Sussex Clinic Limited

Sussex Clinic

Inspection report

44-48 Shelley Road
Worthing
West Sussex
BN11 4BX

Tel: 01903239822

Date of inspection visit:
10 January 2019

Date of publication:
10 April 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We undertook an unannounced focused inspection of Sussex Clinic on 10 January 2019. This inspection was undertaken to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 4 and 6 December had been made. The team inspected the service against two of the five questions we ask about services: is the service well led and is the service safe? This is because the service was not meeting some legal requirements.

We did not inspect the remaining Key Questions because this inspection focused on the immediate risks and urgent concerns identified at the inspection on the 4 and 6 December 2018. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating in this inspection.

Sussex Clinic is a nursing home in Worthing for up to 40 people. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both premises and the care provided, and both were looked at during this inspection. There were 24 people living at the service at the time of the inspection. This included older people, younger adults and those with a physical disability. Some people were living with dementia. By the nature of their complex health and social care support needs, people who live at Sussex Clinic are considered extremely vulnerable

We previously inspected Sussex Clinic on 4 and 6 December 2018 and the service was rated as Inadequate. We identified serious failings and shortfalls in the care and safety of people living at the service which either placed people at or exposed them to significant risk of harm. There were multiple breaches of the Health and Social Care Regulations 2014. After the inspection we asked the registered provider to act to address the urgent risks and concerns we had identified. The provider responded and said what action they had taken to address the urgent concerns and what they would do to improve and meet legal requirements.

In response to the level of serious concerns in relation to safeguarding urgent conditions were placed upon the providers registration. Initially there was a restriction on all new admissions into the service until 9 February 2019. After this date there is a phased approach until July 2019. The condition was made to give the provider time to make sufficient improvements to the care people receive and the safety of the service. The provider has supported this condition which will remain on their registration until 9 July 2019.

At this inspection we identified continuing failings and shortfalls in the care and safety of people living at the service which either placed people at or exposed them to significant harm. The service was rated Inadequate and remains 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.

The service has been without a registered manager since June 2017. A registered manager is a person who has 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.

People were not always protected from abuse and improper treatment. Systems and processes to protect people from abuse were not operating effectively. There were three incidents that the provider failed to report to the local authority under safeguarding guidance. These included a grade four pressure wound, an unexplained injury and an allegation of physical assault by a person who lived at the service. This placed people at significant risk of harm as allegations and injuries were not being responded to appropriately.

People were exposed to the potential risk of harm as reasonable steps had not always been taken to assess and mitigate risks. There was a repeated incidence of a person cared for in bed not having access to a call bell. This placed the person at risk of not being able to receive the help they required. A person with a pressure wound was not receiving dressing changes in line with advice from the specialist health care professional and staff had not considered the risk of the wound deteriorating. This placed the person at risk of infection and further deterioration.

People were not always provided with safe care and treatment. The provider had failed to follow safety guidance and address the risk of harm from accidental ingestions or choking identified at the previous inspection. We observed a repeated incidence of fluid thickening powder being left easily accessible to a person with dementia. The provider had not made changes to the way fluid intake was documented to ensure people had sufficient amounts to drink.

The provider did not have an effective oversight of staff recruitment and had not ensured robust processes for ensuring people had suitable pre- employments checks undertaken, including a criminal records check (DBS). The provider had not taken measures to assures themselves of the suitability of employing a person with a criminal record. We had asked the provider to take immediate action to ensure peoples safety. The Provider wrote to us and gave assurances that they had applied for a DBS for this person which had been returned 'clear' of any criminal convictions. The person had returned to work. This information was incorrect and during the inspection the provider confirmed that this persons DBS was still in the application stage.

The provider had written to us to tell us about the measures they had put in place to address the concerns

raised at our last inspection. Some of the actions the provided told us they had done had not been undertaken. Staff had not received supervision in line with the providers action plan, audits of accidents and incidents and safeguarding concerns had not yet been undertaken. The manager outlined their plans to address these on behalf of the provider, along with rewriting all care plans and risk assessments which they described as being out of date.

The service was not well-led. The provider had made steps to recruit a new manager and five had been employed since April 2018. An interim manager had commenced the week before the inspection. This person is a registered manager at another care home owned by the provider and will be providing 24 hours a week management support to Sussex Clinic whilst a new manager is recruited. The provider had not ensured good governance and management oversight whilst the service has been without a registered manager. The findings throughout this inspection showed that there was a significant failure to assess, monitor and mitigate risks relating to the health, safety and welfare of people

Some actions had been taken since our last inspection, these included additional training sessions relating to safeguarding and completing documents appropriately. In response to our request for the provider to act to address urgent concerns relating to safeguarding, the provider had engaged an independent safeguarding consultant. Rooms previously occupied by staff were vacant and the provider informed us that they were no longer allowing staff to live in empty bedrooms within the service.

We identified multiple breaches of the Health and Social Care Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

People were not always safeguarded from abuse.

Risks to people were not managed to make sure they received the correct care and treatment they needed.

Safe recruitment practices were not followed.

Is the service well-led?

Inadequate

The service was not well led.

There was no registered manager and there had been many management changes.

There was no system in place to check that the service was being managed well.

Important records about what care people needed were not always accurate and up to date.

Sussex Clinic

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 was planned to check 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 home, and to provide a rating for the service under the Care Act 2014.

We previously inspected Sussex Clinic on the 4 and 6 December 2018. We identified serious failings and shortfalls in the care and safety of people living at the home which either placed people at or exposed them to significant risk of harm. We raised 13 safeguarding alerts to the local authority to enable them to consider these under their safeguarding procedures. There were multiple breaches of the Health and Social Care Regulations 2014. The service was rated inadequate and was placed in special measures.

We undertook an unannounced focused inspection of Sussex Clinic on the 10 January 2019. This inspection was undertaken to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 4 and 6 December 2018 had been made. The inspection team consisted of two inspectors. The team inspected the home against two of the five questions we ask about services: is the service Safe and Well-led? This is because the home was not meeting some legal requirements. This report only covers our findings in relation to those requirements. We did not inspect the remaining Key Questions because this inspection focused on the immediate risks and urgent concerns identified at the previous inspection on 4 and 6 December 2018. The ratings from the previous comprehensive inspection for these Key Questions were included in calculating the overall rating of this inspection. You can read the report from our previous comprehensive inspection, by selecting the 'all reports' link for Sussex Clinic on our website at www.cqc.org.uk"

Prior to the inspection we spoke with the local authority to seek their feedback. We looked at the information we held as well as information we had received about the service. We reviewed notifications the provider had submitted. A notification is information about important events which the provider is required to tell us about by law. We did not ask the provider to complete a Provider Information Return (PIR). This is because the inspection was unannounced and we were returning to the home to identify where improvements had been made. A PIR is information we require providers to send us at least once annually to give some key information about the home, what the home does well and improvements they plan to

make.

During the inspection we spoke with two people, the manager and the Nominated Individual. We viewed a range of records about people's care and how the home was managed. These included daily records for 24 people, accident and incident records, wound charts, staff recruitment records and records relating to the management of the home

Inadequate

Is the service safe?

Our findings

We have inspected this key question to follow up on the concerns found during our previous inspection on 4 and 6 December 2018. The provider was found to be in breach of Regulations 12, 13 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In response to the level of serious concerns about safeguarding the following condition was placed on the providers registration. The provider will not admit any new people into Sussex Clinic until 6 February 2019. Between the 6 February 2019 and the 9 July 2019 there shall be no more than one new admission every 10 days up to a maximum of 31 people living in the home. The condition was made to give the provider time to make sufficient improvements to the care people receive and the safety of the home. The provider has supported this condition which will remain on their registration until 9 July 2019.

This was because systems and processes to protect people from abuse were not operated effectively. The provider had failed to identify and report multiple incidents under safe guarding guidance. These included unexplained injuries and allegations of physical assault. Some incidents and accidents had not been recorded and staff did not know how to report an incident to the local authority to enable them to consider them under their safeguarding procedures. After the inspection we made 13 safeguarding referrals to the local authority.

Risks were not always assessed and mitigated. The provider had not considered the potential risk to some people who spent considerable amounts of time alone in their rooms. Some people had their doors closed. It was not apparent if this was in accordance with their preferences and something that they had consented to. Some people, due to their cognitive abilities, were not able to use their call bells to call for staff's assistance. This meant that people were at risk of being socially isolated and unable to call for help if needed. Substances, which had the potential to cause people harm if ingested, were not stored in a secure way. There was a risk that people who were living with dementia could have come to harm if they had come into contact with the substances. People did not always have access to sufficient fluids to maintain their hydration. Drinks were, at times, placed out of people's reach. Staff were not correctly recording people's fluid intake to enable them to accurately monitor people's access to fluids. People, who were at risk of developing pressure wounds, did not always have access to appropriate equipment to meet their needs and mitigate risk. There were concerns about the safety of the environment and equipment within it to ensure people were protected if there was a fire. The provider was not undertaking regular fire safety checks on equipment or the premises to ensure fire prevention and safety.

At this inspection on 10 January 2019, although the provider had made plans to make improvements relating to how incidents were monitored these were not yet implemented and we continued to have concerns in relation to people's safety. The provider told that they had reviewed the 13 incidents identified at the last inspection and incidents that had occurred since. At this inspection on 10 January 2019, records showed that this had not been robustly applied. A review of one person's care showed that they had made a previous allegation of physical assault in March 2018. This had not been considered under the local authority's safeguarding guidance at the time and had not been considered retrospectively following the

review. This person's previous allegations of physical abuse, identified during the inspection on 4 and 6 December was currently being investigated by the local authority had not yet been concluded.

A further two recorded incidents had not been reviewed or considered as safeguarding concerns. Neither had they been reported to the local authority to enable them to consider these under their safeguarding guidance. Both people had current safeguarding investigations with the local authority following the inspection on the 4 and 6 December 2018. One of the people had a grade four pressure wound, the other person sustained an injury whilst receiving support with their personal care needs. Staff had recorded this but there was no management review to ensure appropriate action had been taken to safeguard the person from potential harm. This placed people at significant risk of harm as incidents and allegations were still not being responded to appropriately.

People were not always protected from abuse and improper treatment. The provider has failed to respond to allegations, report and investigate safeguarding incidents. This is a continued breach of Regulation 13 of the Health and Social Care Act 2008(Regulated activities) Regulations 2014.Safeguarding services users from abuse and improper treatment.

People continued to be exposed to the potential risk of harm as reasonable steps had not always been taken to assess and mitigate risks. At this inspection we observed that a person who was cared for in bed, still did not have access to their call bed, this had been raised at the previous inspection on the 4 and 6 December 2018. The person had been verbally calling for staff for 10 minutes. A member of staff was in the adjoining bedroom changing bed linin, both bedroom doors were open but the staff member did not respond to the person calling. This person had also previously alleged that their call bell was taken away from them by staff. This was raised to the local authority following the previous inspection. The provider had failed to asses this risk and people were placed at potential risk of not being able to call or receive help when required.

The European Pressure Ulcer Advisory Panel (EPUAP) categorise pressure wounds dependent on their severity. According to guidance produced by EPUAP a category four pressure wound is a full thickness tissue loss with exposed bone, tendon or muscle. One-person's pressure wound had deteriorated from a category two to a category four within a month. The person was seen by a Tissue Viability Nurse (TVN) who issued very specific advice for cleaning and dressing the wound. Guidance stated that dressings should be changed every two days for two weeks. Records show that the first documented dressing change was five days after the advice was given. Subsequent dressing changes were not in line with advice from the TVN and staff had not considered the risk of the wound deteriorating further. This placed the person at risk of infection and further deterioration.

National safety requirements and advice were not being followed. During the previous inspection on 4 and 6 December 2018, we reported to the manager that two people, who were living with dementia, were placed at risk of harm. Thickening powder had been left within their reach and there was a potential risk of them of choking from accidental ingestion. At this inspection on the 10 January, this continued to be a risk. One person was calling out, "Have you brought dinner? I'm hungry" They were observed to be tapping their hand on a tub of thickening powder with an unsecured lid. This had been left on their bedside table. This was also observed by a member of staff who immediately removed the thickening powder. They told us that they were aware of the risk of asphyxiation by accidental ingestion of thickening powder, as outlined in the NHS England patient safety alert 2015. The provider also witnessed the incident and told us that because people at Sussex Clinic had limited mobility they had not considered this to be a risk. The provider had failed recognise that the persons mobility did not mitigate the risk as staff actions had left the thickening powder within the persons reach and with an unsecure lid.

The provider has failed to assess, record and do all that was reasonably practicable to mitigate risks to people's health and safety. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

In response to some urgent action we asked the provider to take following the comprehensive inspection on 4 and 6 December 2018, they informed us of what actions they had taken to assure themselves of safe recruitment practices for two people. They told us that one member of staff was no longer employed at the care home. For another member of staff, they had taken measures to assure themselves of the persons suitability by undertaking a DBS check. The provider said that further steps to ensure peoples safety had been taken by not allowing the person to work whilst the application was being applied for. We were told that "This person had now returned to work as their most recent DBS check had been received and came back clear" At this inspection on 10 January 2019, we asked for confirmation that the DBS had been returned. The provider was unable to provide us with this and told us that the information they had included in their written response was incorrect and they had yet to receive it back. The provider told us that the member of staff had not worked at the home since the inspection on 4 and 6 December 2018. However, records of a staff meeting raised concerns about the accuracy of this information as the member of staff had signed to confirm their attendance. The provider had not ensured that they considered the risks of staff being employed with criminal convictions. Neither had they followed their policy of ensuring that they had updated information about staff's suitability to work, to help assure people's safety.

Safe recruitment checks were not always followed to ensure that fit and proper persons were employed. This was a continued breach of Regulation 19 of the Health and Social Care Act 2008(Regulated activities) Regulations 2014. Fit and proper persons employed.

At this inspection on 10 January 2019, the provider had systems and processes in place to ensure safe practices with medicines. Appropriate action had been taken in identifying and reporting a pharmacy error due to a prescribed dosage change. This had resulted in the person missing a morning dose of medication. An incident report had been completed and a referral to the local authority for them to consider under their safeguarding procedures had been made. The person's daily notes showed that appropriate medical advice had been sought and the person was checked hourly until they received their next dose of medicine. The person's relative had also been informed and the person experienced no adverse effects.

Some measures had been taken to addresses concerns that had been identified at the previous comprehensive inspection on 4 and 6 December 2019. In December 2018, a registered manager from the provider's other care home had provided 10 staff with a two-and-a-half-hour training session on safeguarding. Not all staff attended this training and the provider informed us that an external training provider had delivered additional training the day before the inspection on 10 January 2019.

Some measures had been taken to improve the accuracy of care records. 22 staff attended a team meeting led by registered manager of the provider's other care home. The agenda showed that the importance of completing records with honesty and clarity was discussed. New body charts to identify any bruising or injury were in place in people's care plans and two referrals to the local authority to enable them to consider them under their safeguarding procedures, had been made. A new policy for skin tears had been introduced and the provider told us that they would be renewing DBS checks for staff every three years.

At the inspection on 4 and 6 December 2018, we asked the provider to take immediate action to ensure the safety of people and mitigate risks from staff living in the service. The provider wrote to us to tell us that they had taken the decision to cease allowing staff to sleep at the service. At this inspection rooms previously occupied and all other vacant bedrooms at Sussex Clinic were empty.

Inadequate

Is the service well-led?

Our findings

We have inspected this key question to follow up the concerns found during our previous inspection on 4 and 6 December 2018. During this time the provider was found to be in breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014, this was a continued breach from the previous comprehensive inspection on 28 November 2017. There was a breach of Regulation 33 (Failure to comply with the condition of registration that there was no registered manager) of the Health and Social Care Act 2008 (Registration Activities) Regulations 2014 and a breach of Regulation 18 (Notification of other incidents) of the Health and Social Care Act 2008 (Registration Activities) Regulations 2014.

Concern was raised at the last inspection on the 4 and 6 December 2018 that the provider had not taken ownership of the oversight of the service or fulfilled their obligations and responsibilities in the absence of a registered manager. Staff were not being monitored or supervised and there were no quality assurance processes or governance systems in place to ensure that people were receiving a safe and effective service.

At the inspection on the 10 January 2018 the provider had continued not to take ownership of some of the concerns identified at the last inspection and had not made sufficient improvements to the care people received and the safety of the home. There had been a further change of manager, bringing the total of mangers in the last 12 months to five. The provider told us that all the previous managers were unsuitable and therefore did not register them with CQC to be the registered manager for the care home the service remained without a registered manager since June 2017.

Concerns and shortfalls raised at the last inspection about the lack of governance and quality assurance processes had not been addressed. The provider did not have oversight of accidents and incidents, and had failed to implement processes to audit and monitor these to ensure the correct action had been taken. The lack of oversight and monitoring of accidents and injuries meant that the provider had failed to identify that a further three recorded incidents since the last inspection had not been considered under the local authorities safeguarding guidance. They had also failed to identify that CQC had not always been informed of significant events in line with the requirements of their own registration.

There was not an adequate process for assessing and monitoring the quality of the services provided and that records were accurate and complete. There was a failure of management oversight and monitoring which placed people at continued exposure to the potential risk of harm as reasonable steps were not being taken to asses and mitigate risks. For example, there was a repeated incidence of people being placed at risk of asphyxiation because safety guidance was still not being followed and the provider had not been truthful with information given to CQC about following safe recruitment practices. The provider had failed to put in place processes to ensure care plans and risk assessments were reviewed. This meant that the provider could not be assured that people were receiving care in line with their assessed needs. Care plans and risk assessments remained out of date and the providers lack of governance and oversight had failed to identify that support was not always being given in line with health professional guidance. People were placed at potential risk of not receiving constant and safe care are support because the provider had not acted to

improve the governance of the service. Concern was raised at the last inspection on the 4 and 6 December 2018 that the provider had not taken ownership of the oversight of the service or fulfilled their obligations and responsibilities in the absence of a registered manager.

The home has been without a registered manager since June 2017. Not having a registered manager continues to be a breach of Regulation 33 (Failure to comply with a condition) of the Health and Social Care Act 2008 (Registration Activities) Regulations 2014.

The provider had acted to provide consistent management and oversight whilst a permanent manager was being recruited by arranging for an interim manager to oversee the service. This arrangement was made for 24 hours a week. This person is a registered manager of another care home operated by the provider and has temporally managed Sussex Clinic before. They had a good understanding of what was required to ensure people are provided with safe and effective care which meets fundamental standards. This person had been in post for one week and had therefore not begun to audit practices and procedures at the service or drive improvements. They told us that their priority was to ensure people were safe and this required them to rewrite all the care plans and risk assessments which they described as being out of date. They spoke to us about their plan to implement a process that will give management oversight and review of incident and accidents to ensure appropriate actions are taken, and to produce a monthly management report for the provider. The manager told us that there was a lot of work to do and they were prioritising keeping people safe. They showed us a new procedure they had written for testing blood glucose levels stating there had not been one in place previously.

In response to some urgent action we asked the provider to take to safeguard people from the risk of abuse following our inspection on the 4 and 6 December 2018, they wrote to us and told us that the new manager would undertake an audit of incidents and accidents and check the previous managers audit of such incidents. This audit had not been undertaken and a robust oversight of accidents and incidents was not yet in place. There was improved recording of incidents and injuries but there were no processes in place to identify, themes or trends and to try and prevent re-occurrence. The lack of processes and oversight meant that the provider was unaware that three incidents recorded since the last inspection on the 6 December 2018 that had not been considered under the local authorities safeguarding guidance. We were also not assured of the management support and arrangements outside of the 24hours a week the manager was currently providing. Neither the manager of the provider could confirm what these arrangements would be.

In response to some urgent action we asked the provider to take, the provider wrote to us and told us what immediate actions had been taken following the last inspection this included staff being offered supervisions to address the concerns raised and remedy them. Supervision records for staff showed that the last staff supervisions took place in July 2018. The manager confirmed that the information given to us by the provider had been incorrect. Staff had not received or been offered supervision since the last inspection. This meant that the provider had given CQC inaccurate information and had not monitored or supervised staff to ensure that people were receiving a safe and effective service.

The lack of auditing and processes meant that the provider had failed to identify the concerns and shortfalls found during this inspection on the 10 January 2019, and to act upon the risks and concerns identified at the last inspection. This included a failure to identify the continued inconsistencies in the recording of fluid intake for people who required their fluid to be monitored. The manager told us that action had not been taken to address this as the provider had not made them aware of the concern we had raised. The provider had not ensured good governance and management oversight of the service whilst there was no registered manager in place. They had failed to assess, monitor and mitigate risks relating to the health, safety and welfare of people.

There was not an adequate process for assessing and monitoring the quality of the services provided and that records were accurate and complete. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.Good governance.

Services that provide health and social care to people are required to inform CQC of important events that happen in the service. At the last inspection we identified 12 incidents that the provider had failed to notify CQC about. At this inspection we identified a further four which included a death of a person living at the service, one unexplained injury, a grade 4 pressure wound and one allegation of physical assault. This meant that CQC were unable to ensure that the correct action had been taken following each important event.

The provider has failed to notify CQC of relevant incidents that affected the health safety and welfare of people using the service. This was a continued breach of Regulation 18 (Notification of other incidents) of the Health and Social Care Act 2008 (Registration Activities) Regulations 14.

In response to some urgent action we asked the provider to take they wrote to us and confirmed that that they had engaged an independent safeguarding consultant. The consultant will support them to improve safeguarding practices and will undertake an audit of incidents and accidents over the last 6 months. The provider told us that the consultant will use this information to provide training and development for staff and support them to identify themes and mitigate risks.

The provider is engaging with the local authority to move the service forward. The local authority is providing staff training in moving and positioning in order to support safe practices. They have also been carrying out reviews of care plans for people who live at Sussex Clinic