Clapham Village Care Ltd

Clapham Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Clapham Lodge Care Home is a residential care home providing personal care to up to 27 people. The service provides support to people who have a diagnosis of a dementia, Parkinson's disease and other conditions which included diabetes. At the time of our inspection there were 20 people using the service.

People's experience of using this service and what we found
Systems to identify and mitigate people's risk of falls was not effective, records were incomplete and there was no evidence of actions taken to prevent repeated incidents. People told us there were times when the care staff were under pressure. The deployment of care staff added to this pressure as additional tasks, such as cooking, routinely fell to them. Staff told us the administration of medicines did not feel safe, as they were constantly interrupted. Staff were recruited safely.

The service was not effectively managed, records were not fully completed, complaints were not recorded, and CQC was not notified of significant events. There was a lack of oversight and governance by the manager. Checks and audits were not effective to monitor the quality and safety of the service. Systems were not in place to demonstrate the service operated effectively to ensure compliance with the regulations. People and staff and had limited opportunity to feedback about the service.

People were 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.

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 on 6 December 2018).

Why we inspected
The inspection was prompted in part due to concerns received about accidents and incidents, staffing levels, medicines management and infection control practices. A decision was made for us to inspect and examine those risks.

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 good to requires improvement based on the findings of this inspection.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the

service can respond to COVID-19 and other infection outbreaks effectively.

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 see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Clapham Lodge Care Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to safe care and treatment, good governance and failure to notify CQC of significant events at this inspection

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

Follow up
We met with the provider to discuss the findings of this inspection and how they will make changes to ensure they improve their rating to at least good. We will request an action plan from the provider to further understand what they will do to improve the standards of quality and safety. 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 five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always 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.

Clapham Lodge Care Home

Detailed findings

Background to this inspection

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

Service and service type
Clapham Lodge Care 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. Clapham Lodge Care Home is a care home without 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. Following our inspection, the current manager has submitted an application to register. We are currently assessing this application.

Notice of inspection
This inspection was unannounced. Inspection activity started on 7 February 2023 and ended on 28 February.

We visited the service on 7 February 2023 and spoke with the provider and nominated individual on 28 February. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We spoke with 5 people who used the service and 6 relatives about their experience of the care provided. We spoke with 11 members of staff including the manager and 3 visiting professionals.

We reviewed a range of records. This included people's care records and medication records. We looked at records in relation to recruitment, staff supervision, audits, accident and incident records, staffing rotas and a sample of policies and procedures.

Following our visit to the service we looked at additional documents the manger and provider sent us. This included a variety of records relating to the management of the service.

Requires Improvement

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 good. At this inspection the rating has changed to requires improvement.

This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People were protected from potential abuse, they were not protected from the risk of falls and lessons were not learned from incidents.
- People's risk of falls had been assessed. However, we saw gaps in the recording of falls. The falls incident reports contained a section for the manager to complete detailing all actions taken as a result of the incident. We saw this section was not routinely completed. This meant it was not clear if any actions were taken to prevent a reoccurrence.
- The manager told us measures were in place to reduce risks to people. They said a member of staff was always present in communal areas such as the lounge and dining room. However, we observed several times when there was not a staff presence in the lounge.
- Staff were able to give details of falls people had had and were able to detail actions they had taken. However, there was little documentation to support this. For example, a member of staff told us that one person had a fall resulting in a minor injury that required stitches, this had not been documented in the persons care records. The lack of recording placed people at risk of inconsistent and uncoordinated care.
- A member of staff told us of an incident where a person had been found on their knees outside in the courtyard area. The persons care records gave details of observations staff had taken following the incident including checking the grazes to the persons knees. However, there was no evidence that the cause of the incident had been investigated or any actions were put in place to prevent a reoccurrence.

Systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This is a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- This was discussed with the provider following our inspection and they have changed how incidents are monitored, reviewed and used to improve the care provided. They told us, "Accident and incident records will be reviewed and … [electronic records system] will notify the manager/provider to read the content and review… to allow reflection and discussion with the team on prevention of further accidents."
- People and their relatives told us they felt safe living at Clapham Lodge Care Home. Staff were aware of their responsibilities to raise concerns and knew the correct steps to take and who to contact to raise these.

Staffing and recruitment

● Staff recruitment was safe but there was not always enough staff deployed to meet people's needs.
● People and staff told us they thought the service needed more staff at certain times of the day. A person said, "The mornings are very busy. If you ring the call bell, ring it at 7.45am you wait half hour. Ring it now, they'll be here in minutes."
● We saw care staff were also carrying out kitchen tasks. The duty rota showed, and staff confirmed, there was only one chef employed at the service. This meant that the job of cooking routinely fell to the care staff. This was discussed with the provider following our inspection. They told us they were in the process of recruiting an additional chef so care staff would no longer be working in the kitchen.

The provider had failed to ensure there were sufficient numbers of staff deployed. This placed people at risk of harm. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff recruitment processes promoted safety. The provider followed safe recruitment practices which included requesting references from previous employers and checks with the Disclosure and Barring Service (DBS). DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely
● Medicines were not always managed safely.
● We saw liquid medicines, which required discarding 28 days after opening, did not have an opening date recorded. This shortfall had not been picked up by the manager's audit.
● We could not be assured that people were receiving their time specific medicine as prescribed. For example, a person told us their medicine was not given at the correct time. The medicine administration record (MAR) did not specify the time the persons medicine was given.
● Staff expressed concern that the deployment of staff meant they were constantly interrupted whilst giving people their medicines. A staff member told us, "The interruptions make it hard to concentrate." They expressed concern that it did not feel safe and the interruptions could result in mistakes being made.
● We discussed this with the provider, they told us the action they were taking in response to the concern raised by staff. Staff would now be wearing a clearly marked tabard whilst administering medicines, to reduce the number of interruptions.
● Medicines were stored securely following current guidelines for the storage of medicines. There were dedicated places for storing people's medicines which were locked when not in use.

Preventing and controlling infection
● Safe infection control process were not always being followed by staff. For example, we observed staff assisting to hoist a person in the lounge, who was also responsible for food preparation on the day. The staff member had not changed their uniform. Staff told us this was common practice.
● There was an infection control policy in place and we were assured the provider was supporting people to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.

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 working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

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 good. At this inspection the rating has changed 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; 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; Continuous learning and improving care; Working in partnership with others

- The manager did not understand their responsibilities to raise concerns, record safety incidents, concerns and near misses, and report these internally and externally as necessary. The provider had not followed their responsibilities under the legislation and had not ensured that all significant events were notified to the Care Quality Commission.

The providers failure to notify the Care Quality Commission of significant events was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

- We were not assured the manager was following the duty of candour, improving the care provided or was effectively monitoring the quality and safety of the care provided. The manager told us, "There was a delay reporting safeguarding incidents because I was off work." We discussed whether any measures were put in place to prevent this happening again. The manager told us she was, "Training the care team leaders and showing them how to do things on the system." Staff we spoke to had no knowledge of this.
- We received prior information of concern regarding, accidents and incidents, staffing levels and deployment, medicines management and some of the infection control practices. Assurances were provided by the manager, however these assurances contradicted what staff told us and what we found during our inspection. For example, we saw that staff were not always present in communal areas as a measure to reduce people's risk of falls. Care staff did not routinely change their uniform when cooking and providing direct care as an infection control measure.
- Records relating to people's care and the running of the service were not fully completed. For example, there were 23 days in January with no activities recorded gaps in the recording of falls. Concerns and complaints were not documented.
- We could not be assured people's records were accurate. Fluid records viewed on site differed to the records submitted after our inspection visit. For example, a person's fluid record stated they had a fluid intake of 400mls for a 24 hour period, however the records sent to us by the manager stated the person had a fluid intake of 600mls for the same day. The reason for the discrepancy was not clear.
- The manager's audits were not effective and had not picked up issues identified during the inspection. For

example, an audit stated there were no areas of non-compliance with regulations and no audit or follow up on incidents of falls. This meant that any patterns or trends would not be recognised, addressed and the risk of re-occurrence reduced. The audit stated, 'We are currently monitoring and putting into place monitoring systems and ensure that the staff know where each resident is at any given time.' However, there was no evidence to support this.

● The provider carried out monthly visits to assess and monitor the quality of the service provision but had not identified the concerns we found during the inspection. The provider had not ensured that effective systems and processes were in place to assess, monitor and improve the quality and safety of the service. In addition, systems were not in place to demonstrate the service operated effectively to ensure compliance with the regulations.

The provider had not ensured that effective systems and processes were in place to assess, monitor and improve the quality and safety of the service. Systems were not in place to demonstrate the service operated effectively to ensure compliance with the regulations. This is a breach of regulation 17 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● The manager did not promote a positive and inclusive culture which promoted good outcomes for people. The manager told us people were able to give feedback regarding the service which included completing feedback surveys. Records showed only a small number of people had given feedback and there was no evidence of actions taken or improvements made in response to feedback.

● Staff surveys completed as part of supervision. Records showed the manager asked staff their opinion of the management during their supervision. Staff told us they did not feel able to share their views in this way. A staff member told us, "We were given a questionnaire about the manager, but I did not fill it is as it was not anonymous." Staff were apprehensive about talking to CQC, they did not want any comments they made attributed to them. They said they were, "Worried about repercussions."

● The manager told us there had been no complaints or concerns raised by staff, people or their relatives. Staff told us they had raised concerns with the manager regarding the staffing levels, however this was not documented and there was no evidence of any action taken by the manager.

● A relative told us they had raised a complaint with the manager regarding the tone of voice used by a named member of staff. This was not documented and there was no evidence of any action taken by the manager. Other relatives told us they had raised minor issues with the manager and were satisfied they had been resolved.

The provider did not have systems in place to receive or review feedback about the service effectively and had not used informal feedback to improve the quality of care provided. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider told us they were unaware any complaints had been raised. They said, "Concerns and complaints will be dealt with promptly in accordance with the homes complaints management policy. I will take an active role in dealing with all complaints from staff residents and their relatives to seek good outcomes."

● The provider shared details of the actions they had taken in response to our feedback and issues identified. They told us, "The home will be closely monitored by myself and my partner… we are very passionate about what we do and look to improve the quality of our 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	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the Care Quality Commission of significant events Regulation 18(1)(2)(e)(5)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to adequately assess, manage, monitor and mitigate risk to people's safety and wellbeing. Regulation 12 (1)(2)1,2

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider did not have effective systems in place to demonstrate the service was well managed. The provider failed to ensure the regulations were being met. Regulation 17(1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had failed to ensure there were sufficient numbers of staff deployed.

Regulation 18 (1).