Clovelly House Residential Home Limited

Clovelly House Residential Home LTD

Inspection report

81-89 Torrington Park
Finchley
London
N12 9PN

Tel: 02084456775

Date of inspection visit:
01 April 2021
20 April 2021

Date of publication:
31 August 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Clovelly House Residential Home Ltd is a residential care home providing accommodation and personal care to 41 people at the time of the inspection, most of whom were living with dementia. The service can support up to 48 people.

Clovelly House is a large care home comprising of separate residential houses linked together. The home also has access to a large spacious and well-maintained garden.

People's experience of using this service and what we found

Feedback from relatives on the care provided at Clovelly House was positive such as kind and caring staff, clean and well-maintained environment and a responsive management team. However, we found significant concerns throughout the inspection which impacted on safety and quality of care and people's well-being.

Seclusion was used at the service, for example locking people in a bedroom or communal lounge. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Safeguarding procedures were not well established at the service. Allegations of abuse and incidents of a safeguarding nature were not always reported to the local safeguarding authority or CQC. Not all staff understood what whistleblowing meant and how to report concerns.

Accidents and incidents were not always appropriately reported or investigated. Learning was not always identified.

Some staff spoke of a bullying culture where they felt unable to report concerns without repercussion for their employment at the service.

Staff were not deployed across the home in a way that met people's needs adequately and communal areas were left unattended for significant periods of time which placed people at risk of harm.

Not all people were receiving care which was personalised to their needs and preferences. We saw instances of where people were taken to other people's bedrooms for significant periods of time, without sufficient reason. We observed some kind and caring interactions, however we also observed people were left for long time periods with little stimulation or staff engagement.

The home was clean and well-maintained and infection prevention measures were in place to manage the

risk of COVID-19. However, we observed staff not always wear personal protective equipment (PPE) in line with national guidance.

People's personal risks were assessed and risk assessments provided staff with information on how to minimise known risks, however, we observed people were not always safely supported with moving and handling, which placed people and staff at risk of harm.

Medicines were managed safely.

People were supported to eat and drink, the dining experience was inconsistent across the service with people not always offered choice.

Appropriate recruitment procedures ensured prospective staff were assessed as suitable to work in the home.

Following the inspection, the provider accepted that care fell below acceptable standards, advised that lessons had been learned and put steps in place to improve quality of care for people using the service.

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

Rating at last inspection
The last rating for this service was good (published 30 October 2019).

A thematic infection prevention and control inspection was carried out on 14 August 2020. At that inspection, we were overall assured that appropriate measures were in place to manage the risks posed by the COVID-19 pandemic. The service was not rated at this inspection.

Why we inspected
The inspection was prompted due to concerns received about staffing levels and allegations of abuse. A decision was made for us to inspect and examine those risks.

We undertook this targeted inspection to follow up on specific concerns which we had received about the service. We inspected and found there were wider ranging care concerns, so we widened the scope of the inspection to become a comprehensive inspection which included all five key questions.

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 five breaches in relation to staffing, protecting people from abuse, safe care and treatment, person centred care and good governance at this inspection.

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

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

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

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

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

This service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below

Inadequate

Clovelly House Residential Home LTD

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
This inspection was carried out by four inspectors and an inspection manager on two days. An Expert by Experience supported the inspection by making telephone calls to families for feedback on the care their loved one received. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Clovelly House Residential Home Ltd 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 registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The registered manager was also the Nominated Individual and Company Director.

Notice of inspection

This inspection was unannounced on both days of site visits which happened on 1 April 2021 and 20 April 2021.

What we did before the inspection
We reviewed information we held about the service since the last inspection. We liaised with the local authority safeguarding team. 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. This information helps support our inspections. We used all this information to plan our inspection.

During the inspection
We spoke with two people who used the service and seven relatives. We spoke 12 members of staff including the registered manager, deputy manager, head of care, senior care staff, care staff and domestic staff.

We undertook observations of people receiving care to help us understand their experiences, especially for those people who could not talk with us.

We reviewed a range of records. This included eight people's care records and ten medication administration records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures, rotas and audits and training records were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We reviewed CCTV footage. We liaised with and received feedback from the local authority safeguarding team, police and some health and social care professionals who have regular involvement with the service.

Inadequate

Is the service safe?

Our findings

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

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

Systems and processes to safeguard people from the risk of abuse

- We were not assured that the provider has adequate systems and processes in place to safeguard people from the risk of abuse.
- On review of CCTV footage, we found instances of where people were locked into a lounge by staff and left for long periods of time. People were unable to enter or leave the lounge or summon assistance if needed. We reported our findings to the registered manager who advised that the lock which had been fitted for another purpose had been misused by staff and was subsequently removed from the door following the first day of the inspection.
- On commencement of the inspection, we also found a person locked into a different person's bedroom. The lock and handle had been disabled and the door was locked from the outside with a lock that had been fitted at height. The person was unable to leave the room once the door was locked unless it was opened from the outside. This is a form of seclusion. This was reported to the police and at the time of reporting subject to investigation.
- Some staff we spoke with told us that it was a common occurrence for people to be taken to a bedroom and kept there. One staff told us they thought it was "cruel."
- The provider's policy on restraint and seclusion was not clear around what constituted restraint or seclusion in their care setting or what appropriate circumstances seclusion could be used. It referred to staff being trained to understand restraint and how to avoid circumstances where restraint was used. From review of training records, staff had not received this training.
- We found an incident of a safeguarding nature that should have been reported to the local safeguarding authority and CQC, which had not been done. This was an allegation of physical abuse. We spoke to the management team about this who advised that they did not think these were reportable as they had investigated and concluded the incident had not happened. The management team were not clear on what type of incident constituted a possible safeguarding concern and when to report.
- We reviewed the provider's safeguarding policy and saw it did not provide clear guidance on all of the different types of abuse that could occur in a care setting and also the specific procedure all staff should follow on how to report safeguarding concerns to the local authority or other appropriate external bodies.
- Not all staff were knowledgeable on what whistleblowing meant and how to report concerns. We checked the provider's training records and saw that seven staff in employment at the service had not received training in safeguarding some of whom had been employed over nine months at the time of the inspection.

The provider had failed to safeguard people from abuse and improper treatment. This was in breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

- Following the inspection, the provider sent updated policies for restraint and safeguarding. The

safeguarding policy had additional information procedures staff should follow if they had safeguarding concerns.
● Safeguarding training was subsequently arranged for most staff who had not received any training.
● Posters providing guidance on safeguarding, reporting concerns and whistleblowing were visible on notice boards and staff and visitor bathrooms throughout the service.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Preventing and controlling infection
● Risks associated with people's care and well-being were assessed and guidance was available to staff on how to keep people safe. Risk assessments were regularly reviewed and updated as and when people's care needs changed.
● However, in practice, risks were not always effectively managed, and in line with risk assessments. For example, we observed on CCTV staff enter a person's bedroom alone with a hoist and sling to assist a person with moving and transfer on two occasions. We raised his with the registered manager who advised that this would not have happened. This placed the person and staff member at increased risk of injury. We heard from staff that there were occasions where they assisted or observed colleagues assist people with moving and transfer alone, when two staff were required.
● Furthermore, a person sustained an injury from a fall when receiving support from a single staff member with their mobility needs. The person told the local authority that the staff member supported them alone which was disputed by the management team and the incident records stated that two staff assisted the person. Subsequently, the management team acknowledged that the person was being supported by a single staff member who was new and not familiar with the person's mobility needs.
● We reviewed the provider's training records and saw that six staff employed over one month at the time of the inspection had not yet attended moving and handling training. Following the inspection, the registered manager confirmed that moving and handling training had been provided for all staff.
● On CCTV footage, we observed one lounge left unattended at various points throughout the day and in particular during the evening from approximately 6pm until 8pm with minimal staff presence. We observed staff lock the door to the lounge and return periodically to check on people by looking through the glass on the door or enter the room briefly.
● Staff were supporting other people to bed at the time. Some of the people left in the lounge at this time were at high risk of falls which placed people at increased risk of harm from falls or injury. We raised this with the registered manager who advised that lounges should not be left unattended at any time and that enhanced monitoring would take place to ensure this did not happen again.
● We observed on CCTV people were supported to the toilet by staff throughout the day. However, we observed that staff on three occasions left people on toilets for periods of between 24 and 35 minutes. Staff returned to communal areas during these periods and checked in people at intervals. These people required assistance with mobility and were unable to independently use the toilet or return to communal areas without staff assistance. People were placed at risk of harm from falls or being unable to summon assistance. Following this, the provider advised that additional supervision would take place to ensure people were safely supported when using the toilet.
● Accidents and incidents, including falls were documented and reviewed by the management team monthly. However, we noted that there was little investigation to establish the cause of falls or if any learning could be applied to reduce the likelihood of reoccurrence. This is further reported in the 'Is the service well-led?' section of the report.
● We observed on CCTV that on two days staff did not always wear PPE appropriately. We saw some staff wear facemasks below their chin and nose and other care staff not wearing face masks at all throughout their shift. This had not been addressed by the management team on the days in question. We reported this to the registered manager who advised that this would be addressed with the staff in question via their

disciplinary procedure.

The poor moving and handling practices, lack of observation of communal areas, lacking oversight of accidents and incidents and poor infection prevention and control practices put people at risk of harm and meant that the service was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Aside from the IPC concerns reported above, the provider had procedures in place to prevent and control infection. The service had a significant COVID-19 outbreak in January 2021. At the time the provider worked with Public Health England and local health protection team to deal with the outbreak.
● The premises were clean and there were clear processes in place with regards to daily cleaning to prevent the spread of infections. There was also up to date guidance available, including policies and risk assessments, around managing COVID-19 safely. One relative told us, "The cleanliness is outstanding; both of the living environment and the individual person."
● Staff had access to Personal Protective Equipment (PPE) such as face masks, gloves and aprons and additional training around infection control. We saw hand sanitiser stations around the home.
● Safe visiting procedures were in place, including temperature monitoring, lateral flow testing and designated visiting areas, including the garden.

Staffing and recruitment
● There were not always enough numbers of competent staff deployed to meet people's needs and keep them safe. We observed people being left for lengthy periods unattended in communal areas when staff were supporting people with personal care or in their bedrooms.
● Staff gave a mixed response, with some staff telling us the staffing levels were enough, had recently improved or were not enough. Comments from staff included, "We are pretty much coping with the staffing", "The staffing levels are okay. We have time at the moment" and "On [date] we were struggling with two staff. Next day it was four again."
● On the day of the initial inspection visit and the day before, we found staffing levels were not as set out by the rotas. On one day, there were four care staff on duty in the afternoon when there should have been five. This meant that where people required two staff to assist with personal care, lounges were left unattended. The registered manage told us that the staffing levels had been affected by short notice absence and other staff on annual leave. However, we observed that additional staff or senior staff who were present did not provide assistance to care staff on the floor.
● In one lounge, where people with more advanced dementia and care needs were supported, we observed two staff, both new to their roles assigned to that particular lounge. On the afternoon of the initial site visit, there were up to 12 people in the lounge, some of whom were attempting to get out of their chairs and walk. We observed staff attempt to keep people in their chairs which increased anxiety for some of the people who were trying to mobilise.
●The provider had a staffing dependency tool which took into account people's assessed care needs. This calculated total hours of care per week the service provided, however this did not then translate into how many staff was needed to ensure people's assessed needs were met.
● The registered manager spoke of a difficult period at the service staffing wise due to staff shielding or isolating at different times and some staff leaving employment at the service. They had also recruited several new staff in the past six months, who, at the time of the inspection had yet to complete some of the required training. Despite these staffing and recruitment challenges, the service continued to accept new admissions to the service.

The provider failed to ensure there were enough staff deployed to meet people's needs. This placed people

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

● Recruitment checks including Disclosure and Barring Service check (DBS), proof of identification and references from previous employment had been completed. DBS checks inform the service if a prospective staff member has a criminal record or has been judged to be unfit to work with vulnerable adults.
● However, we also found that application forms were not always completed with a full employment history and a written explanation of any gaps in employment.
● Where a reference could not be obtained the service did not always keep a written record of the actions it had taken to be assured of the employees conduct in their previous employment.
● We raised these issues with the registered manager, and they assured us that they would address them moving forward.

Using medicines safely
● People received their medicines safely and as prescribed.
● Medicines Administration Records (MAR) were completed accurately and where minor gaps in recording were identified through the provider's auditing processes, these were addressed.
● Medicines were stored safely, and checks showed that medicine stocks matched records.
● The service had a medication policy in place and carried out weekly and monthly medication audits. Staff were knowledgeable about people's medicines and the specific ways they needed to be administered.
● However, we did identify some minor issues with the management of medicines. All staff had received medication training and a knowledge check. However, the provider did not assess the competency of all staff to administer medication annually in line with national guidance.
● These issues were brought to the attention of the registered manager who agreed to address them.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- The home had a good relationship with their local GP practice who conducted weekly visits. Senior staff facilitated the visits and care records were kept updated to reflect any changes to people's care needs.
- The registered manager commented that they found accessing mental health and dementia specialist services during the past year difficult.
- The registered manager advised that they were looking at further improving relationships with local health teams.

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

- People ate and drank well. One person told us, "The food is fine." Relatives told us, "The food seems okay. Lots of it and proper meals, cooked on site in the kitchens" and "The food is great."
- People were observed to be supported appropriately during mealtimes with staff observed to kneel to people's level or sit at their level to encourage them to eat. People were seen to eat well and enjoy their meals.
- Specialist diets such as pureed or gluten free were provided. We observed that a pureed meal did not look appealing and the different elements were mixed together. The registered manager advised that the meal left the kitchen well-presented but was mixed by staff. They advised us that they would ensure this was rectified.
- However, we observed that there were inconsistencies with the dining experience in the different lounges at the service. In one lounge we observed that people were not told what they were being served. They were not offered choices of drinks and were not reminded what they had previously ordered or offered a choice at the time of the meal being served. We raised this with the registered manager who told us the staff in that lounge that day were new and still getting to know the people they were supporting.
- We saw that when staff observed one person not eating their meal, they immediately informed a member of the management team who carried out observations on the person and advised staff to obtain a urine sample for analysis to rule out a Urinary Tract Infection (UTI).
- People's nutritional needs were identified in their care plans. People at risk of not eating and drinking enough to maintain their health, had their intake monitored and weight regularly checked which reduced the risk of malnutrition, dehydration and associated illness such as UTI's.

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

- The service was overall well maintained and decorated to a high standard. Most people's bedrooms were

spacious, airy and decorated to their taste, with personal mementos.
● However, we found that one person's bedroom was in a poor state of repair and decoration. They had no bedside table and the chair was missing a cushion. The bathroom was not accessible, and the walls were chipped and marked.
● Following the initial site visit, the person was supported to move to another bedroom and redecoration of the bedroom had commenced.
● People had access to a large garden, accessible from communal lounges with ample seating. On the day of the inspection, we observed people were supported to spend time in the gardens as the weather was nice.
● At the last inspection, we reported that some aspects of communal areas were not dementia friendly, such as the use of whiteboards to display menu choices and activities. At the time, the registered manager told us they would look into the use of more dementia friendly signage and visual communication aids.
● At this inspection on both days, we observed the same as described above. We asked the registered manager about this and were advised that new staff were working and had not yet taken on the tasks of setting up the picture boards yet, although they were in use.
We recommend that the provider seek and implement national guidance on the provision of dementia friendly environments.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs were assessed prior to admission to the service. However, due to the COVID-19 restrictions in place, full face to face assessments was not always possible prior to accepting a new person into the service.
● The registered manager advised that this had brought about some additional challenges as they were not always fully aware of all people's care needs prior to them arriving at the service.
● We saw that following an assessment, care plans were developed based on the information obtained during the assessment process and initial observations of the person. Care plans were reviewed and updated regularly as people's needs changed.

Staff support: induction, training, skills and experience
● Most staff had received sufficient training in order to carry out their roles. We noted that due to COVID-19 restrictions, most face to face training had been suspended and as a result some staff had not received refresher training in 2020 or early 2021.
● At the time of the inspection, face to face training had resumed and the provider had a plan to catch up with missed training by the end of June 2021. We asked the provider to send an updated staff training overview, which was received.
● Most staff we spoke to told us they had attended some of the recent training sessions. Staff told us, "I have had recent safeguarding and moving and handling training" and "I had safeguarding and food hygiene training recently."
● Staff told us they had regular supervisions which was confirmed by records seen. The registered manager told us that despite the difficult year, they were able to maintain regular supervisions with staff. The registered manage gave examples of how they supported staff during the COVID-19 pandemic where staff were off work, isolating or experienced personal loss and unable to visit family abroad. Despite this, not all staff felt supported in their role at Clovelly House. This will be elaborated further in the 'Is the service well-led?' section of the report.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible,

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- Care plans documented people's assessed capacity and how that impacted on the care they required.
- Consent to care was appropriately documented and where people had decisions made in their best interests, this was clear from records seen.
- Most people living in the home required a DoLS authorisation which had been appropriately applied for. However, as referred to in the 'Is the Service Safe?' section of the report, we were not assured that in practice, staff used the least restrictive methods of care delivery. Daily care records did not state whether restrictive interventions, including locking people in the lounge or in bedrooms, were in people's best interests.
- The management team kept an overview of DoLS authorisations and reapplied for renewals in a timely manner.
- Family members told us that they were appropriately asked for consent around flu jabs and COVID-19 vaccinations for people using the service.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to Requires Improvement. This meant that some people were not always appropriately cared for or treated with dignity and respect

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- People and their families were complimentary about the caring staff at Clovelly House. One person told us, "They are polite." A second person told us, "Feedback from families included, "Fine really. They do a good job" and "Clovelly have always been very good since my relative went there in 2016."
- Most relatives told us they were involved in their loved one's care and consulted around decisions affecting their health and wellbeing. One relative told us, "Allowing me to keep in touch throughout the pandemic has been really helpful" and "They are very good at making sure I know what is going on when I call them."
- Care plans detailed people's cultural background and whether they required any support to practice a religion. Where people followed a cultural or religious diet, this was provided by the service.
- We observed some positive interactions where staff treated people with kindness and respect. We observed staff gently engaging people in conversations about their families and their interests. We observed staff chatting to people about current affairs and what was on television.
- We also observed some interactions which did not promote people's dignity or respect people's human rights. Some staff told us and we observed instances where some people were isolated from others in the home and were taken to other people's bedrooms, as reported elsewhere in this report. This indicated that not all people were treated with dignity and respect.
- We observed one staff member when speaking about the lunch time routine refer to people who did not require staff assistance at mealtimes as 'normals' and those who required assistance as 'feeders', which indicated a lack of respect towards people using the service. We spoke to the registered manager about this and were advised that they would ensure language like that was not used again.

Requires Improvement

Is the service responsive?

Our findings

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

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

● Relatives told us they were satisfied that their loved one's health and care needs were met at Clovelly House. They told us, "The staff are all helpful and responsive" and "Everything is excellent, they do everything so well and I'd recommend them to anyone."
● Care plans were detailed and reviewed regularly. There was information on people's backgrounds and where possible, families had been involved in the care planning process.
● Despite the positive feedback and detailed care planning process, we were not assured that all people were receiving care which was responsive to their needs or their wishes.
● We observed on CCTV a person being taken to different person's bedroom and they remained there for over three hours. When we queried this with the registered manager, we were advised that they had been taken to bed in the afternoon but were taken to another person's bedroom as opposed to their own bedroom.
● A second person was taken to another person's bedroom for a period of over five hours. We asked the registered manager about this and were advised that the person wanted to watch the traffic and the communal lounges were occupied that day. We requested their daily notes and noted the following was documented, "[Person] was very vocal in the morning, therefore [Person] was taken to the room when [Person] can watch traffic, people through the window. Snacks and lunch were served there and [Person] was assisted with personal care on a regular basis." It was not clear whether the person wanted to be taken to the bedroom or whether the decision was made by staff due to them being vocal in the lounge. The person had a mobility impairment and would have depended on staff to assist them with moving and transfer should they have wanted to leave the bedroom.
● A third person was taken to a different person's bedroom and was kept there for over three hours. We observed that this person required significant staff input as they liked to walk a lot which required staff to observe and support them for their own safety. However, at the time, their bedroom was occupied by the person noted above to be watching traffic, therefore they were taken to a different room. Their daily notes on that date did not reflect the account of events given by the registered manager when asked about this, in that their notes state that they were, "restless and irritated most of the day and kept walking around at all times." The care notes state that they were taken to their bedroom after supper time. This is not what was observed on CCTV as they were taken to a bedroom just before 2pm when the staff member supporting them was finishing their shift and did not return to the communal area until after 5pm.
● As a result of the restrictions posed by the pandemic, external entertainment such as singers and shows had been suspended. The registered manager told us that as restrictions eased, they had booked some of

their regular entertainers and were resuming a full programme of activities again.
● We observed some activities delivered by staff during the inspection visit, such as a quiz, a ball game and staff delivering manicures, which people were observed to engage well with.
● However, in a different lounge, we found staff interaction to be lacking. We observed staff engaging well with people who could respond and engage in conversation, but for other people who could not engage in conversation, we observed them sitting with little or no staff engagement.
● Staff were seen playing puzzles and games with people, but they were left unattended once staff had to assist another person or were called away.

The above evidences a lack of person-centred care. This is in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Families told us they had been supported to maintain contact with their loved one throughout the COVID-19 pandemic and were supported to visit safely as per government guidelines.
● Relatives told us, "My relative has a device and we can use it to chat/video call whenever we want", "Allowing me to keep in touch throughout the pandemic has been really helpful."
● On the days of the inspection, we observed families visiting the service and spending time with their loved ones in the garden and via a visiting window.

Meeting people's communication needs
Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
● Care plans included information about people's individual communication needs which we observed was being followed by staff. This included information about communication aids used by people, such as hearing aids or whether people needed to view documents in large print.

Improving care quality in response to complaints or concerns
● There was a complaint procedure in place. The registered manager investigated and responded to complaints with an outcome and actions taken documented.
● Relatives told us they had no concerns with making a complaint if needed and told us that any issues raised in the past had been resolved to their satisfaction.

End of life care and support
● People's care plans included their preferences for end of life care. Where people did not wish to discuss this, this was noted.
● Senior staff had received training around how to support people at the end of their lives and worked with the appropriate health professionals such as the community nursing team to meet people's end of life care needs.

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 Good. At this inspection this key question has now deteriorated to Inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● There was not an open culture within the service. Some of the staff we spoke with during and after the inspection reported a bullying culture, lack of support from some members of the management team and when staff raised concerns, they were asked to leave the service. One staff told us, "Clovelly has always had some staff who were rude. Some of them to colleagues and residents" and "Rude and bullying. No one wants to report anything."
● Other staff spoke positively of the management team and the support they received in their role.
● On commencement of the inspection on 1 April 2021, we immediately found that the concerns reported to CQC had been substantiated. The registered manager did not appear to understand the gravity of the concerns, and that as a result some people were receiving poor levels of care and placed at risk of harm.
● We asked staff about their understanding of whistleblowing and how to report concerns. Some staff did not understand what the term meant. Some staff told us that they reported concerns to members of the management team but did not know what happened afterwards. One staff told us that until they had recent safeguarding training, they did not know that staff who whistle blow were protected by legislation.
● We were not confident that the provider had been open and transparent with CQC and external stakeholders and agencies. We found instances of safeguarding that had not been reported to the local authority per local safeguarding procedures. Following the inspection, the registered manager gave assurances that they would make improvements to how accidents, incidents and safeguarding incidents would be reported to the appropriate external bodies in a timely manner.
● Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The provider had failed to inform the CQC of significant events including incidents and safeguarding concerns.
● A range of audits took place at the service and which included health and safety checks, infection control audits, care plan audits and night spot checks. However, these audits were mostly ineffective as they failed to identify the concerns highlighted on this inspection, particularly around poor moving and handling practices, low staffing levels, unattended communal areas, people being taken to other people's bedrooms rather than to their own bedrooms and poor safeguarding procedures.

● The registered manager advised that the day in question was a particularly busy day at the service, due to short staffing and demands on the management team however the care practices seen indicated that the concerns seen were not isolated to one particular day as supported by CCTV footage. .
● We were not assured of the accuracy of care records. One incident where a person sustained an injury whilst being supported to transfer had been inaccurately documented, in that the incident reported stated that they were being supported by two staff which, was established by the safeguarding enquiry had not been the case.
● We also found that a retrospective entry had been made into another person's care record after we had queried why they had been taken to another person's bedroom for over three hours. On initial review of the care record, there was no entry on the day to support what we had observed on CCTV. Following the inspection, we received additional documentation from the registered manager regarding this person and noted that an entry had been made to refer them being taken to their room as they were restless and irritated that day.
● Accidents and incidents, such as falls were not appropriately reviewed to establish the cause of an incident or whether any learning or steps can be taken to reduce the incident happening again.
● For example, we saw where a person had two unwitnessed falls in a communal lounge in the evening, the review of the incidents did not evidence what an investigation took place by the management team to establish the circumstances of the falls or whether the lounge was unstaffed and for how long, since we also observed the lounge being left unattended frequently.

This was in breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During and after the site visits, requests for information, care records, CCTV and additional documents were made to the registered manager, who co-operated and provided all information requested. The registered manager also provided an action plan which set out how they proposed to make improvements at the service.
● Most relatives were happy with the care their loved ones received at Clovelly House and had a high level of confidence in the staff and management team. Relatives told us, "I wouldn't want my [Service User] moved anywhere else", "Everything is excellent, they do everything so well and I'd recommend them to anyone" and "We feel lucky we chose Clovelly after researching many other places, and I have been most satisfied whenever I have visited in previous years." We noted that many of the relatives we received feedback from had not been able to visit their loved one regularly due to the restrictions posed by the pandemic.
● After the inspection concluded, the registered manager provided evidence and updates that they were addressing the concerns identified in the inspection and their commitment to making positive changes to improve systems and processes at the service and overall improve the care people received.
● A new manager was appointed with the intention of applying for registration with CQC. They introduced new quality checks at the service such as daily documented manager walkarounds to ensure that care was delivered safely and in a person centred way.
● The service also evidenced that they were working with the local authority care quality team to develop an action and improvement plan and avail of support and staff training opportunities.
● The management team also confirmed that they accepted that the inspection highlighted areas where they needed to improve and they advised that lessons had been learned and steps would be taken to ensure this would not happen again.

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 9 HSCA RA Regulations 2014 Person-centred care Regulation 9(1) The provider had not ensured all people were receiving care in line with their needs or preferences.

The enforcement action we took:

We imposed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1) The provider was not providing care in a safe way as they were not doing all that was reasonably practicable to mitigate risks to service users.

The enforcement action we took:

We imposed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13(1) The provider had not safeguarded people from abuse and improper treatment. The provider had not appropriately reported safeguarding concerns to the local safeguarding authority.

The enforcement action we took:

We imposed conditions on the providers registration.

Regulated activity	Regulation

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17(1) The service did not have effective systems in place to record and monitor the quality and safety of service provision in order to improve, learn and develop

The enforcement action we took:

We imposed conditions on the providers registration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18(1) The provider did not ensure there were sufficient levels of staff were suitable deployed to ensure all other regulatory requirements were met.

The enforcement action we took:

We imposed conditions on the providers registration.