Avery Homes (Nelson) Limited

Clare Court 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 effective?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Clare Court Care Home is a nursing home providing personal and nursing care to up to 80 people. The service provides support to older adults and people living with dementia. At the time of our inspection there were 57 people using the service. The home is split into three floors. The ground floor accommodates people who require residential care, the middle floor provides support to people living with dementia and the top floor accommodates people with nursing care needs. However, there were people on all floors living with dementia. Everyone had en-suite facilities in their rooms. People shared lounges and a separate dining area on each floor. There was also a communal garden area.

People's experience of using this service and what we found
We found a number of risks to people's health and safety around the home which had not been identified by the management team. Staff who could administer medication had not all completed their competencies to ensure they were still practicing safely. Some errors in recording of people's medicines were found. People at risk of losing weight had not had their food and fluid intake measured adequately to ensure the risk was mitigated. The management team had struggled to recruit staff and some agency staff had been needed. Some people and their relatives were concerned about this and wanted a stable staff team.

People and their loved ones were not always involved in their care planning. Care plans lacked information to support staff to provide more person-centred care. Staff had not received adequate supervision and many of the staff we spoke with felt unsupported by the management team. More adaptations to the home were needed to meet people's health care needs. People and relatives spoke highly of the food, but improvements could be made to support people living with dementia to make choices about what they wanted to eat.

Systems and processes had failed to identify many of the concerns we found during the inspection. In some cases, risk had been identified but insufficient action had been taken to mitigate it. For example health and safety audits had noted carpets were odorous and needed replacing, but action was not taken to do this in a timely way. The management team had not ensured staff had completed all the mandatory training in line with organisational policy.

People were not supported to have maximum choice and control of their lives and staff did not always 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.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 06 January 2022) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they

would do and by when to improve. At this inspection we found the provider remained in breach of regulations. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
We received concerns in relation to medicines and managing choking risk. As a result, we undertook a focused inspection to review the key questions Safe, Effective 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 of the service has remained requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. We found the provider had taken effective action to improve care for people with choking risk. We found some concerns with regard to medicines management. Please see the Safe Effective 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.

Enforcement and Recommendations
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 and will take further action if needed.
We have identified breaches in relation to health and safety, training and supervision of staff, assessing mental capacity, person centred care and the governance systems at this inspection.
Please see the action we have told the provider to take at the end of this report.
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
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 will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and 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 effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our Well-Led findings below.

Clare Court 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 completed by an Inspector, an Assistant Inspector, a Nurse Specialist Advisor and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Clare Court 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. Clare Court Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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.

At the time of our inspection there was not a registered manager in post. A home manager had been recruited and was scheduled to join the team later in the summer. Interim management cover was in place to support the home and the staff team whilst waiting for the home manager to take up their post. The management team explained the new home manager would apply to become the registered manager.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed the information we had received about the service since the last inspection. We sought feedback from the local authority and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with seven people using the service and eight relatives. We spoke with 14 staff, including the interim manager, regional manager, operations manager, carers, senior carers, nurses, the chef and domestic staff. We sought information from external professionals working with the staff team. We reviewed a range of documents including six care plans and other records of care monitoring. We looked at multiple medication administration records. We reviewed policies, procedures, quality assurance checks and documentation. We reviewed two staff files. 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.

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 requires improvement. At this inspection the rating for this key question has remained 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; Using medicines safely; Preventing and controlling infection.

At our last inspection we found that risk to people had not always been assessed and mitigated; medicines were not always administered and stored safely. 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.

● We saw records to monitor the food and fluid consumption, for people who had been identified at risk of losing weight. These records were inconsistently kept. For example, some days there was little or no recording of people's fluid or food consumption. The total amount of fluid people were drinking daily was not always being calculated. This meant staff could not be sure whether those people were eating and drinking enough to improve their health or remained at risk. This left people at risk of further deterioration.
● The risk assessment for one person with a specific health diagnosis did not contain key information to help guide staff in supporting them safely. Staff had not successfully obtained further information about their care needs. Assessments of risk did not provide staff with specific details relating to people's known health conditions. This put them at risk of receiving inconsistent care. However, staff did demonstrate knowledge of key risks for people, for example they knew about specific dietary requirements.
● During our inspection the electronic medication administration record (MAR) was not fully working. In part of the home staff were using paper MAR as a temporary measure. We saw signatures for three medications had not been signed for to indicate whether or not they had been administered. We also saw a person had received medicine without a required health check being recorded. This meant staff could not evidence whether it was appropriate to administer the medication.
● A bottle of medication was found not to have a date on it showing when it had been opened. This meant staff could not know when the medication was past its expiry date and no longer potentially effective. We reviewed the electronic MAR and found this had been used to correctly record medicines administration. Guidance for staff was available to ensure they knew how to administer 'as needed' medicines safely.

● We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. We saw tables people were using to place drinks and snacks on were damaged, unclean and in

need of replacement. The regional manager assured us these tables would be immediately removed and replaced. We saw a toilet seat was worn and damaged and in need of replacement. We discussed this with the interim manager, and it was replaced during our second site visit. We saw a bin was in use which had no bag or lid, this posed a contamination risk to people. This was removed when it was brought to the attention of the interim manager.

● We were not assured that the provider was making sure infection outbreaks can be effectively prevented and managed. We noted the carpet on the ground floor was odorous. We saw a health and safety audit completed in March 2022 had identified the ground floor carpet needed replacing. At the time of our visit the replacement had not been agreed. The carpet posed a contamination risk to people and was also unpleasant for them.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes

The management team had taken the decision not to impose any restrictions on visiting for people. People and their relatives did not raise any concerns about the visiting arrangements in place.

Systems to assess monitor and mitigate risk to health, safety and welfare of people using the service were not always effective. This placed people at risk of harm. This was a continued breach of regulation 12 (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

● Checks on recruitment files showed not all gaps in employment had been explored with staff prior to their employment.

● The interim manager told us recruiting suitable numbers of appropriately experienced and qualified staff had been challenging. This had resulted in regular use of agency staff as well as asking current staff to work additional shifts.

● The management team ensured staff were subject to Disclosure and Barring (DBS) checks prior to recruitment. These checks provide information including details about convictions and cautions held on the Police National Computer. This information helps employers make safer recruitment decisions.

● Staff gave mixed reviews about how staffing levels were managed. Some told us it was a continuous problem which created hard work for them, others said regular agency staff were helpful and recent changes introduced to staff deployment had been helpful.

● Some relatives expressed concerns about the home seeming to be short staffed, others felt the staff teams lacked consistency due to the level of agency use.

● The interim manager advised there had been a recent successful recruitment campaign which they hoped would solve most of the staffing issues.

Learning lessons when things go wrong

● The service did not always manage incidents affecting people's safety well.
● The staff and management team were responsive to issues highlighted during the inspection. However, where concerns had already been highlighted, they had not always been acted upon. For example, gaps in information in a person's risk assessment had been identified in March 2022 but had not been addressed prior to our inspection.

Systems and processes to safeguard people from the risk of abuse
● Staff had received training in and understood how to recognise and report abuse.
● Staff had liaised with appropriate health professionals to report and investigate any concerns identified.

Requires Improvement

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 our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs

- Some people's care plans lacked detail about their preferences and their life history. For example, one person who had been living at Clare Court for 18 months had a life history lacked information. Other care plans lacked information about what people liked to eat and drink, some lacked information about people's cultural and spiritual needs. This meant staff lacked vital information which could help them understand people's preferences and ensure they were being cared for in line with their wishes.
- There was little evidence people had participated in the development of their care plans. The information recorded was phrased about them rather than by them.
- All the relatives we spoke with told us they had not participated in the development of people's care plans. This meant particularly for people who could not express their wishes and views clearly, the opportunity to learn about them from the people who knew them best had not always been taken.
- We saw one person was identified as at risk of isolation. However, assessments of the person's needs had not been made in a timely way. This meant staff had not been able to order equipment which could support the person to move around their home. The person had not been supported to reduce the risk of isolation identified. The management team gave assurance this would be addressed immediately.
- Signage to help people orientate themselves and find their way around their home was lacking in some places. This is especially important for people living with dementia who may need help to find the places they are looking for. People's doors were uniformly labelled with a current photograph and their name. People had not participated in a choice about how they wanted their door to be presented. Staff had not explored options for people who might find other images more meaningful and useful to them.
- We saw some people who were living with dementia were shown typed menus of meal choices. The menus did not include photographs. On one floor we saw plated options of meals being offered to people to help them chose. This was not consistent practice across all floors. Some people were therefore not presented with the information about meal choices in a clear and accessible way for them. This put people at risk of their likes and dislikes being neglected.

People's wishes and needs had not been fully assessed and adaptions to support people's needs were lacking. This was a breach of Regulation 9 (3) (a) (b) (c) (d) (e) (Person Centred Care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team gave assurance the concerns identified would be addressed. For example, they advised the well-being coordinators had been tasked with learning more about people's life histories.

Staff support: induction, training, skills and experience

● Completion of some staff training was low. The organisational policy was for staff to complete some training within specific time frames, these deadlines had not always been met. For example, 17% of staff had completed basic life support training or refresher training within the specified time. This meant people were not consistently supported by staff who received effective training to meet their needs.

● Some staff had not had supervision or an appraisal for more than a year. This was not in line with the organisational policy. People were not cared for by a staff team who felt supported by the provider. One staff member told us; "I have never had supervision or an appraisal, I just don't feel appreciated."

● Staff gave mixed reviews about the support they received from the management team. Some expressed confusion about who was managing the service and the roles of the management team. Some said they had raised issues with the management team and had not received a resolution or in some cases a response. One staff member told us; "I feel I can approach [the management team] … they don't always address the issues raised".

● Relatives gave mixed reviews about the staff, some described them as knowledgeable and skilled. Others said they felt unsure about staff skills and competence. They attributed this to not knowing staff very well and seeing different unfamiliar staff a lot.

Some staff had not received the support, supervision and training necessary to ensure they were able to carry out their duties. This put people at risk of neglect from staff who had not had appropriate guidance and support. This was a breach of Regulation 18 (2) (a) (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the management team about these concerns. They advised efforts would be made to ensure all staff had completed the training they needed to. They also gave assurance staff would receive regular supervision and annual appraisals in line with organisational policy.

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 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 MCA.

In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA and whether appropriate legal authorisations were in place when needed to deprive a person of their liberty.

● We saw one person's pre assessment did not contain information about their mental capacity. The section of the assessment containing these prompts was blank. There had been no mental capacity assessment recorded for this person during their time living at Clare Court Care Home.

● Staff supporting the person told us they believed they were subject to DoLS as they did not have capacity to make significant decisions. Staff lacked clear guidance about whether this person needed support to make decisions for themselves. The care plan showed they were not subject to DoLS.

● The person's relative had been asked to make a decision on their behalf. However they had not been assessed as lacking capacity to make the decision themselves. The MCA states that decisions can only be made in someone's best interests when they are not able to make the decision themselves. No DoLs authorisation had been applied for to seek permission to keep the person there without their ability to consent. This meant staff had no legal authority to keep them at Clare Court Care Home.
● One staff member told us they were not sure whether they had had MCA training. They also told us they did not know who was subject to DoLS in the part of the home they worked in. This meant they did not have a clear understanding of who was able to give consent for care and who may not be able to.

The principles of the Mental Capacity Act 2005 (MCA) had not always been followed. This was a breach of Regulation 11 (3) (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The management team took immediate action to address the concerns identified for the specific individual during the inspection.

Supporting people to eat and drink enough to maintain a balanced diet
● Records to demonstrate monitoring of how much people ate and drank who were at risk of losing weight were incomplete and ineffective. This left people at risk of continued weight loss and dehydration.
● People were sometimes asked to make choices about their meal options the day before. This method is not best practice for people living with dementia, who may not remember their choice and may therefore not want the food when it was served.
● People told us they enjoyed the food which was served. A relative told us "food quality is good."
● We saw people were offered meals appropriate to their culture.
● Meals were cooked from scratch and people were offered regular fresh fruit and vegetables to support a healthy balanced diet.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● One person had not received an assessment needed in a timely way. Staff had therefore not been able to order equipment to support the person to move around their home.
● Although some people had been identified as needing additional support to eat and drink sufficiently, the monitoring of this support was not effective.
● Some staff told us they had not received any specific training to learn how to use the electronic care plan recording system. They also told us they did not know how to access care plans without assistance and had not been able to read care plans for everyone they supported. They were able to tell us about people's key risks. They told us this information was shared effectively during handover meetings. However, staff had not been supported to utilise the system designed to provide guidance about people's care wishes and needs. This meant people were at risk of not having significant information about their needs and wishes shared effectively with other professionals.
● We saw evidence of people being supported to receive services from other health professionals. These included occupational therapy, chiropody and the speech and language therapy (SALT) team.
● Staff knew about the decisions made by the SALT team regarding people's food and drink preparation. A summary was available on each floor of the home to ensure all staff including new members of the team had access to this information.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred 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

At our last inspection we found that governance systems had failed to identify concerns with medicine storage and administration. We also found governance systems for care plans were insufficient. This was a breach of Regulations 17 (Good governance) 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 17.

● Systems and processes to monitor health and safety were not effective and had failed to identify the issues noted during the inspection. Daily checks had failed to identify issues with the environment including infection prevention risks. These posed a contamination risk to people.
● The management team had not ensured staff who could administer medicines had completed their competency checks in line with organisational policy and procedure. Some staff had not completed the competency checks within the specified time. Two staff had been signed as competent but had not completed the assessments fully. This meant the management team could not be assured staff were administering medicines safely.
● Systems to record and monitor medicine administrations had failed to identify gaps in MAR charts where medications had not been signed for. They had also failed to note the correct checks had not been completed prior to administering medication for one person. Medications administration systems were therefore not robust and could not ensure people were receiving medications as prescribed. This left people at risk of avoidable harm.
● Governance systems in place to support staff were ineffective. Some staff had not had supervision. Opportunities to identify gaps in knowledge and explore staff concerns had been missed. Recruitment systems had failed to identify missing information from job application forms. The management team had failed to ensure staff completed required training within specified deadline. This meant people were at risk of avoidable harm from inappropriate or unsafe care from staff.

● The management team had not identified some staff found the electronic care plan recording system too

difficult to use. This meant there was a risk of staff not being aware of significant information contained in people's care plans. This could result in people not receiving safe care or care in the way they wished to receive it.

● Checks and audits of care plans had not identified the issues noted in the inspection. Some care plans lacked evidence that people and their relatives had contributed to their development. Some care plans lacked information about people's wishes, cultural and spiritual needs. They had failed to identify a person had not been assessed to receive support to move around their home in a timely way. This meant people were at risk of not receiving care in the way they wished.

● The management team had not ensured everyone who needed a mental capacity assessment had received one. Governance checks of care plans had not identified this and not ensured people were supported in line with the Mental Capacity Act (2005). This meant consideration had not been given to a person's capacity to give consent to remain at Clare Court Care Home. The need to seek legal authorisation to retain the person at the home was not identified.

The management team assured us they were working towards making the improvements necessary to ensure they met the requirements of this breach. However, not enough improvement had been made at this inspection and this remained a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

● Care plans did not always reflect people's cultural and religious needs.

● Some staff told us they had not been consulted or informed about recent changes in the home. They did not know who was leading them. Staff had not always had the opportunity to discuss any concerns or contribute ideas as they had not always received supervision.

● Staff told us they had recently had a staff meeting for the first time in 2022. They felt it was useful and wanted to meet more often. The management team told us more team meetings were planned.

● Some relatives told us they found communication at Clare Court Care Home was not effective. They told us they had asked for information but had not received it, or in some cases had not had a response.

● Relatives and people had been invited to complete a survey about their experience of care received at the home. The management team had made changes following feedback from these surveys. For example, changes were made to the menu following the feedback received.

Continuous learning and improving care

● The management team had not utilised systems and processes to enable continuous learning and improvement in all areas of care. Systems and processes had failed to identify a number of concerns which were highlighted during the inspection.

● We saw that following an incident around choking, improvements had been made to how people were supported with choking risk.

Working in partnership with others

● We received mixed feedback from professionals working alongside the service. One professional told us communication had been good and they considered the staff team proactive. Another professional told us there had been occasions where communication had not been effective, and they had noted concerns about high staff turnover.

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

● A duty of candour incident is where an unintended or unexpected incident occurs which results in the death of someone receiving support, severe or moderate physical harm or prolonged psychological harm. When there is a duty of candour event the provider must act in an open and transparent way and apologise for the incident.

● As part of internal investigations when mistakes had been made, the management team had apologised to people. The management team understood their duty of candour responsibilities.

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 9 HSCA RA Regulations 2014 Person-centred care People's wishes and needs had not been fully assessed and adaptions to support people's needs were lacking.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The principles of the Mental Capacity Act 2005 (MCA) had not always been followed. Not everyone who needed a mental capacity assessment had received one.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Health and safety

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Some staff had not received support, supervision and training in line with organisational policies.