Care UK Community Partnerships Ltd

Francis Court

Inspection report

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Tel: 01342488148

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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

Francis Court is a residential care home providing personal and nursing care to people with long term conditions, mobility needs and people living with dementia. The service can support up to 87 people in one purpose-built building, arranged over three floors. There were 64 people living at the home on the day of the inspection.

People's experience of using this service and what we found
Risks to people's safety were not always monitored and managed effectively. Some people were at risk of choking, care plans did not provide clear guidance for staff. This meant people were at risk of not receiving food and drink appropriate for their needs. Some people were at risk of falling, incident monitoring was not consistent and care plans were not always reviewed to ensure that risks were mitigated. Shortfalls in administration of medicines did not support good practice.

There were enough staff to care for people safely, but the deployment of staff was not effective in ensuring that people's needs were met. Some people had to wait longer then they should expect for the support they needed. People's social needs were not consistently met. Staff did not always follow good practice with regard to infection control procedures.

There were continued concerns about the accuracy of records and the system for governance was not robust and had not identified all the shortfalls that we found. However, the provider had already identified similar themes and had an action plan to make improvements. A new manager had been in post since October 2019 and staff spoke positively about the leadership of the home.

People told us they felt safe living at Frances Court. One person commented, "The care is very good really." Staff understood their responsibilities for safeguarding people and knew how to report concerns.

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 June 2019). The provider completed an action plan after the last inspection to show what they would do, and by when, to improve. At this inspection not enough improvement had been made and sustained and the provider was in breach of three regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
We received concerns in relation to the management of medicines and people's nursing care needs. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only. The ratings from the previous comprehensive inspection for those Key Questions not looked at on this occasion were used in calculating the overall rating at this inspection.

The overall rating for the service has remained as Requires Improvement. This is based on the findings at this inspection. 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 Francis Court on our website at www.cqc.org.uk.

Enforcement
We identified one continued breach of regulation in relation to maintaining accurate records and ensuring the quality and safety of the services provided. We also identified new breaches of regulation in relation to safe care and treatment and staffing. Following the inspection, the operations support manager sent us an action plan. This provided clear details of immediate actions they were taking with timescales to address all the concerns we had raised. This gave us further confidence that improvements in management and oversight of the home were in progress, but not yet embedded and sustained.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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.

Francis 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.

Inspection team
The inspection team consisted of three inspectors.

Service and service type
Francis 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 did not have 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. A new manager had been in post since October 2019 but had not yet applied to become the registered manager for this location.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. This included feedback from the local authority and professionals who work with the service.

During the inspection
We spoke with 12 people about their experience of the care provided. We spoke with eight staff including, the regional support manager, quality development manager, deputy manager, nurses, senior care workers, and care workers. We spoke with one visiting health care professional.

We reviewed a range of records. This included five people's care records and multiple medication records. We looked at four staff files in relation to recruitment and staff supervision. We looked at training records and a variety of records relating to the management of the service, including policies and procedures and governance reports.

After the inspection
We continued to seek clarification from the provider to validate evidence found and received a report on actions taken during and following the inspection.

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 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.

Assessing risk, safety monitoring and management; learning lessons when things go wrong; Using medicines safely;

At our last inspection the provider had failed to maintain accurate records relating to assessing risks to people, administration of medicines and environmental risks relating to the health, safety and welfare of people. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this focussed inspection, we continued to have concerns about the accuracy of records and found a continued breach of regulation 17, this is identified in the Well- Led domain of this report. We found that care was not always provided in a safe way.

● Risks to people were not always managed effectively. Some people were at risk of choking and had been assessed by a Speech and Language Therapist (SALT) as needing a modified diet. Care plans were not always clear and accurate to guide staff in how to meet people's current needs. One person's needs had changed, a SALT assessment had identified they needed a minced and moist diet to comply with IDDSI (International Dysphagia Diet Standardisation Initiative) level 5 guidelines. This information had not been updated in the person's care plans until ten days after the assessment and information had not been communicated effectively to staff. We observed the person's lunchtime meal did not comply with IDDSI level 5 guidelines. Staff we spoke with were not aware of the change. The staff member who brought the food to the person had not been aware of their needs and was relying on old information that had not been taken out of circulation. This meant the person was at risk of receiving food that was not appropriate for their needs.

● One person had been assessed as needing a soft and bite sized diet. This information was included in their care plan but not in the specialist diet log that staff, including the chef, referred to when providing people with their meals. This log had not been updated and referred to previous information that the person was on a regular diet. We observed the mid-day meal was left whole and not served in bite sized pieces in line with the person's assessed needs. We asked the staff member about the person's needs and they were aware of some of their needs but did not identify that they needed a soft and bite-sized diet. The person's care plan provided contradictory information about the support the person needed, stating both that the person could eat on their own and that they needed support from staff with encouragement and prompts. We observed the lunchtime meal was left in front of the person and no support was provided. This meant that there was a risk that the person was not provided with food that was appropriate and that they did not receive the support they needed to eat their food.

● Some people were at risk of falls. Risk assessments and care plans guided staff in how to support people to move around safely. Falls were recorded as incidents or accidents on the provider's electronic system.

Staff told us that risk assessments and care plans were regularly reviewed including after a person had a fall. Some people had fallen on more than one occasion, but their risk assessment and care plan had not been reviewed and amended to reduce risks of further falls.

● The manager had oversight of incidents and accidents on the electronic system. Staff told us that the manager was responsible for ensuring that analysis had taken place to identify the cause of the incidents and that actions were taken to reduce risks of further occurrences. The system showed that 18 incident records had not been signed off by the manager. This meant that the provider could not be assured route cause analysis had taken place and that appropriate measures were in place to reduce further risks and that lessons had been learned when things went wrong.

● Medicines were not always managed safely. Only staff who were trained and had been assessed as competent were able to administer medicines. We observed that staff practice was not always safe. Used clinical needles were not disposed of safely in a secure container. This meant that staff were at risk of contamination from the used needles. We spoke to the nurse on duty about this and they took immediate actions to address this shortfall.

●Some medicines were in tablet form and staff were completing a stock check of each medicine every time a tablet was administered. This was very time consuming and took staff away from other important duties. Staff used a counting triangle tool to assist this process but had not considered risks of cross contamination between medicines.

● Medicines were stored in a locked room. Procedures for holding the keys to the medicines room were not robust and staff who had not been trained in administering medicines had access to the medicines room. This meant that the provider could not be assured that medicines were stored securely.

● Some people had been prescribed food supplements, these were included on people's Medication Administration Record (MAR) charts. We observed two staff members administering medicines. We noted that they signed to say food supplements had been administered but they had not given the supplement themselves. Staff told us that it was common practice for staff who administered medicines to sign for supplements although care staff had often given the supplement. This was not good practice and meant that the provider could not be assured that people were always receiving their supplements in line with their prescription.

Preventing and controlling infection

● People were not consistently protected by the prevention and control of infection. We observed a staff member was not following safe practice in relation to hygiene and infection control and had not used appropriate protective personal equipment. This was an area of improvement. The team leader took immediate action to address this lapse in good hygiene practice.

● People's rooms and communal areas of the home were clean. People told us that they were satisfied with standards of hygiene. One person told us, "It's always beautifully clean here."

Risks to people were not managed consistently to ensure that people received safe care and treatment. Medicines were not managed safely. This was a breach of regulation 12 (Safe Care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the deputy manager and the regional support manager about our concerns regarding the management of medicines and risks associated with choking. Following the inspection, they sent us a report detailing what they have done to address these shortfalls in management of medicines and actions they intended to take for the other concerns identified.

Staffing and recruitment

● Staff were not always deployed effectively to keep people safe. The provider used a dependency tool to

assess how many staff were needed to meet people's needs. We noted staff levels were consistent and agency staff were used to ensure that staff levels were maintained. However, the deployment of staff meant that people sometimes had to wait longer then they should expect for care and support. One person told us, "Sometimes they are so short staffed here, they can't always get to me when I need them." The person said this meant they sometimes had to wait for help to get to the toilet. Another person told us they could not rely on staff coming quickly if they used their call bell. They said, "Sometimes they come immediately, but sometimes I wait for ages."

● Staff told us there were enough staff on duty but that they could not always respond if they were busy with other people. We observed there were not always staff around to support people. For example, during the morning a person who was living with dementia told an inspector they could not find their room. There were no staff around to support the person. A staff member in the lounge area said all the other staff were busy, and they could not support the person back to their room because they were unable to leave the people in the lounge area alone. This meant the person had to wait for support and they showed signs of becoming distressed and agitated.

● During the day we observed other occasions when staff were not available when people needed support. One person who was living with dementia became distressed at tea time. Staff were busy supporting other people with medicines and with serving tea and no staff came to support the person for more than 20 minutes, during which time they became increasingly distressed. When we asked staff to support the person they responded straight away, and the person became calmer.

● Staff were task focussed and did not always respond to people's social needs. People were left with little to occupy them for long periods during the day. Although some organised activities took place there were missed opportunities for staff to interact with people during the day. One person told us, "There's nothing to do really." Another person was heard saying, "I'm bored out of my mind," on several occasions during the day. Staff engaged with people briefly but did not have time to sit and chat or interact with people in a meaningful way

●The size and layout of the building made communication challenging for staff and sometimes staff were not able to locate each other. We spoke to the deputy manager and the regional support manager about our concerns regarding the deployment of staff and identified this as an area of practice that needed to improve. Following the inspection, the provider sent us information about what they had done to address these concerns and to mitigate risks.

The provider had not ensured that there were enough suitable staff deployed to care for people safely. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider had effective recruitment systems in place to assure themselves that staff were appropriate for their roles. Appropriate checks and references were carried out before staff started working with people. Agency staff were supported with an induction when they first worked at the home.

Systems and processes to safeguard people from the risk of abuse

● People were protected from risks of abuse. Staff had received training in safeguarding and demonstrated a clear understanding of their responsibilities. One staff member described how they would report any concerns or disclosures to the manager. Records showed that appropriate alerts had been reported when required. People told us they felt safe living at Francis Court. One person said, "Yes, there is no question about that." Another person said they felt safe because all the staff were, "Friendly and kind."

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 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

● At our last inspection we found that accurate records were not maintained, governance was not robust and shortfalls in quality had not always been identified and addressed. At this inspection we continued to have concerns because information was not always up to date and accurate. Shortfalls we found, which affected people's safety, had not been identified and addressed through the provider's management systems. For example, a medicine administration audit had not identified the shortfalls that we found. Care plan audits had not identified inconsistencies with care plans. Systems for updating staff about changes in needs were not robust and staff were relying on old information when providing care to people. Governance systems had not identified these shortfalls.

There was a continued failure to assess, monitor and improve the quality and safety of the service and records were not always accurate. This was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● We spoke with the deputy manager and the operations support manager about our concerns including how the deployment of staff had an impact on people's quality of life at the home. They explained the provider had undertaken a governance review in October 2019 and had identified similar quality issues throughout the home. This gave us confidence that the provider had already identified themes. A Service Improvement Plan (SIP) was in place to address these issues and themes. The deputy manager, operations support manager and the quality development manager described how they were already working with the new manager to implement actions from the SIP.

● The new manager had been in post since October 2019 and was in the process of submitting an application to become the registered manager. Staff were clear about their roles and spoke positively about the new management team. One staff member said, "It's been a difficult time since the last manager left, but I do have confidence in the new manager. They have an open-door policy, I would feel able to raise any issues with them."

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider had informed the CQC of significant events in a timely way. This meant we could check that appropriate action had been taken.

● The leadership team demonstrated an open and transparent approach during the inspection. Shortfalls we identified were accepted and some actions were taken immediately to address concerns. A culture of openness was not embedded throughout the staff team and some staff were defensive in their response to inspector's questions. Senior managers we spoke with recognised this issue and attributed this to the slippage in effective supervision and support during the period when the home was without a manager. The operations support manager sent us information about actions taken and planned improvements after the inspection, which gave us confidence that appropriate actions were being taken.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

● Systems for engagement and continuous learning were not yet fully embedded to drive improvements at the home. The provider had systems in place for engagement with staff, people living at the home and their relatives. Engagement had not been maintained when the service was without a registered manager. Suggestions and learning from mistakes had not been used consistently to drive improvements. However, the provider had identified these issues and had started to address this shortfall. For example, where concerns had been raised through the provider's complaints system or suggestions for improvements were identified in resident and relative's meetings, these were added to the service improvement plan to drive improvements.

● The quality development manager told us learning from incident analysis had led to falls prevention training for staff. In response to our concerns about lack of meaningful activities for people they described planned training to equip staff with more knowledge in how to engage with people who are living with dementia. Following the inspection, we received a detailed plan from the provider showing how, and by when, improvements would be made.

●Staff were involved in meetings on a regular basis. One staff member explained how this supported communication. They said they felt able to raise concerns and make suggestions for improvements. They told us, "The new manager is open to suggestions we have about how things could be better here".

Working in partnership with others

● Staff worked in partnership with other agencies and had developed positive working relationships. One health care professional spoke positively about communication with staff at the home.

● Records confirmed that appropriate referrals were made to health and social care professionals in a timely way.

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 12 HSCA RA Regulations 2014 Safe care and treatment Risks to people were not managed consistently to ensure that people received safe care and treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was a continued failure to assess, monitor and improve the quality and safety of the service and records were not always accurate.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider had not ensured there were enough suitable staff deployed to care for people safely.