Family Care Private Company Limited

Conifers Care Home

Inspection report

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Date of inspection visit:
30 July 2020

Date of publication:
07 January 2021

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
Conifers Care Home is a residential care home that provides accommodation and personal care support for up to 20 people. People have a range of care and support needs including diabetes and some people were living with dementia.

Conifers Care Home is a detached house located in a residential area of Selsey. The service had been adapted and was over three floors. At the time of our inspection 18 people were living at the service.

People's experience of using this service and what we found
There was not an adequate process for assessing and monitoring the quality of the services provided and that records were accurate and complete. People's care risk assessments lacked important detail to guide staff on how to make people safe. People did not always receive person centred care that met their needs and preferences.

Aspects of leadership and governance of the service were not effective in identifying some service shortfalls, such as failing to assess, monitor and mitigate risks relating to the health and safety and welfare of people.

Systems were in place to protect people from the risk of abuse and improper treatment and staff knew how to identify potential harm and report concerns.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

Positive and caring relationships had been developed between staff and people. People were treated with kindness and compassion and staff were friendly and respectful.

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 8 May 2020) and there were multiple 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 enough improvement had not been made and the provider was still in breach of regulations.

The service remains rated requires improvement. This service has been rated requires improvement for the last four consecutive inspections.

Why we inspected

This was a planned inspection based on the previous rating.

We carried out an unannounced comprehensive inspection of this service on 7 and 22 January 2020. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve. We identified three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment, protecting people from harm and good governance.

Following the inspection, the provider was issued with a Warning Notice for Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

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 the same. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Conifers Care Home on our website at www.cqc.org.uk.

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 action was necessary and proportionate to keep people safe as a result of this inspection.

We have identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to safe care and treatment and good governance.

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 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 section below.

Conifers 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 Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted as part of our Thematic Review of infection control and prevention in care homes.

Inspection team
The inspection was undertaken by two inspectors.

Service and service type
Conifers Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. The new manager was in the process of applying to CQC to become the registered manager of the service. The registered manager 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
We gave a short period notice of the inspection. This was because of the COVID-19 pandemic. We wanted to check if anyone was displaying any symptoms of the virus and to be aware of the provider's infection control procedures.

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

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

We reviewed information we had received about the service since the last inspection. We spoke to professionals and relatives who have regular contact with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with three people who used the service and four relatives about their experience of the care provided. We spoke with eight members of staff including the manager, deputy manager, head of care, and five members of the care team. Due to the COVID-19 pandemic, we adhered to safe working practices this included social distancing and wearing Personal Protective Equipment (PPE). Due to these restrictions we had difficulty speaking directly with people. We used observation from a safe distance to gain feedback on people's care experiences. We observed 10 people.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at two staff files in relation to safe recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
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 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

At our last inspection the provider had failed to robustly assess the risks relating to the health safety and welfare of people. 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.

- People continued to be at risk of avoidable harm. At the previous inspection risks to people in relation to their care and support needs had not been fully assessed with regard to the completeness of records. At this inspection the provider had not made improvement to the way that risks were assessed and recorded.
- Risks protecting people from harm had not always been identified or assessed. Risk assessments lacked detail and did not include measures on how the risk could be mitigated. For example, a person whose care and risk plan said they experienced periods of anxiety and confusion did not contain any further detail or guidance to ensure the person's well-being and safety during these periods. This lack of detail was consistent across all of the care and risk plans reviewed. This meant that people could not be assured of being protected from risks associated with their health and well-being.
- Another person's care plan and risk assessment for diabetes had not been updated to reflect information provided in February 2020 from a healthcare professional. This included information on when to seek medical advice and diet. This meant that people could not be assured of receiving appropriate and safe care and treatment to manage their diabetes.
- People did not always receive care and treatment in line with medical advice or guidance. For example, records showed when people had been diagnosed with a UTI and medical advice had been to "push fluids," fluid monitoring had not been implemented. Staff confirmed that fluid monitoring did not take place within the service.
- For another person, staff had failed to follow NHS guidance on head injuries following a fall. The person had received appropriate medical treatment at the time of the injury but had not been monitored for 24 hours afterwards and this was confirmed by staff. Staff were not aware of a provider policy on head injuries. This meant that people were at risk of their health deteriorating because processes to monitor their health and wellbeing were not in place.

The provider had failed to assess and manage risks relating to people's health and welfare. This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

● PRN is used to describe medicines that have been prescribed 'as and when required'. PRN protocols did not always provide guidance on the criteria for giving PRN medicines, monitoring processes or risks. Some PRN protocols were not in place. There was no evidence that people were always asked if they needed the medicine prior to it being given, or that PRN protocols and care plan guidance had been considered.

● For example, a person's medicine administration record (MAR) showed the person was receiving a PRN sedative called Lorazepam at the same time every morning. Their PRN protocol stated it should only be given when the person was agitated or showing signs of aggression, and 1-1 time and distractions should be tried prior to the medicine being offered. The person did not have a behaviour support plan and there was no other information to guide staff on the appropriateness of when to offer this medicine or associated risks. We reviewed the persons daily notes, and these did not reflect a change in the persons behaviour or preventative strategies implemented prior to the PRN medicine being given each morning. People could not be assured of a person-centred approach to receiving PRN medicines or that these were being administered in line with the prescriber's intended usage.

● Safe processes for medicines management were not always adhered to. For example, we observed the keys for the medicine trolley kept in a location that was accessible to all staff. On two occasions we observed medicines being dispensed from their original packaging within the care office and taken to the person in another part of the building in an unmarked plastic pot or syringe. This is known as secondary dispensing and is not considered good practice. Without the original pharmacy packaging and label the person administering cannot be sure that people are receiving the right medicine at the right time, as prescribed. On one occasion staff dispensed more tablets than prescribed for the person. This error was realised once in the persons bedroom and the correct prescribed dose was administered. Staff were not following safe practice requirements or the providers own policy for administering medicines.

● Current processes for ensuring new staff were appropriately trained and competent to administer medicines were not robust. Due to the current COVID-19 pandemic, new staff did not receive the providers usual medicine training. Temporary measures in place to prepare new staff included direct observation of staff administering medicines and a competency-based assessment undertaken by a senior member of staff.

● We identified two errors made by the same person. The deputy manager told us this person had been assessed as being competent to administer medicines using the temporary measures. Following these errors, additional and more robust training had not been considered, and the staff concerned had been able to continue to administer medicines. This meant that people could not be assured of receiving their medicines safely by appropriately skilled and trained staff.

● Staff told us there were occasions when they had to work late or return to the service to administer 10pm medicines because sometimes there were no medicine trained staff on duty during the night. The rota and staff training records confirmed this had happened. People could not be assured of always having access to their prescribed PRN medicines during the night, such as pain relief, because there was no one trained to administer to them. We spoke to the provider and manager about this. We were provided with verbal assurances this would be addressed immediately, including only using agency staff at night who had an in-date medicines training certificate.

The provider had failed to ensure that staff were suitably trained and competent to administer medicines. This was a breach of Regulation 12 of the Health and Social Care Act 2008(regulated Activities) Regulations 2014. Safe care and treatment

Systems and processes to safeguard people from the risk of abuse

At the last inspection the provider had failed to record, report and investigate injuries in line with safeguarding guidance. This was a breach of Regulation 13 (Safeguarding service users from abuse and

improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection enough improvement had been made and the provider was no longer in breach of Regulation 13.

● Systems and processes protected people from the risk abuse. Staff understood how to report any concerns they may have to relevant professionals and worked in line with the local authority safeguarding policy and procedures. Records showed there had been an improvement in the recording of unexplained bruises and skin tears and considering incidents in line with local authority safeguarding guidance.
● Staff received training to support their understanding of correct procedures to follow to keep people safe. Safeguarding training was completed by new staff during induction. Due to the current COVID-19 pandemic staff have not had access to usual training methods. New staff have received safeguarding guidance and information from senior staff. New staff demonstrated an appropriate level of knowledge of safeguarding including how to recognise abuse and how to raise a concern.
● Relatives told us the service provided a level of care that made their loved one feel safe and provided them with peace of mind. One relative described how their loved one's health had improved since moving to Conifers Care Home adding, "I can't fault the home." Another told us their loved one was very well looked after adding "They take good care of her; she is very well looked after."
● Social distancing restrictions and adhering to Public Health England (PHE) and CQC infection control requirements made it difficult to have face to face conversations with people. Some people found it difficult to read our facial expressions or hear what we were saying when face masks were worn. We spoke to two people and observed 10 people from a safe distance and saw positive and compassionate engagement between staff and people. Staff approached people respectfully and showed warmth and empathy. People responded with smiles and conversations that demonstrated they were comfortable with the support they were receiving. One person told us, "It is good here."

Learning lessons when things go wrong
● The provider had not always learnt lessons when things had gone wrong. Required actions from the previous inspection report had not been fully met. This is covered in more detail in the Well-Led section of this report.
● Since the last inspection the provider had acted to address the risks to people and staff caused by environmental factors. Improvements had been made including new flooring in some areas and a new boiler and heating system had been installed. This had significantly reduced the risk of injury to people and staff.
● Relatives told us the improvements made to the environment were better, one said, "Everything is fine, looks clean, doesn't smell and it has new flooring." Another told us, "When you go in it doesn't smell it's homely and comfortable. They've had home improvements, very positive and ticks all the boxes." People told us it was much better now that the heating had been fixed.

Staffing and recruitment
● There were safe systems and processes for the recruitment of staff. The provider followed safe recruitment processes to ensure people were suitable for their roles. This included undertaking appropriate checks with the Disclosure and Baring Service (DBS) and obtaining suitable references
● The provider had maintained safe recruitment processes throughout the current COVID-19 pandemic. The rota demonstrated that the safe staffing levels had also been maintained.
● Relatives and visiting professionals provided positive feedback about the staff. Feedback received included, "Great management and kind and caring staff", and "They engage so well with everyone, they really are a great team". We received positive feedback from visitors about staffing levels and staff skills.

Preventing and controlling infection

● As part of CQC's response to the coronavirus pandemic we are conducting a thematic review of infection control and prevention measures in care homes.
● We observed the following examples of good practice. People in the service were being supported with communication through staff using whiteboards to reduce the impact of them wearing facemasks.
● We were assured that the provider was promoting safety through their hygiene practices and changes to the environment. The service was very clean and there was an adequate supply of hand sanitiser, disinfectant wipes and Personal Protective Equipment (PPE) around the service. We were assured that the provider was using PPE effectively and safely.
● The provider was meeting shielding and social distancing rules and was admitting people safely to the service. The provider was accessing testing for people using the service and staff.
● We were assured that the provider was making sure infection outbreaks could be effectively prevented or managed. The provider had processes in place preventing visitors from catching and spreading infection.

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 inadequate. At this inspection this key question has improved to 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.

We inspected the service on 7 and 22 January 2020. The provider had not ensured there were adequate systems to assess, monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people and others. Accurate and contemporaneous records were not always maintained regarding people's care. This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection, the provider was issued with a Warning Notice for Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider was required to become compliant with this Regulation by 20 April 2020. The provider sent CQC an action plan which set out the actions they would take to achieve the required level of compliance. At this inspection we found that not enough improvement had been made. The provider had not met the requirement of the warning notice and was still in breach of this regulation.

• There was a continued failure to ensure adequate systems to assess, monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of others. Accurate and contemporaneous records were not always maintained regarding people's care.

• Processes for quality audit had failed to identify a lack of personalised information within people's care plans and risk assessments. People's preferences and abilities had not been captured. There was a lack of guidance for staff to ensure they provided personalised support in line with people's preferences and needs.

• Systems and processes for quality monitoring had failed to identify the lack of accurate and contemporaneous information in people's care records. Some information contained within care plans was not up to date. Records were not always sufficient to monitor the effectiveness of people's support or to ensure safe care. Risk assessments did not included guidance on how to mitigate identified risks.

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; Continuous learning and improving care

● At the time of our site visit, not all the improvements the manager told us about in their action plan had been made. This included ensuring care plans remained accurate, up to date and personalised. There was a continued failure to ensure adequate systems to assess, monitor and improve the quality and safety of services provided.

● Quality monitoring and audits of the service were in place. There was no provider oversight of quality

monitoring processes. These processes had failed to identify and address the issues of some care records not being accurate or complete and their lack of detail. For example, care plans for diabetes continued to lack information to ensure the person's health was managed and monitored safely and did not include any risks relating to diabetes.

● For another person their Medicine Assessment Record (MAR's) showed they were prescribed a laxative to be given as and when required (PRN) which was being given every night. There was no guidance as to when this person might require this medicine, preventative measures or why they were having it every day. The persons infection control risk assessments mentioned episodes of faecal incontinence which were considered as behavioural. Prescribed laxatives were not mentioned and had not been considered as a possible cause. The provider had failed to ensure care records contained enough information about people's needs to guide staff to support people appropriately.

● Management oversight and quality assurance processes had failed to identify the continued lack of personalised information within people's care plans and risk assessments. People's preferences and abilities had not been captured. The monthly review of care plans outlined in the providers action plan had failed to identify the disrespectful and degrading content of a care plan written in May 2020. The care plan used terminology that did not value the person or demonstrate a dignified and person centred approach to supporting their care needs. We spoke to the manager, area manager and provider about this. All said that they had not been aware of the care plan and agreed that it's content was unacceptable and inappropriate. The provider who took immediate action to commence updating the care plan.

● The provider did not have oversight of medicines and had failed to implement a robust process to audit and monitor these. Processes were not in place to ensure people were receiving their medicines safely and as prescribed by a medical practitioner. For example, where MAR's showed that sedatives prescribed for PRN usage were being administered at the same time every day the provider had not considered if people's behaviour was being controlled by inappropriate use of medicines.

● Management skills, knowledge and oversight did not foster a culture that ensured people received safe and personalised care. Staff responsible for writing risk assessments and care plans did not have the skills and knowledge required to ensure these were fit for purpose or contained the relevant information to provide staff with guidance on how to mitigate risks safely. We observed examples of poor practice from senior staff who were being used as role models for new and less experienced staff, for example, when administering medicines. Following medicine errors made by new staff the provider had not considered if the practices of those who had been training these staff, along with the culture within the service had contributed to these errors being made.

● Accident and incident reports were not audited in order to identify any themes and trends to mitigate a further occurrences. For example, where there were recorded incidents of falls, confusion and urinary tract infections (UTI), consideration had not been given to take measures to mitigate these risks such as ensuring people remained hydrated. Staff confirmed they were unaware of people's daily recommended allowance for fluid intake and did not monitor people's hydration. Dehydration is known to cause UTI's and can lead to an increased risk of falls and confusion.

There was a continued failure to ensure adequate systems to assess, monitor and improve the quality and safety of services provided. Accurate and contemporaneous records were not always maintained regarding people's care. This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The service had been without a registered manager since 21 October 2019. There had been a manager employed between October 2019 and July 2020. This person had withdrawn their application to CQC to register as the manager of the service. At this inspection a new manager had been in employed for two weeks and was in the process of applying to CQC to become the registered manager for the service.

● Visitors, relatives and staff spoke highly of the service and felt it was well-led. Relatives told us they had received good communication during the COVID-19 pandemic and were kept up to date with the health and well-being of their loved ones. One relative said, "They've been doing very well regarding the pandemic very good management" and another told us "They have handled the virus really well I saw [name] last week she looks good."
● Following the inspection, we spoke with the provider. They informed us of the immediate actions they were going to take to address the concerns and failings in the operational oversight of the service and quality assurance processes. This included sourcing additional resources including engaging a consultant to support the quality assurances processes and writing of care plans and risk assessments.

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
● Relatives told us they had been assured of their loved ones' well-being during the COVID-19 pandemic and felt included and informed. One relative said, "They are very good, when we had lockdown, they put pictures of relatives on an electronic tablet to let me know that she's okay." Other relatives told us were kept informed of any changes or medical appointments by letter and phone calls.
● Relatives and visitors to the service felt able to speak openly to the senior team and care staff. Feedback from relatives informed us they felt there was open and honest communication in place between the management and families and people.
● Records showed that when incidents had happened, families had been communicated with in a timely way. One relative said, "I've been asked recently about being informed about minor incidents and whether I want to know about minor marks and bruises." Another relative told us, "If I am going in, they would tell me about any changes in the care plan or calls to the doctor."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others
● Staff told us they felt supported by the management of the service. There had been an increase in staffing levels which they said was positive. Staff felt able to report concerns and share ideas to the management team. They felt listened to and valued. One said "I have no safety concerns. It is a very friendly place" and "the residents are happy."
● Management, and staff had developed a close working relationship with health and social care partners. Staff told us they felt they had been very well supported throughout the COVID-19 pandemic by local healthcare professionals. People had received access to healthcare services whenever they needed them. Updates from the local community matron had been useful and welcomed. We were told that the senior team had really appreciated the help and support given to them by the GP practice, health professionals, local authority and CQC during this time.
● Feedback from health professionals was positive. One described the staff as brilliant and said they showed respect for the people they were supporting. They said, "I have no concerns regarding safety. They are very good with end of life care."
● The provider had ensured visitors to the service were kept up to date with arrangements for visiting. One relative told us, "Its's gone very well, they sent a letter about three weeks back about visiting and the booking process to go through. They are going to take your temperature and get you to sign in and to stay two metres apart." Another relative told us they were looking forward to seeing their loved one for the first time since lockdown restrictions had eased and had planned for the coming weekend.

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
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that staff were suitably trained and competent to administer medicines. There was a continued failure to assess and manage risks relating to people's health and welfare.

The enforcement action we took:

The provider was issued with a warning notice for Regulation 12 with required compliance of this regulation by 10 December 2020

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 ensure adequate systems to assess, monitor and improve the quality and safety of services provided. Accurate and contemporaneous records were not always maintained regarding people's care.

The enforcement action we took:

A condition was placed upon the providers registration. The registered provider must send a written report by the 28th day of each calendar month to the Care Quality Commission. The report must include the results of audits undertaken in care plan's, risk assessments, medicines and staff training.