Pepperhall Limited

Valley Court

Inspection report

Valley Road
Cradley Heath
West Midlands
B64 7LT

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18 November 2020
19 November 2020
30 November 2020

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Valley Court is a nursing home providing personal and nursing care to 55 people aged 65 and over at the time of the inspection. The service can support up to 69 people.

The care home provides care for people in one adapted building. The home is split over two floors with access to both floors through the lift.

People's experience of using this service and what we found
People received support from staff who understood how to recognise and escalate safeguarding concerns. People received safe support with their medicines. Improvements had been made to the way staff were recruited to ensure this was carried out safely.

We identified further improvement was needed around how staffing levels were worked out, in the monitoring of people's fluid intake, and the analysis of accidents to prevent reoccurrence.

People had not received a service that was consistently well-led. We found improvements were needed in the way the quality and safety of the service were monitored. There was a recently appointed new manager at the service who had identified areas that needed improvement. These improvements had not yet been fully introduced or embedded into the service and more time was needed to enable this to happen.

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 27 November 2019). We found the provider was in breach of regulations 12 and 17. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection enough improvement had been made in one of the breaches which had been met. Sufficient improvement had not been made in the governance of the service and the provider was still in breach of regulation 17 (Good Governance).

Why we inspected
The inspection was prompted in part due to concerns received about people not receiving safe care and infection control concerns. We also looked at the intelligence we held about the service which indicated the need for us to inspect the service. A decision was made for us to inspect and examine those risks.

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.

We reviewed the information we held about the service. No areas of concern were identified in the other key

questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

We have found evidence that the provider needs to make improvement. Please see the Safe and Well led sections of this full report. You can see what action we have asked the provider to take at the end of this full report.

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

Follow up
We will request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Valley Court

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.

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 site visit was carried out on 18 November by two inspectors and a nurse. The nurse had specialist knowledge of the needs of the people living at the home.
An Expert by Experience carried out phone calls to relatives on the 19 November 2020. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.
Inspection activity started on 18 November 2020 and ended on 30 November 2020 due to continued analysis of the evidence sent to us.

Service and service type
Valley Court 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. We informed the service of the inspection shortly before entering the building because of the risks associated with COVID19. This meant that we could discuss how to ensure

everyone remained safe during 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 to help us plan our inspection.

During the inspection-
We spoke with eight members of staff including the registered manager, clinical lead, deputy manager, care workers and domestic staff.
We reviewed a range of records. This included two peoples care records and multiple medication records.
We looked at three staff files in relation to recruitment and staff supervision.

After the inspection –
We spoke with nine relatives to seek their views of the service. We reviewed quality assurance records and policies. We continued to seek clarification from the provider to validate evidence found.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. 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.

At our last inspection the provider had failed to mitigate risks to the health and safety of people because people were not protected against the risk of sore skin or the risk of malnutrition. This constituted a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act (2008) Regulated Activities (2014). At this inspection sufficient improvement had been made and the provider was no longer in breach of this regulation.

Assessing risk, safety monitoring and management

- At our last inspection we found that there were ineffective systems in place to monitor the fluids that people were taking. Whilst we found some improvements further improvements were needed to ensure this became more robust.
- For example, where people were having their fluids monitored due to poor intake we found discrepancies on the recorded fluid intake. Staff were able to inform us of action they took when people had lower fluid consumption such as prompting more often but these actions were not consistently recorded.
- People had the individual risks associated with their care identified and plans put in place to minimise these risks.

Staffing and recruitment

- Relatives we spoke with were not able to comment fully on the staffing levels at the home due to current visiting restrictions in place. We received mixed comments with some relatives feeling there were sufficient staff and other relatives commenting about having to wait a little to answer the phone and family members having to wait for support due to staff being busy.
- We saw there were sufficient staffing levels to support people living at the service. Whilst staff informed us the staffing levels ensured safe care, some staff commented that there wasn't always time to spend more quality time with the people living at the home. One staff member told us, "From minute you get in you seem to be running around and you don't have time to spend with residents."
- The registered manager informed us of the required staffing levels at the home. However, we found that a staffing dependency tool had not been used to work out the staffing levels at the home. This meant the staffing levels at the home were not consistently based on the needs of the people living there. The registered manager advised they had sourced a dependency tool and that this would be used in the future.
- Staff were safely recruited prior to starting work at the service. We saw that recruitment checks such as obtaining a DBS were carried out. A DBS is a check that homes carry out to reduce the risk of unsuitable staff working at the home. We noted that improvements had been made from our last inspection around the recording of gaps in employment and this was now being completed.

Systems and processes to safeguard people from the risk of abuse

● People were supported by staff who understood the signs of abuse and appropriate action to take should they have any concerns. When asked about the safeguarding process one staff member told us, "I would raise concern with the deputy manager and head nurse unless the safeguarding was about them and in that case go higher and I know I can always report to CQC and in really bad extremes you can ring 999."

● Relatives told us they felt their relative was safe at the home. One relative told us, "I'd say Mum is absolutely safe. She does respond well to the staff and she'll talk to them about anything and everything." Another relative told us, "She's safe without a doubt. Mum is on the ball and would say if there was anything wrong."

● We saw that learning was taken from safeguarding concerns that had been raised. This reduced the chance of similar concerns occurring again.

Using medicines safely

● People received safe support with their medicines. A relative we spoke with was happy with the support their relative received with their medicines and told us, "I'd say he does get the right support with medicines. He's getting creams for his skin."

● Staff told us they had received training in medicine administration. We saw that checks were carried out on staff members practice in medicine management to ensure they were safe to administer medicines.

Preventing and controlling infection

We looked at the infection prevention and control measures in the home. These were our findings.

● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were somewhat assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

Learning lessons when things go wrong

● There were systems in place to monitor accidents or incidents within the home. Following accidents, analysis was carried out to see if the risk of a similar accident happening again could be reduced. We also saw that external healthcare professionals such as the falls team were consulted.

●Whilst analysis took place of individual accidents, we found that there had been no recorded analysis of trends or patterns across the home which could further mitigate risk.

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 the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same. 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.

At our last inspection we found that systems had not been established to monitor the risks to people's health and safety. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst we found some improvements, not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

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

- Systems around the monitoring of fluid intake were not effective to protect people from the potential risk of dehydration. We were informed of the monitoring systems in place but found discrepancies on the recorded fluid intake. Care plans we viewed did not state action to take should there be lower fluid consumption for the day although this was updated following the inspection.
- Where audits had been completed and follow up actions had been identified, there was no plan in place to ensure these actions were carried out. For example, care plan audits had detailed further information that was needed in people's care plans. It was not evident whether these required actions had been achieved or who was responsible for completing this.
- There was a number of agency staff working at the service at the time of the inspection, which the registered manager was in the process of reducing. We found ineffective systems around the monitoring and supervision of agency staff practice. For example, we found there was no system to state who was responsible for the routine testing of agency staff for Covid 19. We were informed this was resolved following our prompts at the inspection.
- Systems in place to determine the number of staff on shift were not robust. We were informed of a new tool that was to be used to ensure people's individual needs had been considered when determining staffing levels needed at the service.
- The system to analyse accidents that had happened at the service was not robust. We had raised this at our last inspection of the service. Further work was needed to ensure accidents were analysed for trends to reduce the chance of similar incidents reoccurring.
- Systems in place had not identified the need for further detail available in people's care plans. For example, we found further instruction was needed around instructions to support people to mobilise safely. In another example we found that further detail was needed around the safe systems of support the person

would need in the event of an emergency.
● There was a need for increased oversight from the registered provider and registered manager to ensure the systems in place were effective in monitoring the quality and safety of the service.

We found no evidence that people had been harmed however, the systems in place to monitor and improve the quality of the service were not robust. This was a continued breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● A new manager had started working at the service in July 2020 and was open about a number of identified improvements that were needed at the home. They had devised a plan that detailed how and when these improvements would be made. The registered manager needed more time to ensure these changes could be implemented and embedded into practice.
● Relatives we spoke with were aware there had been a change in management but had not had the opportunity to meet with the new manager. We raised this with the registered manager who was aware and was working on further engagement with relatives.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Relatives spoke highly of the caring nature of the staff team. One relative commented, "Nothing is too much trouble for them. They heard Mum say that she fancied a curry and they went and bought her one." Another relative told us, "I love the staff. They're all friendly and helpful and nothing is too much trouble. They love Mum and they're always laughing with her."
● We saw that people had their preferences for care detailed in their care plans and there had been steps taken to identify people's diversity and cultural needs.
● Staff we spoke with knew people well. They spoke with knowledge about people's needs and what was important to them.
● The registered manager was in the process of setting up a visiting booth that would enable families to see each other, although it was not ready to be used at the time of the inspection.

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 registered manager understood their responsibility to notify us of significant events that had occurred at the service. We saw the last inspection rating was displayed as required.
● The registered manager was open about the improvements that were still needed at the service and their plans to enable these improvements to be made. They were receptive to open conversations throughout the inspection process.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● Relatives told us they were happy that the service involved them in their loved ones care and kept them informed of any changes. This had been particularly important due to restrictions on visiting due to Covid 19. Relatives described different methods the service had used to support communication such as video and phone calls. One relative told us, "They phone often about her care and always let us know what's happening with her."
● Whilst this regular contact was appreciated, relatives also commented that they hadn't been asked for feedback about the service for some time. This would enable relatives to be involved in providing further feedback about the service which in turn could support improvement.
● There had been a significant amount of change at the service since the new manager commenced

work.The registered manager informed us of a number of meetings that had occurred to share these changes with the various staff teams. Whilst some staff were complimentary of the changes being made at the home, some felt a need for further consultation and involvement in the changes that were being made. This involvement would support staff to feel more valued and be on board with the proposed changes.

● The registered manager had introduced regular meetings that occurred throughout the day that enabled communication between different teams to occur. These meetings also allowed changes to peoples care needs to be communicated and monitored.

Working in partnership with others

● The service had worked in partnership with other healthcare agencies such as GP's, speech and language therapists and tissue viability nurse to ensure people received care in line with their needs. Approaches to the communication between these healthcare professionals had been adapted due to Covid-19 restrictions such as telephone or video calls to enable people to receive the healthcare they needed.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure there were effective and robust systems in place to monitor the quality and safety of the service. Regulation 17 (1)(2)(a)(b)(c).