Healthcare Homes Group Limited

Claremont Nursing Home

Inspection report

Claremont House and Lodge
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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Claremont Nursing home is a purpose-built care home providing personal and nursing care. The home is split into two separate ground floor units, Claremont House and the Lodge. Nursing care is provided to people living in Claremont House whilst specialist dementia care is provided to people living in the Lodge. At the time of our inspection 42 people were living at the service. The service can support up to 52 people.

People's experience of using this service and what we found
Improvement was needed to ensure people always received good quality, compassionate, individualised and safe care as a minimum standard.

Actions to detect, investigate and report allegations of abuse or neglect were not sufficient. Adults at risk were not always effectively safeguarded in a timely manner. The local authority had received a high number of safeguarding referrals from relatives and external professionals raising concerns about people's care. Due to the poor record keeping within the service, some concerns had been difficult for the local authority to investigate.

People did not always receive personalised care that met their needs. Some care records were poorly completed and did not reflect that people were receiving care in accordance with their assessed needs.

Staff had not ensured that risks relating to the development of pressure ulcers were fully mitigated, and that pressure relieving equipment in place was suitable and in line with best practice guidance.
Where people were at risk of falls, or had sustained falls, systems were not sufficiently robust to mitigate risk as far as possible; individual data was not being reviewed to identify themes or trends to reduce risk.

Staff had not always received regular supervision that ensured good practice within the service. Clinical training had not always been completed by all registered nurses, and training relating to falls prevention and pressure area care was not set as mandatory for staff to complete to ensure they were sufficiently skilled. Staff told us, and we observed, they were very rushed when supporting people, and felt they could not spend quality time with people. Some people told us that they had to wait for staff to respond to their request for support. Staff were recruited safely.

Auditing processes had not been effective. Analysis of accidents and incidents were not robust. Some areas we identified as requiring improvement at the last inspection continued to be unmet. This included completion of documentation to ensure people's assessed needs were being met, and the management of risk.

People were mostly supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Improvements were found in the management of people's medicines with some minor improvements still required. Where the supply of people's medicines had been an issue, staff had not always followed incident procedures, so that the issues could be promptly resolved.

Infection control procedures across the home were improved. However, some further improvements were required to ensure complete cleanliness within the home.

Systems and processes designed to identify shortfalls, and to improve the quality of care were not always effective. While some improvements were noted since the last inspection in February 2022, on-going concerns were raised on this inspection.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 24 February 2022).

We issued the provider with a Warning Notice, notifying them that they were failing to comply with the relevant requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, and a timescale by which they were required to become compliant. We undertook a remote review of the Warning Notice in November 2022, and found not all areas had been met.

At this inspection we found the provider remained in breach of regulations.

Why we inspected
We received concerns in relation to people's nursing care needs and safeguarding procedures. As a result, we undertook a focused inspection to review the key questions of safe and well-led only. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

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

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, staffing, safeguarding and 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 their rating to at least good. We will work with the local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Claremont Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

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
One specialist nurse advisor and 2 inspectors (one who specialised in medicines) carried out this inspection. An Expert by Experience spoke with people who used the service. 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
Claremont nursing home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Claremont nursing home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. A new manager had started in post in November 2022 but was not yet registered.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 10 people who lived at the home to hear their views about the care they received. We also observed staff providing support to people. We spoke with the manager, regional manager, service development and regulation director, a health care practitioner, the deputy manager, and a visiting paramedic linked with the GP practice who visited the home weekly. We reviewed 6 care plans, 21 medicines records, and documents relating to maintenance of the service. We requested further records such as audits, staff meeting minutes, and supervision records sent to us electronically.

After the inspection we spoke with 2 care assistants, and 7 relatives. We also received feedback from the local authority quality monitoring officer, a tissue viability nurse and a safeguarding practice consultant/social worker.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question inadequate. At this inspection the rating has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse;
- Information provided to us by the local authority informed us of 10 current alleged safeguarding incidents under investigation.
- People were not always protected from the risk of abuse. Actions to detect, investigate and report allegations of abuse were not always sufficient. Adults at risk were not always effectively safeguarded in a timely manner. An incident which had occurred in the home should have been reported to the local authority but had not been identified as reportable. This meant there was no independent oversight to ensure people were fully protected.
- An incident involving an altercation between two people had not been reported to safeguarding in a timely manner or investigated internally. The local authority told us this made it difficult for them to carry out their own enquiries as there was limited detail documented.
- Care staff were not always reporting skin injuries or bruising to senior staff so action could be taken and reported promptly where needed.
- External professionals such as tissue viability nurses raised safeguarding referrals in relation to concerns about the management of people's pressure area care, and how staff were monitoring this.
- Family members had also raised concerns directly to us and external professionals about their relatives' care. Following the inspection, further safeguarding concerns had been raised by family members.

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

Staffing and recruitment
- Improvement was required in relation to staffing levels and in meeting people's holistic needs. Staff told us they were rushed, and our observations confirmed this. A staff member told us, "It's like a conveyer belt really because so many people need [repositioning], we need one extra staff member it would make a huge difference. I'd like to sit and chat to people more."
- Some people living in the home told us that they sometimes had to wait for assistance. One person told us, "At times I feel I am waiting for the [toilet], I know they have got others to look after. I keep shouting to get them." Another said, "Not enough staff, sometimes they say we have not got enough staff so you will have to wait a bit longer, lunchtimes usually." Relatives also felt that staffing levels were not always sufficient. One relative said, "I don't think that there is enough staff, we sometimes have to wait at the door over 10 minutes before getting in."
- Some staff had not received regular supervision in line with company policy. Staff should receive appropriate ongoing or periodic supervision in their role to make sure competence is maintained.

● We could not be assured that staff were supported to undertake training and learning to enable them to fulfil the requirements of their role and keep people safe. For example, falls awareness and pressure area care were completed at induction, but were not set as mandatory training for staff to complete on a regular basis to ensure they remained skilled. Some registered nurses had not completed clinical training sessions as required.

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

● Safe recruitment checks were in place which included the completion of Disclosure and Barring Service (DBS) checks on employees. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to ensure risks had been fully identified, managed and mitigated. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made and the provider remained in breach of regulation 12.

● One person had developed deep tissue injuries which staff had not identified. The person was also provided with pressure relieving equipment which was not suitable for their needs, and which was not in line with best practice. Records completed by the service identified that poor practice could have attributed to the skin damage.
● Repositioning records did not always evidence people were repositioned in line with their assessed needs. This meant people may not be repositioned frequently enough to protect them from the risk of skin breakdown.
● Body maps that staff were completing daily did not always provide enough detail to understand what skin issues had been identified, and what action had been taken as a result. This was especially important as the service had acknowledged that changes in people's skin condition were not being reported promptly by staff.
● Where needed, it was not clear if people were being offered regular fluids as charts showed that fluids often stopped between 5 and 6pm. This meant that people were at increased risk of dehydration.
● Falls were not being reviewed robustly for themes and trends. The falls tracker and people's falls diaries did not contain the times of the falls so patterns could be identified. One new person had experienced falls prior to arriving at the service, but equipment was not put in place to mitigate this known risk. Equipment was put in place after the person had sustained a fall.
● Two people's care plans and risk assessments were not readily available to care staff, as these had been stored on a computer and had not been printed off. This meant that staff did not have access to guidance and information on people's care needs.
● Accidents and incidents were logged, and a root cause analysis (RCA) undertaken. However, these were not always sufficiently detailed. RCA's were not always carried out in a timely manner. For example, a person fell over the top of bed rails that were raised and should not have been, but the RCA was completed 12 days after the event, which included a recommendation to remove the bed rails. This did not demonstrate that the risk was immediately removed to prevent further incidences.

This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Checks for fire safety were in place. There were procedures in place to reduce the risks of legionella bacteria in the water system.

Using medicines safely

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

Enough improvement had been made and the provider was no longer in breach of regulation 12 in relation to medicines.

● Medicines were stored safely and at correct temperatures.
● Staff authorised to give people their medicines had been assessed as competent and we observed that they followed safe procedures when giving people their medicines.
● Information was available for staff to refer to about people's medicines. Written guidance for medicines prescribed on a when required basis (PRN) was available for medicines prescribed in this way and there was person-centred guidance on how people have their medicines given to them.
● When people were prescribed medicated skin patches there was sometimes a lack of additional records confirming patches had been applied to varying sites of the body to reduce the risks of skin side effects occurring.
● Records showed overall that the majority people living at the service had received their medicines as prescribed. However, for some people recent records showed they had not received all of their medicines because there had been delays in obtaining them. The service later told us that action had been taken to resolve medicine supply issues at the home.
● The service carried out regular medicine checks on people's medicines. However, we found that medicine related issues, for example around the supply of people's medicines, had not been raised by staff by following incident procedures. This is so that the issues could be promptly resolved, investigated and overseen by the manager in a way that led to learning and improvements.

Preventing and controlling infection

At our last inspection we were not assured that effective infection prevention and control procedures were in place. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12 in relation to infection prevention and control. However, further improvements are required to ensure complete cleanliness within the home.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises. However, some areas still required improvement, such as carpets which were torn, and storage of items on top of people's wardrobes.
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of

infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● Relatives we spoke with told us they were able to visit their relatives at the home.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)
● We found the service was mostly working within the principles of the MCA. One person was not consenting to aspects of their care, but an MCA was not in place. Once we raised it with the manager, this was implemented.
● If needed, appropriate legal authorisations were in place to deprive a person of their liberty.
● People's mental capacity had been assessed and where required, best interest decisions had taken place in partnership with the person and their representatives.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has changed to inadequate. This meant there were 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

At our last inspection the provider had failed to ensure robust oversight and leadership. This was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made and the provider remained in breach of regulation 17.

● The previous registered manager left the service in September 2022. There was a new manager in post who had not yet registered. There had been a lack of consistency in how the service had been managed, and there had also been changes at senior manager level.
● Despite issues being identified at the inspection in February 2022, the provider had not resolved all of the breaches from the last inspection and new issues had also emerged. The provider had failed to ensure people received a well-managed service which was safe. This exposed people to unnecessary risk.
● The lack of robust oversight had resulted in safeguarding concerns not always being reported or investigated in a timely manner.
● Analysis of accidents and incidents was not undertaken promptly enough, meaning that risks were not always identified and mitigated in a timely way and people were exposed to the risk of harm.
● Records relating to people's care were not always completed to show care was being delivered in accordance with people's assessed needs.
● The management team carried out a program of audits. However, these had not identified all of the areas of concern we identified at this inspection. Further work was needed to review the longer-term oversight of safety and quality at the service to ensure improvements are made, understood, embedded and sustained.

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People did not always achieve good outcomes or receive person-centred care. Where people had come to harm, reduction of risk was not always explored fully or in a timely manner.
● We observed that staff were kind and caring when interacting with people. People we spoke with told us

they felt safe with staff, but also told us they thought they were overworked. One person told us, "Not always enough [staff] like if someone is sick, that has been common, lots of regulars have left, they put too much on them but it seems to have settled down over the last six months, several times staff have come to my room in tears mostly from pressure of work."

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

● Reporting of notifiable incidents to CQC had improved. However, there was sometimes a delay on CQC receiving the information.

● The current manager understood their responsibility to be open and honest when things had gone wrong.

● Relatives generally told us the service made contact with them when incidents occurred, however, not all relatives felt this was the case.

● The new manager had recently taken steps to meet with relatives to improve their involvement in people's care, including in reviews of their care. Relative meetings had been planned.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● A 'resident' feedback survey had been completed in September 2022, and 12 responses were received. Whilst these showed mainly positive responses, it was unclear how other resident views were currently sought. The manager told us that more regular care reviews will be undertaken going forward where people will be asked for their views.

● We received mixed feedback from relatives as to how involved they felt. One relative said, "There are ongoing issues here that is why sometimes I question safety. The previous manager spent a lot of time in the office." Another told us, "I don't remember anyone asking my opinion." And a third, "I have not been asked for feedback on the service, but I am happy with the service."

● Staff told us that they enjoyed working at the home, but staffing levels impacted on the level of care they could provide. One staff member said, "New manager seems okay, but its early days. I just wish we had more time to spend with people."

Continuous learning and improving care

● Some staff had not received regular supervision. This means staff did not receive constructive feedback on their performance to support them to improve. The provider needed to ensure staff understood the training they received and that it was completed on a regular basis. More robust oversight in relation to staff training was required to ensure staff remained skilled and up to date with their learning.

● Lessons had not always been learnt to improve the safety and quality of the care that people received.

Working in partnership with others

● The local authority advised the service had not always responded promptly when information was requested in relation to safeguarding investigations.

● We observed on the day of the inspection that staff engaged well with healthcare professionals who attended the service.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks were not always mitigated in a timely manner. The service had not always provided appropriate equipment to minimise risk. Analyses to determine why incidents had occurred were not always promptly completed or well detailed. Falls were not reviewed to determine themes or trends. 12 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Safeguarding incidents had not always been identified as reportable, or reported in a timely manner. Internal investigations had not always been carried out. 13 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure people received a well-managed service which was

	safe. This exposed people to unnecessary risk. Systems and processes did not always enable the provider to identify where quality and/or safety are being compromised and to respond appropriately and without delay. 17 (1) (2) (a) (b) (c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staffing levels did not enable staff to meet people's holistic needs. Staff did not receive training relevant to their role on a regular basis to enable them to fulfil the requirements of their role. Clinical training was not always completed by registered nurses working in the service. 18 (1)