. This included works needed to maintain the existing roof. The layout of the home did not always lend itself to the needs of the people living at the home. For example, at our last inspection, we recommended that the provider researched and implemented changes to ensure a more dementia friendly environment. One of the concerns we had raised was about an enclosed courtyard which was not accessible to people. At this inspection, this courtyard was overgrown with weeds and grass. The doors to the courtyard were kept locked because the area would have been a hazard to people with impaired mobility or unsteady gaits. During the inspection maintenance staff were instructed by the management team and the weeds were removed.

The provider carried out assessments regarding people's physical, mental health and social needs prior to them moving into Clemsfold House. However, information was not always utilised in how risks were managed effectively and safely at the time of this inspection. We have discussed this further in the Safe section of this report. The initial assessment processes of people's needs considered certain protected characteristics as defined under the Equality Act. For example, people's religion and disability. However, throughout the inspection we observed staff did not consistently consider people's disability when supporting them.

Communication between staff working at the home overall was not effective. Daily handover meetings took place and daily notes were recorded. However, we found important information was not consistently shared between each shift to ensure safe and effective care was provided to people. The risks were increased further due to the reliance on agency care staff who may have known less about people's current needs. The impact of poor communication between staff on people is discussed throughout the report.

Inadequate

Is the service caring?

Our findings

The service was not consistently caring. Although we received positive feedback from people and relatives who were able to speak to us our observations and findings showed that not every person had positive experiences. At our last inspection, people received minimal staff interaction at times; and we reported inconsistencies in caring approaches by staff. At this inspection, we continued to have concerns in these areas, but also observed situations when some staff showed a lack of care and consideration for people.

Staff did not always treat people with dignity or respect. An agency care staff woke a person who was sleeping in a reclining armchair by shaking them by their shoulders. The person was startled and distressed and became physical, striking out with their arms and legs and shouting "Get out, get out". The agency staff did not react to this but continued to attempt to place a pillow behind the person, who was making it very clear that they did not welcome this intervention. The agency staff told us they had received training about behaviours that may challenge at one of the provider's other homes. We asked what their instructions were if this person became aggressive and they said it was to lower their voice and speak calmly. They did not consider moving back from the person to give them time and space to come around from their sleep and it was unclear why staff felt it was necessary to disturb the person. There was no behavioural care plan for this person and the manager told us that they had not shown any previous challenges at all. This suggested that the agency staff actions had provoked the person to behave in a way which was out of character; and was upsetting for them and others sitting nearby.

At lunchtime on the first day of the inspection, a different agency staff leant across a person who was reading a newspaper at the table and started to fold up the newspaper to remove it. They did not ask if they could do so or give any explanation. The staff member repeatedly called this person by the wrong name while placing their lunch in front of them. The person became very agitated and shouted, "I don't want it, I don't want to see it, take it away; go away". The agency staff ignored this and attempted to place a food protector on the person without seeking consent or having any dialogue with them. The person pushed the food protector and the meal away, but the agency staff persisted in, what was perceived to be in a forceful way, that they needed to have their meal. Eventually a permanent staff member intervened and told the agency staff to, "Just leave it", after which the agency staff stood close to the person and stared straight at them for a while before moving away. The person remained unsettled after this confrontation and ate very little of their meal. The same agency staff was heard repeatedly telling a person to, "Sit down, sit down", what was perceived to be an overly firm tone.

On the second day of the inspection, two agency staff were trying to transfer a person from their armchair in the lounge to a wheelchair, using special equipment to support them to stand. Staff placed a sling around the person and fastened it but they were crying out "Take it off, take it off, I can't keep it on, I can't keep it on" and were clearly distressed. Staff replied, "You're welcome, well done love". The person continued to shout as the sling was being connected to the equipment, saying "It's giving me pains" and hitting and attempting to bite staff. The person was very upset and tried to resist the manoeuvre. Both staff continued regardless, with the person struggling throughout.

We also observed agency care staff changed the TV channel without asking anyone using the lounge if this was what they wanted. People had been watching a programme about home renovation, but the agency staff switched to Jeremy Kyle and then sat in an armchair and watched some of the show. During this time, a person sitting next to them tried to engage in conversation by saying, "I like your shoes" several times. The staff member ignored the person and carried on watching TV. Another person sat in the dining room in bright sunlight, with the sun shining directly onto their head. The temperature outside was around 20 degrees but staff did not pull the curtains to give the person some shade until they observed us watching what was happening with the person. Staff were seen walking through the lounge without acknowledging anyone seated there.

Not all staff were discreet when they supported people. One agency staff was heard loudly asking a person if they needed to use the toilet, and another staff told a colleague, "We need to change her" in front of other people and visitors. This was not respectful of people's dignity. Some people were noted to have long or dirty finger nails and some ladies had facial hair growth. The manager said that one person did not like staff to cut their nails, but they were so long they may have been a hazard to their own and others' skin. The manager said they would make further attempts to persuade this person to have their nails cut. Staff were unable to tell us if it was people's choice to have facial hair and there was no record in ladies' care plans about this preference.

On the third day of the inspection, one person was sat in a reclining armchair in the lounge. They had a hole in their jumper under the armpit and their stomach was exposed. Staff in the lounge did not approach the person to see if they wanted support to cover up their exposed stomach until we brought this to their attention. This meant staff had failed to consider the person's feelings and promote the person's dignity without being prompted to do so. We brought our concerns about staff behaviour to the manager's attention. All of the staff involved in the incidences we had observed were employed via the same agency. The manager told us that this agency would not be used again.

The failure to treat people with dignity and respect is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also observed staff members who promoted people's privacy and dignity. This included staff knocking on bedroom doors and calling out before entering. One staff member told us how they involved people in their own care and promoted their independence. They said, "We ask them if they would like to get up, some people can tell you". They also told us how they promoted a person's independence and said, "We help them to wash themselves". One staff member gently massaged a person's hands while speaking softly to them, however, other people in the lounge at the same time received no interaction or conversation from staff.

A relative told us, "The staff are good with [Named person] when attending to private matters". People praised the staff by saying "Staff are wonderful with all of us, they are all very caring" and "Staff are very good here they are always kind and considerate, you only have to ask and they provide it". Relatives added, "Staff have been so kind to Dad, they have been wonderful" and "Some staff are very compassionate".

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, some people did not receive a responsive service based on their individual needs. For example, falls management was not always robust and timely and staff did not always give everyone effective care at mealtimes and interactions by some staff were task focused.

At this inspection we also had similar concerns. Staff were observed to be task-driven and some staff did not appear to listen when people said they did not want to move or eat and carried on with the task regardless. This did not consider people's right to choose and did not take account of people's individual needs and preferences. Some records were conflicting and created the risk that people would not receive the right care. For example, one person's care plan said they were independently mobile, but they were using a wheelchair during the inspection. There was no guidance for staff about how to transfer the person correctly and safely and whether the person or their representative had been asked their opinion and been involved with this decision.

Agency staff did not know people's names and called them by different names, even when care records gave clear information about the person's preference. Given that people were living with dementia, this could be confusing and upsetting for them. Important decisions about some people's care, for example, being placed on a pureed diet, were not supported by records of professional advice received. The manager was unable to provide us with this information during the three days of the inspection.

Care plans had not been produced for some conditions which needed staff to be aware of people's specific needs and risks to them. There was no care plan for a person living with diabetes and there was confusion between staff and records about when and if blood sugar levels should be monitored. Another person had a history of anxiety which had led to them placing themselves at risk in the past. This information was not reflected in care plans or risk assessments meaning that staff were not guided in how to manage any similar situation which might arise.

We spoke to the new manager about gaps in care planning. They told us they had been, "Making sure all risk assessments and care plans are up to date and relate to that person". They said this was working progress and were aware more work was needed. The provider was reliant on agency care staff which meant they may have been less familiar with people, their needs and wishes. Therefore, it was essential care plans reflected people's care needs and personal preferences accurately.

Social occupation and activity varied in quality over the three days of the inspection. One staff member sat and completed a jigsaw with a person, but there was very little interaction between them while this happened. Mostly people were sat in the dining area or lounge with very little opportunity to become involved with an activity. In the afternoon of the second day of inspection, eight people were seated in the lounge with the TV on. Some people were watching TV but others were not. One person kept saying "What am I supposed to do now?" and "I don't know what we're meant to do" to which care staff responded, "You're watching TV now". This person did not receive any opportunities to socialise instead was positioned in front of the TV.

There was no detailed end of life care plan for a person we were told had been receiving palliative care. Although there was information about next of kin and funeral arrangements, there was no person-centred record of the person's wishes and hopes for their final days. The end of life care plan for another person was completely blank, which meant staff would not know how to care for the person responsively at the end of their life.

The provider used a written format for care plans which was appropriate for some of the people living at the home but not all. The Accessible Information Standard (AIS) is a requirement of NHS and adult social care services to ensure that people with a disability or sensory loss are given information in a way they can understand.

Whilst care plans referred to the AIS, there was a lack of assessment completed to show how information should be recorded or shared with the person in an accessible way that specifically met their communication needs. Reasonable adjustments had not always been made to ensure that people's information needs had been identified or consistently met according to their needs. For example, people's care plans were in the written form, other alternative's such as a larger letter font or pictorial references had not been considered.

The lack of person-centred care, based on people's preferences is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, at other times people were more engaged in activity. There was a sing-along one day and a lively church service with a choir another. An activities coordinator worked full time and told us about the events on offer to people; which included music, quizzes, exercises, visiting entertainers and outings. People who were able to tell us their views said, "They do try to provide entertainment for us all, like visiting singers" and "There's enough going on for my interest". A relative said, "The events they put on for residents and relatives have been great".

During the inspection we spoke with the providers recently appointed engagement director. They told us about the steps they were taking to improve opportunities for people living at Clemsfold House. They spoke positively about the plan to link up people with one of the other homes owned by the same provider. The engagement director said this was to improve on the amount of opportunities people had to socialise with other people and spend time in a different environment.

People and their relatives who were able to speak with us said they knew how to make a complaint if they needed to. However, they added that they had not had cause to complain. One person said, "No complaints from me, I would speak up if I had a problem". A relative commented, "I have had no reason to complain about anything". There was an easy to read, picture-based complaints procedure on display in the service and records demonstrated complaints and comments from people's representatives had been acted on and responded to, in accordance with the providers policy.

Inadequate

Is the service well-led?

Our findings

At the last inspection in November 2017 we found there were systems to assess, monitor and improve the service but these were not being operated adequately. There were four breaches of Regulation and because of this the service was rated as Requires Improvement. Shortly after the inspection, the provider informed us of the action they were taking to address this.

At this inspection, we found care had deteriorated significantly and people were not being provided consistent safe care and treatment. There had been a failure by the provider to lead and supervise staff to ensure people's needs were being met safely. This included significant concerns regarding how people were being supported to move, how medicines were managed and how people were supported with specialist diets. We also found people's weights had been audited, but the information that arose from this did not ensure people had received professional input when necessary. The audit clearly showed some significant weight losses but the follow up action did not take place by the provider's management team, until we highlighted this at the inspection. Therefore, the audit was ineffective.

There had also been ineffective oversight of people's DNACPR status, leading to confusing information being held in different places. This created the risk that people may be given CPR when an order had been made that this was not in their best interests. The competency and suitability of agency staff had not been properly assessed or considered, leaving people at risk of inappropriate treatment. Staff both permanent and agency failed to challenge poor and unsafe practices. This created an unsafe culture whereby people experienced poor care and treatment. We have explored these areas fully within other sections of the report.

We fed back our concerns to the management team, throughout the inspection. The provider's nominated individual told us that they were already aware of the problems we highlighted during the inspection. They said, "You're not telling us anything we don't know". They added that their own audits had picked up on similar concerns to those found by inspectors. However, there had been inadequate action to remedy the significant failings for the people living at the home, prior to this inspection. At the end of the inspection the provider's nominated individual informed inspectors they were due to close Clemsfold House. They told us this was temporary and due to recruitment issues; high use of agency staff and maintenance works they intended to carry out.

After the inspection, we wrote to the provider's nominated individual to highlight our concerns further. The nominated individual responded the next day and told us the actions they were taking to mitigate immediate risks to people and confirmed the home would be closing temporarily within 28 days.

Since the last inspection, there had been a change within the management structure. The manager, who had been in post since August 2018 told us they had been supported by a peripatetic manager and the regional operations director. The provider had developed a new senior management team. The new senior management team were making checks on care delivered to people. This included quality auditors carrying out audits on the service which were to include areas that needed improvements. However, the systems to

check the quality and safety of care provided to people remained ineffective at the time of this inspection.

At this inspection we found inconsistencies with the provider working alongside partner agencies. We found people had not been protected from harm and have explored this in the Safe section of this report. Records did not reflect people had always been referred to the appropriate health and social care professionals. Various health and social care professionals visited the service due to the concerns we found during the inspection and a need for people to be reassessed prior to a move to a new home. This included a senior moving and handling advisor. They found further safeguarding concerns relating to how people were being supported to move which was shared with the local authority safeguarding team. This meant despite highlighting similar concerns to the management team earlier in the month during the inspection, the provider had failed to ensure moving and handling support had improved and therefore had placed people at further risk from harm.

The provider had failed to put in place robust measures to drive quality and sustain improvements at the service. We raised some of the concerns at this inspection at the last inspection and in other inspections at other locations owned by the provider. This had not encouraged the provider to ensure improvements to the quality and safety of care provided to all people living at Clemsfold House had been made.

The provider had failed to ensure there were appropriate systems implemented to assess, monitor and improve the quality of the service. The provider failed to maintain accurate records. This was a continuing breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

The manager was not registered with the Commission. This meant they did not have the legal responsibility to meet the requirements of the Health and Social Care Act. They told us they were concerned about what the inspectors had found and told us recruitment had been difficult. However, they told us they were working well with the deputy manager. They told us they had, "action plans and were systematically working through them". They complimented the support they had received from the senior management and said, "I couldn't ask for any more support from [named peripatetic manager].

We spoke to a mixture of permanent and agency care staff during the inspection. A permanent staff member told us they had just received supervision and had an appraisal once a year. They told us this provided an opportunity to discuss issues in relation to their role and responsibilities. However, they told us they were concerned about the current support from the management team. They said, "They don't know what's going on, on the floor". They told us they appreciated the management team were still very new but felt they did not spend enough time with people and said, "The management are always in the office". They explained this was a concern as the office had moved upstairs away from where people spent their time.

We checked how the provider gained people's and when necessary, relative's views of the quality of care provided. People were provided opportunities at care planning reviews and at resident meetings to share their views. Relatives could speak with staff when they visited and surveys were sent out monthly from the provider's head office. Survey responses we read were all positive.

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 9 HSCA RA Regulations 2014 Person-centred care Personalised care was not consistently provided to all service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff failed to consistently respect and promote service user's dignity when supporting them.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider was not consistently working in accordance with MCA legislation.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Service users nutritional needs were not consistently met.

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 Failure to mitigate risks on behalf of service users.

The enforcement action we took:

Imposed provider level conditions see overall summary

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 Failure to escalate and investigate safeguarding concerns therefore failed to protect service users

The enforcement action we took:

Imposed provider level conditions see overall summary

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had ineffective governance systems in place which placed service users at risk from harm.

The enforcement action we took:

Imposed provider level conditions see overall summary

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure staff were skilled and competent placing service users at risk from harm.

The enforcement action we took:

Imposed provider level conditions see overall summary