Clovelly House Residential Home Limited

Clovelly House Residential Home LTD

Inspection report

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Ratings

Overall rating for this service	Inspected but not rated

Is the service safe?	**Inspected but not rated**

Summary of findings

Overall summary

About the service
Clovelly House Residential Home Ltd is a residential care home providing accommodation and personal care to 33 people at the time of the inspection, most of whom were living with dementia. The service can support up to 48 people.

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

People's experience of using this service and what we found
We received concerns around safeguarding and safe care and treatment. This was a targeted inspection that considered safe care and safeguarding people from abuse. Based on our inspection of these areas we were not assured that people were protected from these risks.

We found incidents of a safeguarding nature which had not been reported to the local safeguarding authority or CQC.

We were not assured that people were being safely supported with moving and handling. Not all staff were trained appropriately before providing support to people in this way.

We found one instance of multiple night staff sleeping whilst on duty.

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 inadequate (published 30 July 2021) and there were multiple breaches of regulations. Conditions were imposed on the providers registration around safeguarding, assessing risk, person centred care and governance. We also imposed a condition to restrict admissions without written agreement from CQC. As this was a targeted inspection where specific concerns were examined, the overall rating for the service has not changed and remains in special measures.

Why we inspected
We undertook this targeted inspection to check on specific concerns we had about people's welfare, safe care and safeguarding people from abuse. The overall rating for the service has not changed following this targeted inspection and remains inadequate.

CQC have introduced targeted inspections to follow up on Warning Notices or to check specific concerns. They do not look at an entire key question, only the part of the key question we are specifically concerned about. Targeted inspections do not change the rating from the previous inspection. This is because they do not assess all areas of a key question.

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 monitor the service. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified continued breaches in relation to safe care and treatment and safeguarding people from abuse at this inspection.

At our previous inspection in April 2021, we imposed conditions on the provider's registration. They came into effect on 27 August 2021 following a period to allow for the representations and appeals period to conclude.

Follow up
We will continue to monitor information we receive about the service until we return to visit as per our re-inspection programme. We will work with the local authority to monitor progress. If we receive any concerning information we may inspect sooner.

The overall rating for this service is 'Inadequate' and the service remains 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?

Inspected but not rated

At our last inspection we rated this key question inadequate. We have not reviewed the rating at this inspection. This is because we only looked at the parts of this key question we had specific concerns about.

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Detailed findings

Background to this inspection

The inspection
This was a targeted inspection to check specific concerns we had around safe care and safeguarding people from abuse.

Inspection team
The inspection was carried out by three inspectors and an inspection manager.

Service and service type
Clovelly House Residential 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. The registered manager was also the Nominated Individual and Company Director.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we already held about this service. This included details of its registration, previous inspection reports, subsequent action plan, and any notifications of significant incidents the provider had sent us.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service

does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

During the inspection
We spoke with four people who used the service and one relative about their experience of the care provided. We spoke with five members of staff including the registered manager, head of care, senior care workers and care workers. We undertook observations of people receiving care to help us understand their experiences, especially for those people who could not talk with us. We removed the services mobile phone under Section 63(1)(2)(e) of the Health and Social Care Act 2008 and reviewed video footage.

We reviewed a range of records on a targeted basis. This included incident reports, one person's care plan and risk assessment and two people's daily care records. We looked at two staff files in relation to recruitment and staff training. We reviewed CCTV footage.

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

Inspected but not rated

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 inadequate. We have not changed the rating of this key question, as we have only looked at the part of the key question we had specific concerns about.

The purpose of this inspection was to check specific concerns we had about safe care and safeguarding people from abuse. We will assess all of the key question at the next comprehensive inspection of the service.

Systems and processes to safeguard people from the risk of abuse
At the last inspection we found people were not protected from abuse and avoidable harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of Regulation 13.

● At the last inspection, we found that safeguarding procedures were not well established at the service. Allegations of abuse were not always reported to the local safeguarding authorities or CQC. Restrictive care practices, such as locking people into a bedroom and communal lounge were observed on the inspection and via review of CCTV footage. Following that inspection, a safeguarding plan was put into place to ensure people's safety.
● At this inspection, we noted that the locks had been removed from the doors affected. We did not find any evidence that this practice had continued. However, we observed instances throughout the inspection visit where people who attempted to mobilise from their seats were told by staff to sit down.
● We found video evidence of incidents of a safeguarding and possible criminal nature which had not been reported to the police or the safeguarding team at the time they occurred. These incidents placed people at risk of harm. These incidents had occurred between September 2020 and March 2021. We were not aware of these incidents at the time of the last inspection in April 2021. We reported these incidents to the safeguarding team and police and at the time of drafting this report are subject to further investigation.
● We are also reviewing these incidents outside of the inspection process.
● Most staff had since completed training in safeguarding.

The provider remains in breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management
At the last inspection we found people were not protected from risks associated with their care and treatment. 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 at this inspection and the provider was still in breach of Regulation 12.

● Following the last inspection, the registered manager advised us that staff would receive refresher training in moving and handling and that they would ensure that people who required mobility equipment would be supported to do so appropriately and safely.
● At this inspection, we observed the use of mobility equipment had increased, with people being supported to transfer using hoists. Throughout the day of the inspection, we observed transfers carried out in communal areas. Some transfers were carried out appropriately with good staff interaction seen. However, we observed some people were uncomfortable during the transfers and the equipment used did not appear to be fitted appropriately which resulted in sling belts digging into people's armpits and chests. We also observed in some instances, staff did not speak to or reassure people when they were being transferred.
● We reported these concerns to the registered manager who advised that they would review the equipment they had in place for all people who required this support and work with professionals in this area.
● We reviewed training records and found that nine staff in employment at the date of the inspection had not completed moving and handling training. Three of whom were observed carrying out moving and handling procedures. We discussed this with the registered manager who advised that these staff had not yet attended formal moving and handling training but had completed an in-house assessment carried out by another member of staff. Evidence of which was provided after the inspection. We noted that one of the staff observing their colleagues had not themselves completed formal training in this area.
● We received concerns that some night staff were sleeping on duty and as such regular checks of people were not taking place throughout the night which places people at risk of harm. We checked CCTV footage for the two nights preceding the inspection and found no evidence that staff were asleep whilst on duty. However, we checked CCTV recordings for a night three weeks prior to the inspection and saw footage of three staff sleeping in a communal lounge, two for approximately three hours.
● The registered manager advised that their night spot checks had not found any evidence of this occurring and that night staff were always expected to be awake and accessible throughout their shift, in the event of an emergency. They advised that they would investigate the identified concerns and address these with the staff involved via their disciplinary procedures.

The provider remains in breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the registered manager confirmed that they had booked all staff onto a moving and handling training course and were sourcing training for two senior staff members to obtain a formal training qualification in moving and handling.