Clarendon Mews Care Limited

Clarendon Mews Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Clarendon Mews Care Home is a residential care home providing accommodation and personal care to up to 47 people, many of whom are living with dementia. The accommodation is on three floors with a large lounge and dining area on the ground floor and smaller communal areas on the other floors. There is an accessible and secure garden at the back of the property. At the time of our inspection 46 people were living in the service.

People's experience of using this service and what we found
The provider failed to have adequate systems in place to assess, monitor and mitigate the risks to people's health, safety and welfare. They had not kept up to date with relevant legislation to keep people safe.

Systems to safeguard people from abuse or improper treatment were ineffective. People did not always receive safe care. At times people sustained emotional and physical harm from the care they received.

A lack of quality assurance processes meant there was ineffective management oversight of people's care and welfare needs. Audits were not in place to identify care which did not meet people's needs and care plans not being up to date.

The local authority were not always informed of safeguarding incidents. The provider failed to investigate or follow up incidents, accidents and falls appropriately. Opportunities to learn lessons and mitigate risk were missed.

People did not always receive their medicines as prescribed and medicines were not stored, managed or administered safely.

People's needs were not adequately assessed before they moved to live in the service. People and their representatives were not sufficiently involved in the care planning and review process.

Staff had not received specialist training in areas required to keep people safe and meet their care needs.

Records and risks associated to people's eating and drinking needs were not up to date although practical measures had been put in place to ensure risk was reduced at mealtimes.

Staff had police checks from the Disclosure and Barring Service in place before they started work. Effective processes were in place for maintenance and health and safety issues.

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 20 September 2017).

Why we inspected
The inspection was prompted in part by notification of a specific incident following which a person using the service died. This incident is subject to a criminal investigation. As a result, this inspection did not examine the circumstances of the incident.

The information CQC received about the incident indicated concerns about the management of people's eating support needs and specifically the risk of choking. We undertook a targeted inspection to examine those risks. We inspected and found there were widespread concerns with management oversight, evidence of people being physically restrained and lack of incident reporting to relevant authorities. We widened the scope of the inspection to become a focused inspection which included the key questions of Safe, Caring and Well-Led.

Since the inspection the provider has worked at pace and taken prompt action to start mitigating the risks. They have engaged a consultancy firm to support them make immediate improvements and have provided the CQC with a comprehensive action plan. They are working transparently and co-operatively with all agencies including the police, local authority and clinical commissioning group.

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 coronavirus and other infection outbreaks effectively.

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

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 identified breaches of regulation in relation to safe care and treatment, safeguarding people from abuse and improper treatment, treating people with dignity and respect, governance arrangements, staffing and failing to submit relevant notifications to the CQC.

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.

Follow up
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? The service was not safe. Details are in our safe findings below.	**Inadequate**
Is the service caring? The service was not always caring. Details are in our caring findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our Well-Led findings below.	**Inadequate**

Clarendon Mews 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 Care Act 2014.

Inspection team
This inspection was undertaken by one inspector on site and one inspector making phone calls to relatives and staff off site on 25 September 2020. Two inspectors were on site on 1 October 2020 and one inspector was making further phone calls to relatives and staff members.

Service and service type
Clarendon Mews Care Home 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.

Notice of inspection
This inspection was unannounced on both days.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We liaised with the police, local authority and clinical commissioning group. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information

about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with five people who used the service and three relatives about their experience of the care provided. We spoke with thirteen members of staff including two directors, registered manager, deputy manager, catering manager, senior administrator, senior carer, care and domestic staff. We also spoke with a professional who works with the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed a range of records. This included key elements of thirteen people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service including but not limited to policies and procedures, incident and accident recording and quality assurance processes were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. Amongst other records we looked at training data and health and safety records.

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 people were not safe and were at risk of avoidable harm.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- People were not protected from abuse and harm. Physical intervention can be required to protect people when they are at risk of harm. Records completed by staff for some people showed restraint took place routinely to manage behaviours that challenged. This included being held by their arms and legs during personal care tasks. This put people at high risk of physical and emotional harm. The service did not have a physical intervention or restraint policy in place and the registered manager, provider and staff lacked understanding of what restraint was.
- Staff completed incident and accident forms to report incidents, and body maps to report any marks or injuries. This included, for example, unexplained bruising, allegations made by people using the service, injuries and falls. These were not investigated or followed up appropriately by the registered manager or provider. This meant systems were not in place to protect people from the risk of abuse or recurring harm.
- People were at risk of harm because charts which recorded instances of behaviours that challenged contained very limited information and were not reviewed by management. Daily notes did not refer to significant incidents which had occurred. There was little recording of people's experiences of physical and emotional harm and systems were not in place to identify and remedy this. This increased the risk of abuse or improper treatment not being recognised or investigated.
- There were no systems in place to learn lessons when things went wrong. People were at risk of repeated incidents occurring such as falls and altercations as there were no processes to analyse what happened and how risk could be reduced.

Since the inspection the provider has confirmed no further physical intervention which restricts people's liberty unnecessarily has taken place and staff have received training in de-escalation techniques. The provider is working with all relevant authorities to make urgent improvements to ensure people's safety.

The provider failed to protect people from abuse and improper treatment. This is a breach of Regulation 13 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 - Safeguarding service users from abuse and improper treatment.

Assessing risk, safety monitoring and management; Using medicines safely

- People were at risk of harm as the system in place to update risk assessments and care plans to reflect their current needs was ineffective. For example, people who were assessed by the speech and language team (SALT) to be at higher risk of choking did not always have a risk assessment in place. Incidents of previous choking were not clearly set out in people's care and risk support plans. Where a choking risk

assessment was in place it did not make reference to use of the specialist de-choker suction equipment the service had available.
● Care plans and risk assessments were not updated when people's needs changed. For example, one person had moved from a normal diet to a soft diet, then on to a blended diet and returned to a soft diet. Their nutrition care plan stated they ate a normal diet. This meant they were at higher risk of harm due to eating the wrong diet.
● One person had assaulted a staff member and self-harmed in the night due to staff disturbing them during regular checks. Following this their nights checks were reduced. There was no information in their care records which gave this updated instruction to staff. This meant there was a higher risk of a similar incident occurring.
● Risk assessments were not in place for a range of known risks such as skin integrity, safe moving and handling or mental health support needs. This meant people were at higher risk of receiving unsafe care. Risk assessments for behaviours that challenged were not sufficiently personalised or detailed, and were not up to date.
● People who had behaviours that challenged did not have positive behaviour support plans in place. This meant staff did not have clear guidance on how to support individuals safely and reduce the risk of the behaviour recurring or escalating.
● People did not always have a means of summoning assistance when they needed it. We heard one person whose room was at the end of a corridor shouting loudly for assistance for ten minutes. We visited their room and saw their sensor mat, which set off a call bell when pressure was applied to it, was at the other side of the room and unplugged. This also put them at increased risk of falling. A member of staff rectified this immediately.
● People did not always receive their medicines as prescribed and there were unexplained gaps on medicine administration charts (MAR). Risks to people's health because of this was high. The medicines on handwritten MAR charts were not always recorded accurately. This increased the risk of medicines being given wrongly to people. The provider has accepted specialist support to ensure medicine processes are improved.
● Some people had prescribed medicines to be taken 'as needed' but did not have protocols in place setting out the circumstances when those medicines should be administered. People were at risk of being given medicines for sedation without a clinical reason and without the effectiveness being monitored. This meant people were at risk of being chemically restrained. The provider put protocols in place on the day of inspection.
● Medicines were not stored or managed safely. The medicines trolleys remained in the communal area all day and the temperature had not been checked since June 2020. Good practice guidelines for storing medicines were not followed.

The provider had not ensured people received safe care and treatment. Therefore, people were at risk of harm. These concerns constitute a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.

● People were at risk of being given food and drink of the wrong consistency and foods they were allergic to, as the information on display in the kitchen area was not up to date. This was rectified on the day of inspection. Other measures had been recently put in place to support people safely at mealtimes such as all staff being involved in assisting people, and colour coded plates to identify who needed what level of support.

Staffing and recruitment
● People were at risk of receiving unsafe care because staff had not been provided with specialist training in

supporting people with distressed behaviours. Staff told us they asked for additional training but this had not been arranged. The registered manager and provider told us a lot of people living in the service showed distressed behaviours which couldn't be managed in other services. However, they had failed to provide suitable training to staff to be able to support people effectively.

● Staff had not received training in supporting people with dysphagia who required assistance to safely eat and drink. There were several people who had been assessed by the speech and language team and required additional support from staff. Training had been undertaken for use of the de-choker device and refresher training was scheduled.

The provider had not ensured people received care from staff who were suitably qualified, skilled or competent. These concerns constitute a breach of Regulation 18(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing

● Staff had a Disclosure and Barring Service check completed prior to starting work which checked for any previous criminal convictions, and references were taken up. However, recruitment processes lacked all required information. For example, full employment histories and explanations of any gaps, and clear recording of who references were provided by. Any limits on staff working hours due to restrictions on their work permits was not clearly recorded on their file.

● Although staff told us staffing levels were sufficient and consistent, records showed there were not enough staff to engage meaningfully with people. We observed staff in communal areas but throughout the inspection days people were milling around with little to engage them or occupy their time. For people cared for in bed there were no references in their daily notes to any one to one time other than when care was being provided. An activities coordinator was due to start work but there had been a gap of around six months since anyone was in this post.

Preventing and controlling infection

● We found areas of the service which posed a risk of cross infection. For example, a trolley containing personal protective equipment (PPE), such as aprons and gloves, was kept in a toilet area. An unlocked cupboard was found to have several visors with staff names on them stored together, several laundry bags with dirty linen had been left in a communal area, several slings were stored together on hooks in a stairwell, slings were seen draped over a hoist in the corridor and a razor and toiletries were found in an unlocked communal shower room. The provider rectified these issues immediately following the inspection.

● Cleaning schedules were in place and monthly infection control audits were completed. Additional soap dispensers had been fitted in bedrooms and extra hand washing facilities for staff had been installed since the start of the pandemic.

● Staff were seen to wear masks throughout the inspection days. Trolleys containing personal protective equipment such as gloves and aprons were kept and used on each floor. There was plenty of stock available.

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 outstanding. At this inspection this key question has now deteriorated to requires improvement.

This meant people did not always feel well-supported, 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

- People were not always treated with dignity and respect. One person's communication care plan stated they worked well with female staff and weren't keen on male staff so would tell them to go away. However, one of their risk assessments confirmed two male staff should undertake personal care tasks and do these at speed due to the person showing distressed behaviours. This was also confirmed in charts which recorded numerous incidents of restraint in response to distressed behaviours.
- During lunchtime we observed a carer stand up and walk away from the person they were assisting to eat three times in a 15 minute period. The person was unable to eat without support so was left to wait. We also saw children's cartoons on the television during the lunch period which was not appropriate for people.
- People's confidential information was not always kept securely. The Medicine Administration Charts containing personal details of the medicines people took were visible on top of the medicine trolleys throughout the day in the communal area.

The provider failed to treat people with dignity and respect at all times. This is a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Dignity and respect

- Throughout the inspection we saw positive interactions between staff and the people living in the service. Staff generally spoke warmly about the people they cared for. People were encouraged to walk in and out of the garden freely and staff were seen spending time in the garden with people. One person who had lived at the service for a few months told us, "Oh yes, staff appear to be caring and helpful."
- People's care plans contained information about their preferences, likes and dislikes. Individual cultural and religious needs were outlined. Everyone had a 'plaque' on their bedroom door with conversation starters of things they liked and were generally interested in such as football. Staff were able to get to know people from the information available in the records. The registered manager and staff knew people well.
- Prior to the Covid-19 pandemic relatives were welcome to visit the service freely. Since restrictions commenced the service facilitated video calls with family members along with telephone calls and regular updates. This supported people to keep in touch with their loved ones and vice versa.

Supporting people to express their views and be involved in making decisions about their care

- There were no records showing people's needs were assessed prior to them moving to live in the service or of their, or their representatives, involvement in or consent to the care plans. This meant it was not clear

to what extent people and their supporters were aware of, or agreed to, the plan for their care delivery when they moved into the service.

● Care records were not up to date and the regular reviews recorded in the care records did not take place in consultation with people or their relatives. In addition, resident meetings did not take place. This meant opportunities for people to express their views about their care were missed. The provider told us people's views about things that mattered to them were sought individually and relatives we spoke to felt they were kept updated by the service.

● We saw staff offering choices to people of what they would like at breakfast time and what they would like to do, for example, go out into the garden.

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; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- The registered manager and provider failed to have systems in place to assess, monitor and improve the quality of the service. Processes to maintain oversight of people's care including care plans and risk assessments, medicines, accidents, incidents and falls were ineffective. This meant people were at risk of receiving unsafe care and of this not being identified and remedied.
- The provider failed to have a system in place to monitor the safe use of medicines. Quality assurance checks were ineffective at identifying significant concerns about the storage, recording, administration and use of medicines. This placed people at risk of harm.
- There was a lack of oversight of staff recording of people's care, such as daily notes and care monitoring charts. Records contained gaps, were scant in detail and lacked essential information. When people's food and fluid intake was recorded, there was no management oversight of the information to ascertain if people were eating and drinking sufficiently. This put people at risk of malnutrition and dehydration.
- Charts which were used to record incidents where people had shown distressed behaviours, were not reviewed and analysed regularly by the registered manager. This meant opportunities to review staff practice, understand people's needs better and improve their care were missed.
- The provider failed to have systems in place to assess and monitor care and records to identity safeguarding issues and staff compliance with safeguarding procedures. The registered manager failed to notify the local authority of safeguarding incidents. This meant external agencies were not aware of the emotional and physical harm some people experienced and people were not sufficiently protected from the risk of harm or abuse.
- The provider failed to have a system in place to monitor people's mental capacity to make decisions and to notify CQC when Deprivation of Liberty (DoLS) authorisations were received.
- Management oversight had not identified the poor quality of the mental capacity assessments and best interest decision making process. There were no assessments for some important decisions made on people's behalf when they were not able to make decisions for themselves. For example, one person had been put on a blended diet in January 2020. However, there was no assessment from the speech and language team and no evidence of a best interests meeting being held.
- The service did not always work openly, inclusively or in an empowering way, which meant people did not always have a good quality of life. There was a culture of physical intervention by staff to manage

behaviours that challenged which the registered manager was aware of. This was not in line with the stated ethos of not using restraint and caused emotional and physical harm to people living in the service.
● The registered manager did not promote a person-centred culture in the service. People and their relatives were not involved in regular reviews of people's care. There was no evidence in care records of people or their representatives consenting to care plans.
● Staff did not have access to the most up to date information about people's needs or preferences as their care records were incomplete and not up to date. This impacted upon the ability of staff to support people achieve good outcomes.

People had been harmed and were at risk of harm due to a lack of effective systems and processes to provide quality assurance and management oversight of all aspects of people's care. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The providers had an effective system in place to monitor maintenance and health and safety aspects of the service.

● The registered manager failed to submit notifications to the CQC, required by law, regarding outcomes of Deprivation of Liberty applications, incidents or allegations of abuse, serious injuries, police incidents or the development of pressure wounds.

This is a breach of Regulation 18 Notification of other incidents of the Care Quality Commission (Registration) Regulations 2009 (Part 4).

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
● The provider had not always exercised their duty of candour responsibility to be open and honest when things went wrong. Discussions did not always take place with people and their representatives when incidents had occurred.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● The service worked in partnership with other health professionals involved in people's care. For example, the doctor undertook a weekly visit and community nurses regularly supported people's pressure area care.
● The registered manager told us resident meetings did not take place as people living in the service were not interested in attending. It would be beneficial for people to have the opportunity to attend resident meetings if these could be facilitated, with social distancing measures in place.
● Relatives were contacted via monthly telephone calls which provided reassurance during the pandemic period when they were not able to visit the service. The provider informed us surveys were sent out to relatives but there was no report of the results available at the time of inspection. This meant it was not clear what feedback was received and what action had been taken in response.
● Monthly staff team meetings took place and a range of topics were discussed. Detailed minutes were produced after each meeting and circulated to staff to assist them in their roles.

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 10 HSCA RA Regulations 2014 Dignity and respect People were not always treated with dignity and respect at all times.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to provide training to meet people's identified specialist health and welfare care needs including behaviours that challenge, advanced dementia, complex mental health care, dysphagia.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured risks related to people's physical and emotional welfare and safety were identified, assessed and monitored. Action had not been taken to mitigate known risks to people's welfare and safety. Effective systems were not in place to ensure the proper and safe use of medicines.

The enforcement action we took:

We imposed conditions upon the provider's registration certificate.

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 The provider failed to safeguard people from harm and the risk of abuse. Physical intervention was used against people which was against the policy of no restraint. Systems were not in place to investigate and follow up incidents and accidents. Safeguarding incidents were not reported to the local authority.

The enforcement action we took:

We imposed conditions upon the provider's registration certificate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Quality assurance systems were ineffective and there was a lack of management oversight of all aspects of people's care and safety. There were inadequate systems in place to monitor the quality of care and drive improvements of the service.

The enforcement action we took:

We imposed conditions upon the provider's registration certificate.