The Flowers Care Home Limited

The Flowers Care Home Limited

Inspection report

3 Snape Drive
Horton Bank Top
Bradford
West Yorkshire
BD7 4LZ

Tel: 01274575814

Date of inspection visit:
14 October 2021
19 October 2021

Date of publication:
08 December 2021

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service
The Flowers Care Home is a residential care home providing accommodation and personal care to 23 people including people living with dementia. On the first day of the inspection there were 17 people living at the home. On the second day of the inspection there were 16 people living at the home.

People's experience of using this service and what we found
People were not safe. They were at risk of harm because risks to their health and safety were not managed effectively. Medicines were not managed safely. People's nutritional needs were not always met. Government guidance on the prevention and control of infection was not always followed which meant people were put at increased risk. Staff were not carrying out regular testing for COVID-19.

There were not always enough staff to keep people safe. We saw staff were kind and compassionate, but they were rushed, and routines were often task orientated. Staff were not always able to respond quickly where people needed care, support or comfort.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

Most people and relatives felt people were safe and described staff as being kind and helpful.

The home and grounds were accessible.

Staff received induction, training and supervision to carry out their role. The staff team was consistent and experienced, and they knew people well and we observed warm and caring interactions. Recruitment was managed safely.

Systems to assess, monitor and improve the service had not been effective and there was a lack of management oversight to monitor day to day events and the safety of care. Audits and checks had not identified shortfalls. Opportunities to learn lessons and make improvements to the service had not been taken. Staff and relatives spoke positively about the registered manager and said they were approachable and supportive.

The provider was responsive to inspection findings and responded during and after the inspection.

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 the service was requires improvement (published 23 January 2020). 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.

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

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 have found evidence that the provider needs to make improvement. 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.

The provider has taken action to mitigate the risk. They completed an action plan the day after the inspection and took immediate action to safeguard people, including increasing the staffing levels on an afternoon and night shift.

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

Enforcement
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to safe care and treatment, consent to care, nutrition, staffing 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 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.

Special Measures:
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service.

This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not 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?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

The Flowers Care Home Limited

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 was carried out by one inspector on the first day and two inspectors on the second day.

Service and service type
The Flowers 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 the safety of the care provided.

Notice of inspection
The first day of the inspection was unannounced. The second day of the inspection was planned.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We spoke with one person who used

the service, four relatives of people who used the service and a health care professional. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service and one relative about their experience of the care provided. We spoke with six members of staff including the registered manager, deputy manager, senior care workers and a care worker. 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.

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

After the inspection
We met with the local authority and continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
At our last inspection the provider had failed to manage the administration of medicines 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.

- Medicines were not managed safely.
- Systems were not in place to ensure people were administered their prescribed cream safely. Medicine administration records (MAR) did not provide details of how creams should be applied. MAR records were not signed consistently so we could not be assured people were receiving their creams as prescribed. There were lockable cupboards in people's rooms for the safe storage of creams. On both days of the inspection we saw prescribed creams had been left out.
- Not all people had photographs with their medication administration records for identification purposes and allergies were not recorded. Where MAR sheets were hand-written there was no evidence two staff had checked and booked in the medication.
- The home had a system where people were offered homely remedies. The provider was not following current guidance. There were no risk assessments in place and there was no reference to how this should be safely managed in the homes' medicines policy.
- Medicines audits were in place, but they were not effective and did not provide assurances medicines were managed safely. For example, one person had been prescribed meal supplements to be taken twice a day. We found these had only been administered once a day since September 2021. This had not been identified through weekly checks.

Systems were either not in place or robust enough to demonstrate medicines were managed safely. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff had training and their competency to administer medicines assessed.

Assessing risk, safety monitoring and management; learning lessons when things go wrong
- Risks to people's health and safety were not assessed and care plans did not contain detailed information. For example, risks relating to people's mobility, skin integrity, nutrition and mental health were not assessed

and monitored. Records indicated multiple examples where people were losing weight or having unwitnessed falls, and this was not reflected in their risk assessments.
● One person had fallen three time since their admission in July 2021. The falls were not recorded in their falls diary and there was no management plan or risk assessment in place. This meant they were at an increased risk of harm.
● Another person regularly became anxious and upset. Records showed they had displayed some behaviours which exposed others to risk of harm. There was no detailed risk assessment in place to advise staff on how to support the person. This meant vulnerable people and staff were at an increased risk of harm.
● People's care plans were not always reviewed after serious events. Accidents and incidents were not always recorded. There was no evidence of analysis to identify themes or trends or lessons learnt.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider responded immediately during and after the inspection. They confirmed there would be a full review of people's care records and the risks they were exposed to.
● The provider told us they had recognised improvements were required in record keeping. Plans were in place to move to an electronic care planning system.

Staffing and recruitment
● People were at risk of harm or injury as there were not enough staff to keep them safe.
● After 3pm there were two staff on duty. There were 16 people living at the home and staff were also responsible for administering medicines and serving the evening meal. During the night there was one staff member rostered to be awake with a second member of staff on call. People's bedrooms were located over two floors and the staff member was also responsible for carrying out the laundry in the basement. We were not assured there were enough staff to keep people safe.
● We observed staff were rushed and not able to respond promptly when people needed support. On the second day of the inspection between 16.30pm and 17.05pm we observed one person walking unsteadily without their zimmer using the wall to support them. Another person tried to get up and mobilise. They were unsteady on their feet. Another person required the support of two staff to mobilise and use the bathroom. This meant there were no staff in the lounge for nine minutes.
● People did not always receive a timely response when they were upset or agitated.
● The registered manager did not use a recognised dependency tool to determine the number of staff required. They were not aware staffing levels were unsafe.

The provider was unable to demonstrate there were enough suitably qualified, competent and experienced staff deployed at all times to meet people's needs. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider responded immediately during and after the inspection. They confirmed they had increased staffing during the day and at night. They confirmed they would source a recognised dependency tool in order to determine and monitor future staffing levels.
● The home had a well-established team which meant people were supported by experienced and consistent staff. There were no concerns raised by staff or relatives about the staffing levels.
● Recruitment was managed safely, and all the required checks were completed before staff started work.

Preventing and controlling infection

● Government guidance on the prevention and control of infections was not always followed.

●. People and staff were not completing regular COVID-19 tests in line with government guidance. This meant risks to vulnerable people were increased because they were at a heightened risk of infection.

● Not all areas of the home were clean. There was not a housekeeper on duty every day and there were no detailed cleaning schedules in place. The laundry was disorganised and not clean .

We found no evidence that people had been harmed however systems were not in place to demonstrate infection prevention and control measures were effectively managed. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment)) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider responded immediately during and after the inspection. They confirmed COVID-19 testing was in place for staff and reviews would be held with people who lived at the home.

● The provider was supporting relatives to visit safely. Relatives were complimentary about how the service had managed throughout the pandemic. One relative said, "They have been brilliant throughout it all."

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

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

Systems and processes to safeguard people from the risk of abuse

● People and relatives told us they felt safe living at the home.

● Staff had received up to date safeguarding training. They could describe different forms of abuse and the action they would take.

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

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

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 any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

- The service was not always acting within the legal framework for MCA. People's capacity to consent to their care and treatment was not always assessed.
- Where people lacked capacity there was no evidence of robust best interest decisions being made with the involvement of people's relatives, advocates and other health care professionals.
- We observed most people living at the home had sensor mats in their bedrooms to alert staff when they were moving. There were no consent forms or best interest assessments in place and staff did not view this as a restrictive practice.
- Appropriate DoLS applications had been made in a timely manner. However, we noted there was one person who had a DoLS in place with conditions attached. The person's care plan stated there were no conditions attached to the DoLS which meant there was no effective system in place to monitor this.

People did not have their care and support needs delivered in line with MCA. This was a breach of regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider responded immediately during and after the inspection. They confirmed they would engage with the relevant people and carry out a full review of capacity and best interest assessments for people

living at the home.
● We observed staff routinely asking for consent from people before they provided care or support.

Supporting people to eat and drink enough to maintain a balanced diet
● People's nutritional needs were not consistently assessed and met by the service. People' weights and food intake were monitored but this was not always effective. One person had lost over 6kg since their admission to the home. Their food and fluid charts showed a poor intake and there was no robust care plans or risk assessment to show what was being done to address this.
● We observed the mealtime experience was rushed and disorganised. Staff were responsible for serving the meal which meant they did not always have time to sit and support people who required assistance.
● We received mixed feedback about the quality of the food. Comments in the minutes of the resident's meeting were positive but two people told us they did not like the food. One person said, "The food is awful, just mush…..it is mostly vegetarian, there is not much meat." On both days of the inspection we observed the choice of evening meals were both vegetarian. We discussed this with the provider and they said they would review the menus.
● People were weighed regularly, and referrals made to relevant health professionals. However, there was no effective oversight to ensure this was closely monitored and the appropriate action taken.

People's nutritional needs were not always met. This was a breach of regulation 14 (Meeting nutritional and hydration needs) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs.
● People's needs were assessed before they moved into the home.
● Some information had been transferred into care plans, but this was not comprehensive, and action was not taken to meet people's needs in an effective and holistic way. For example, we reviewed one person's care records who had moved into the home in September 2021 and the only care plans in place were for sleeping, mobility and the use of bedrails.
● The building was adapted to meet people's needs and the environment was homely and comfortable. There were two communal rooms, a conservatory and a traditional bar area. There was some dementia friendly signage which helped people who lived at the home orientate themselves. The home had recently created a dance floor area in one of the lounges. The registered manager told us this provided a popular and welcome addition, particularly during the restrictions experienced throughout the pandemic.
● There was direct access to safe garden area which provided an attractive seating area.

Staff support: induction, training, skills and experience
● Staff spoke positively about the induction and training they received.
● Records showed us staff had completed a range of training. Most staff had achieved a recognised care qualification. Relatives told us they thought staff were well trained. One relative said, "Staff have been brilliant. I think they are well-trained. They are very professional and supportive."
● Records showed staff received regular supervision and an annual appraisal. Notes included a range of discussion topics.
● The registered manager had developed a library of resources to support staff with their ongoing learning and development.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● People's care plans contained some information about their health needs. Care records showed people

saw a range of health professionals. The district nurse team visited the home regularly.

● Relatives spoke positively about the support people received with their health. One relative described the improvements they had seen in their relative's health and wellbeing since they move into the home. They said, "There has been a great change in [person]. They could not have done better."

● The service was part of the Telemeds initiative. This meant staff and people were able to access video consultations with health professionals using a laptop in the service.

● We spoke with a visiting health care professional who praised the home and quality of staff engagement. They described staff as being proactive about seeking support and stated, "Staff have been fantastic. They crack on and deal with things."

Inadequate

Is the service well-led?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- Systems for identifying, capturing and managing organisational risk was ineffective. After the second day of our inspection our concerns for people's health and safety were so serious, we wrote to the provider and requested a response about how they would take immediate action to ensure people were safe. The provider gave us assurances about the action they would take.
- Significant shortfalls within systems and processes were identified at this inspection which placed people at risk of significant harm. Systems were not in place to ensure the provider was aware of how the service was operating to ensure compliance with regulations.
- Management and staff did not consistently understand the principles of good quality assurance processes. Audits were in place, but they were generally completed by senior staff and the registered manager did not have effective oversight and was not fully aware of what was happening in the service.
- There was no robust system for assessing and managing risks to people's health and safety. This meant people were at a heightened risk of injury and their health and well-being deteriorating. Records related to people's care were not always accurate and up to date. On both days of the inspection, systems were chaotic and records we requested were not available.
- We were not fully assured the registered provider understood regulatory requirements and the importance of quality improvement. Breaches of regulation identified at the last inspection had not been fully acted upon and the service remained in breach of regulation.
- Policies were in place but there was no evidence of recent review to ensure they were following current best practise guidance.

People were placed at a significant risk of harm through the lack of management oversight and effective governance systems. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

- After the inspection the provider demonstrated they were working with the local authority and other agencies to make improvements. They took immediate steps to strengthen their oversight of the home. They spoke passionately about ensuring the necessary improvements were made at The Flowers.
- The registered manager had complied with the requirement to notify CQC of various incidents, so we could monitor events happening in the service.

● Staff praised the registered manager and said they were approachable and had an 'open door' approach. They said they felt valued and appreciated. One care worker said, "[Manager] is a fabulous boss."

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

● People did not always receive person centred care that led to good outcomes for them. People's care records did not contain individualised information and people had not been involved in their care planning.

● People and relatives views were sought about the running of the home, including regular residents' meetings. Feedback from relatives was good and they said they felt welcomed at the home and the registered manager and staff kept them up to date with any changes.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● Staff worked well together and demonstrated teamwork. Staff meetings were held regularly and staff said they felt involved in the running of the home.

● The provider completed an annual survey with relatives. Recent feedback was positive. Comments included, 'The home is a family friendly environment' and 'They [staff] are all lovely and true.'

● The service worked in close partnership with health and social care professionals.

● After the inspection the provider liaised with the local authority and engaged the support of an external consultant to support with improvements.

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 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA RA Regulations 2014 Need for consent. The provider failed to deliver people's care and support needs in line with the Mental Capacity Act Reg 11 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Regulation 14 HSCA RA Regulations Meeting nutritional and hydration needs The provider did not have systems in place to ensure people's nutritional and hydration needs were managed effectively Reg 14 (1)(2)(a)

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 Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to assess or manage the risks associated with people's care. Reg 12 (1) (2) (a) (b) Systems were not robust enough to demonstrate the safe and proper use of medicines. Reg 12 (1) (2) (g) The provider failed to demonstrate infection prevention and control measures were implemented effectively. Reg 12 (1)(2)(h)

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to operate effective governance systems to ensure compliance with requirements Reg 17 (1)(2)(a)

The enforcement action we took:

Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA RA Regulations Staffing The provider failed to ensure there were sufficient suitably qualified and experienced staff deployed

to keep people safe. Reg 18 (1)

The enforcement action we took:

Warning Notice