Claremont Carers Limited

Claremont Villas

Inspection report

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Date of inspection visit:
26 September 2019
09 October 2019

Date of publication:
27 January 2020

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
Claremont Villas is a supported living and domiciliary care service supporting people with learning disabilities and autism. At the time of our inspection seven people were receiving support from the service. Four people lived in a house of multi-occupation. The registered manager also lived in this house. A further three people received support from Claremont Villas in their own homes in the community.

People's experience of using this service and what we found
The service was not safe. Risks associated with people's care and support, such as falls, were not managed safely. Poor management of environmental risks, such as fire and food hygiene, placed people at risk of harm. Opportunities to learn from adverse incidents had been missed. Safe recruitment procedures had not been followed, this meant there was a risk people may be supported by unsuitable staff. There were not enough staff to ensure people's safety. Medicines were not managed or stored safely, this increased the risk of error or misuse. There was a risk people may not be protected from abuse. A lack of staff training and absence of any formal systems in relation to safeguarding meant there was a risk allegations of abuse may not be identified or addressed.

People were supported by staff who did not have the training or competency to ensure safe support. People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. People were at risk of inconsistent and unsafe care as their needs were not appropriately assessed or planned for and advice had not always been sought from expert health professionals.

People's right to privacy was not always respected. People were not always supported to express their views. People gave mixed feedback about the approach of staff. Allegations had been made that staff were not kind or caring and this remained under investigation.

There was a risk people may receive support that did not meet their needs. People were not always provided with information in a way they could understand. There was a risk that people's complaints and concerns may not be addressed. People were provided with support to follow their interests and take part in the local community and supported to keep in touch with family and friends.

The service was not well led. The provider did not have the skills or competency to run Claremont Villas safely. People's health and safety was at risk due to a failure to identify and address issues and poor practices. Information had not always been shared in an open and honest way with people, their families or other agencies.

Following our inspection, due to the level of risk, the local authority made arrangements for people to receive support from alternative care providers.

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 21 December 2016).

Why we inspected
This was a planned inspection based on the previous rating.

Enforcement
We have identified breaches in relation to safety, staff recruitment, staffing levels, staff training, dignity and respect and leadership and governance. We took urgent action to impose conditions upon the providers registration to ensure people's safety. We cancelled the providers registration which meant they were not longer able to provide a regulated services to people.

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 of 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 effective? The service was not effective. Details are in our effective 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 responsive? The service was not always responsive. Details are in our responsive findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

Claremont Villas

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 carried out by one inspector.

Service and service type
This service provides care and support to people living in a supported living setting, so that they can live as independently as possible. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care and support. Claremont Villas is also a domiciliary care agency. It provides personal care to people living in their own houses and flats.

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 provider and the registered manager were the same person at Claremont Villas, we have referred to them as the 'responsible person' throughout this report.

Notice of inspection
We gave the service 48 hours' notice of the inspection. This was because it is a small service and we needed to be sure that the responsible person would be available to support the inspection.

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. This is information providers are required to send us with key details about their service, what they do well, and improvements they plan to make. We used all of this

information to plan our inspection.

During the inspection
We spoke with two people who used the service about their experience of the care provided. We spoke with two members of staff and the responsible person. We reviewed a range of records. This included three people's care records and medication records. We looked at two staff employment files. A variety of records relating to the management of the service were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We requested policies and procedures; however, these were not provided.

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.

Assessing risk, safety monitoring and management

- People were exposed to the risk of fire. Measures to reduce the risk of fire were inadequate.
- There was no fire risk assessment in place, fire checks were not adequate and there had not been any recent fire drills. In addition, there were not sufficient measures in place to ensure safe evacuation in the event of a fire and staff did not have up to date fire training.
- The risks associated with smoking were not managed safely. One person smoked in their bedroom. Guidance to reduce risk had not been followed and risk reduction equipment provided by the fire service had not all been implemented. This increased the risk of fire.
- People were at risk of falls. One person had experienced several recent falls. There were insufficient measures in place to reduce the risk of falls. Falls reduction equipment had been purchased but not implemented. This meant the person remained at risk of falling.
- People were at risk of injury due to poor moving and handling. Staff did not have training to support a person to move and transfer and there was no risk assessment in place. Staff told us about unsafe practices used, such as pulling the person up with a towel. This was not a safe technique and could have led to injury.
- People were at risk due to poor food hygiene practices. There was out of date food in the fridge and mouldy vegetables in the kitchen. Some areas of the kitchen were very dirty. This posed a potential risk to people's health.
- People were not supported to keep their home safe and secure. When we arrived at Claremont Villa's we found the front door was unlocked and slightly ajar. A member of the public could have walked into the home. Furthermore, background checks had not been completed on workmen who had free access to people's home. This placed people's safety at risk.

Learning lessons when things go wrong

- Lessons were not learnt when things went wrong.
- There were no systems in place to review or learn from adverse events. For example, one person had recently fallen onto an object and sustained an injury. No changes had been made to reduce the risk of this happening again and we saw they remained in an unsafe situation. This lack of action placed people at risk of avoidable harm.

Using medicines safely

- There was a risk people may not receive their medicines as prescribed. We found multiple concerns about medicines.
- Medicines were not stored safely. Medicines, that could pose a risk to people, were stored in the communal fridge, this was accessible to people using the service or visitors. Other medicines were kept in

carrier bags and there were no records of what medicines were in the building. These issues increased the risk of error or misuse of medicines.
● Medicines records were not consistently completed when people were assisted with medicines. This meant we could not tell if people had received their medicines as prescribed.
● Staff did not have training in the safe administration of medicines and there were no audits in place. The lack of training increased the risk of error and the absence of any audits meant errors may not be identified.

Preventing and controlling infection
● Infection control practices were poor. People had not been supported to keep their home clean and hygienic.
● We found extensive staining in toilets, bodily matter on bathroom flooring and dirty walls, units and equipment in the kitchen and toilets.
● There were no cleaning audits or checks in place. This did not promote the control and prevention of infection and could have had a negative impact upon people's physical wellbeing.

The provider's failure to provide safe care and treatment was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● People were at risk as safe recruitment practices were not followed.
● Pre-employment checks had not been completed on all staff. Two staff had no pre-employment checks, such as references or criminal record checks. This meant the provider did not have the required information to decide about the suitability of these staff.
● When staff had previous criminal convictions there were no measures in place to assess and manage potential risks.
● These failings meant there was a risk people may be supported by unsuitable staff.

The provider's failure to ensure fit and proper staff were employed was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● There were not enough staff to ensure people's safety. There were only two staff officially, employed to provide support. Claremont Villas were paid to provide a total of approximately 130 hours support a week. There were not enough staff employed to cover this.
● There were no safe contingency measures to cover staff absence. Friends and family of the responsible person were covering shifts when needed. This was an informal arrangement and no pre-employment checks had been completed on these people. This was not safe.
● There were no records of what shifts staff had worked so we were unable to determine if people had received the support they needed.

The provider's failure to ensure were enough staff to provide safe support was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Systems and processes to safeguard people from the risk of abuse
● People's feedback about the safety of the service was mixed. One person told us they felt safe, whereas another person described the service as "Horrible." During our inspection the local authority informed us of several allegations of abuse and neglect. These remained under investigation at the time of writing this report.
● Staff had not received training in safeguarding and had a limited understanding in this area. This lack of

training and absence of formal systems meant there was a risk safeguarding concerns may not be identified and addressed as required.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

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 people's care, support and outcomes.

Staff support: induction, training, skills and experience

- People were not supported by staff who were trained or competent to ensure safe support.
- Staff did not have any recent training in key areas such as, medicines management, basic first aid, fire safety, moving and handling or safeguarding. For example, there was no evidence that the responsible person had any recent training at all.
- The lack of training had a negative impact upon people's safety. For example, staff did not have medicines training and we found medicines were not managed safely.
- Although staff felt supported there were no formal systems to review their performance. The responsible person told us they did not do staff supervisions, but sorted things out a day to day basis. This lack of formal processes meant that opportunities to monitor staff performance may have been missed.

The provider's failure to ensure people were supported by competent staff was a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Ensuring consent to care and treatment in line with law and guidance

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 Act 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 MCA. When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

- People's rights under the MCA were not respected.
- No capacity assessments had been completed for people whose capacity to consent was in doubt. The register manager told us they thought one person did not have capacity to manage their day to day money, consequently staff managed this. There was no capacity assessment in place in relation to this and no evidence that the person had consented to this arrangement.
- Staff made day to day decisions on behalf of people with no consideration of the principles of the MCA. We saw staff limited the amount food a person could have and stated, "I had better take some of this away from

[name] otherwise they will eat them all. There was no evidence that the member of staff had considered if this was in their best interests or the least restrictive option. This did not respect people's rights.

The provider's failure to protect people's rights under the Mental Capacity Act was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People were at risk of inconsistent and unsafe care as their needs were not appropriately assessed or planned for.
● The responsible person had not identified when people's needs changed and consequently support did not meet their needs or ensure their safety. For example, one person was no longer able to access the shower as it was upstairs. This meant they had to have a shower at their friend's house instead.
● Care and support was not delivered in line with national good practice. The responsible person did not have a good understanding of good practice and consequently risk assessments and other documents they had implemented were not effective.

Supporting people to eat and drink enough to maintain a balanced diet
● People told us they had enough to eat and drink, however one person told us they were not offered a choice about what they ate as the responsible person chose for them.
● People were at risk of eating unsafe food as it was out of date. We have reported further in this in the 'Is this service safe' section of the report.
● Risks associated with eating and drinking were not managed safely. One person had been identified as being at high risk of choking. However, no advice had been sought from specialist health professionals. Consequently, the rationale for the risk reduction measures in place was unclear.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care
● Referrals had not always been made to specialist health professionals. This meant the responsible person had made decisions about managing risks such as falls and choking without consulting professional experts.

● There was a risk information may not be shared when people moved between services. Care plans did not fully reflect people's needs and there was no quick reference information that could be made available in the event of an emergency, such as a hospital admission. This meant there was a risk people may not receive person centred support.

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 good. 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.

Respecting and promoting people's privacy, dignity and independence
- People's right to privacy was not respected. The responsible person told us that they had moved in to a flat on the top floor of the building. People had not been consulted about this.
- Furthermore, there was only one shower in the building and the flat on the upper floor did not have a toilet or bathing facilities, this meant responsible person used people's toilet and shower. This absence of consultation and lack of regard for the fact that Claremont Villas was people's home did not respect their right to privacy and was not dignified.

The provider's failure to respect people's right to privacy was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supporting people to express their views and be involved in making decisions about their care
- We received mixed feedback in this area. One person told us staff listened to them, however, another person told us they were not consulted about decisions and told us the registered person made decisions on their behalf.
- We observed that whilst people made choices about how they spent their time, we also saw that staff made day to day choices on behalf of people without consulting with them.
- People did not have access to advocacy to support them to express their views. There was no information about local advocacy services and staff knowledge of advocacy was limited.
- This meant we were not assured that people were always supported to express their views.

Ensuring people are well treated and supported; respecting equality and diversity
- Feedback about the approach of staff was mixed. While one person told us, staff were kind and caring towards them, another person told us they were, "Not happy at all." and said staff were not kind to them.
- During our inspection we were informed of several allegations of people not being treated with kindness or respect. These allegations remained under investigation by the local authority safeguarding adults' team at the time of writing this report.
- There was a risk people's diverse needs may not be respected. Staff had not had training in equality and diversity and there was no policy in place in relation to this. The responsible person was not able to provide us with any examples of how they respected people's diverse needs.
- The registered person and a member of staff told us they knew people very well as they had worked with them for years, they told us Claremont Villas was like a family.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- We were not assured that people received support that met their needs and reflected their preferences. A lack of staff and absence of shift planning meant we were unable to determine if people had received the support they required.
- There was a risk people may receive support that did not meet their needs. Although care plans were in place, these had not been updated to reflect people's current needs.
- In addition, people were supported by friends and family of the responsible person. There was no evidence that these people had any training or that they had read people's care plans to ensure they knew how to support people.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People were not always provided with information in a way they could understand. Several people using the service had a learning disability, there had been no assessment of what adjustments they needed to access information and information had not been provided in alternative formats.
- Although we saw staff had a good understanding of how people communicated, staff had not sought advice or explored ways of supporting people to express themselves. This had resulted in them being reliant upon staff to help them communicate.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were supported to stay in touch with family and friends, for example we saw one person had recently been on holiday and staff had supported them to buy gifts for their family members.
- People were provided with support to follow their interests and take part in the local community. For example, one person worked at a local charity shop, another person attended college. People told us they enjoyed this.

Improving care quality in response to complaints or concerns

- There was a risk that people's complaints and concerns may not be addressed. There was no complaints policy or process.
- The responsible person told us there had not been any complaints, however we were informed by the

local authority about a recent complaint. There were no records of the complaint or how it had been dealt with.

End of life care and support

● Although no one was coming towards the end of their life at the time of our inspection there had been no consideration of planning for sudden death. There was no evidence that people had been given the opportunity to discuss their wishes for the end of their lives. Staff had not had training in this area and there was no policy or guidance related to this.

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.

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

- We were concerned that the responsible person was not fit to ensure the safe running of the service.
- We received allegations that the responsible person had been at work whilst under the influence of alcohol. During our inspection, we observed the responsible person to be unsteady on their feet, and they showed difficulty communicating with us. Due to multiple reports of the responsible person's excessive use of alcohol and our observations we felt they posed a risk to people's safety.
- Several other allegations were made about the conduct of the responsible person during our inspection. These concerns remained under investigation by the local authority at the time of writing this report.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Issues with the quality and safety of the service had not been identified as there were no quality assurance systems in place.
- There was no effective leadership or governance. The responsible person told us their role was mainly as a carer and stated that "The home runs itself."
- There were no audits or quality checks completed. This meant that concerns identified throughout our inspection had not been identified or addressed prior to our inspection.
- The lack of governance and leadership placed people at risk of receiving unsafe support that did not meet their needs.
- The responsible person did not keep up to date with good practice. This had resulted in them having a poor knowledge of social care legislation and guidance.
- There was no evidence of any policies to guide safe and effective care at the service. We were not provided with any policies during or after our inspection despite requesting these from the responsible person.
- Sensitive personal information was not stored securely. Documents, such as care plans and staff files were accessible throughout the duration of our inspection. We observed that workmen (with no evidence of background checks) had unsupervised access to this area. This was not in line with data protection regulations.
- The responsible person had failed to ensure accurate and up to date records were kept of the care and support provided. They did not have any information about the people they supported in the community and had a very poor knowledge of basic information, such as people's names.
- Action was not taken to address areas of concern. During our inspection we told the responsible person

they must act to reduce the most urgent risks we found. They did not provide adequate assurance that action would be taken. On the second day of inspection, we found no action had been taken in relation to risk management, recruitment or staffing levels. This increased our concerns about people's safety.

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 responsible person and staff were not open and honest. For example, despite us asking how many people in total were supported by Claremont Villas, the responsible person did not tell us about three people they supported in the community. This demonstrated a lack of transparency.

● There were no systems in place to review adverse incidents or identify when things had gone wrong. This meant the responsible person did not have adequate information to enable them to communicate in an open and honest way with people and their families.

Working in partnership with others

● The responsible person did not work in partnership with others. Due to concerns identified about people's safety during our inspection, the local authority arranged for external care staff to provide people's support. The responsible person declined this support without consulting with people who used the service.

● The responsible person did not recognise the need to make referrals to external health professionals. This had a negative impact on the safety and quality of care people received.

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

● People were not involved in the running of the service. Meetings with people and staff were not held regularly, the most recent meeting was in March 2019. There was no evidence of other ways of engaging staff or people who used the service in the running of the service.

On 10 October 2019, due to the level of risk to people, the local authority took action to source new care packages of care for all seven people supported by Claremont Villas.

The failure to ensure good governance and leadership was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents There were not enough staff to ensure people's safety or meet their needs. People were supported by staff who lacked competency in key areas. Regulation 18 (1) (2)

The enforcement action we took:

We took urgent action to prevent the provider from supporting any new people and we imposed conditions which required the provider to take action to ensure people's safety.

Regulated activity	Regulation
Personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's right to privacy was not respected. Regulation 10 (1)

The enforcement action we took:

We took action to cancel the registration of the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent People's right under the Mental Capacity Act 2005 were not respected. Staff made decisions on behalf of people. Regulation 11(1)

The enforcement action we took:

We took action to cancel the registration of the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk of harm as they were not

	provided with safe care and treatment and environmental risks were not managed safely. Regulation 12(1)

The enforcement action we took:

We took urgent action to prevent the provider from supporting any new people and we imposed conditions which required the provider to take action to ensure people's safety.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems to ensure safety and quality of the home were not effective. The provider was not able to run the service safely and did not take action to address urgent concerns found. Regulation 17(1)

The enforcement action we took:

We took urgent action to prevent the provider from supporting any new people and we imposed conditions which required the provider to take action to ensure people's safety.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe recruitment practices were not followed, this posed a risk people may be supported by unsuitable staff. Regulation 19(1)

The enforcement action we took:

We took urgent action to prevent the provider from supporting any new people and we imposed conditions which required the provider to take action to ensure people's safety.