Cloverfields Care Limited

Cloverfields

Inspection report

Chester Road
Whitchurch
Shropshire
SY13 4QG

Tel: 01948667889

Date of inspection visit:
22 April 2021

Date of publication:
27 May 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
Cloverfields is a nursing home providing personal and nursing care to 17 people aged 55 and over at the time of the inspection. The service can support up to 35 people. The home is split over three floors and people have access to communal areas and a large garden.

People's experience of using this service and what we found
Risks to people's safety were not always considered and governance checks were not robust. Areas with the potential to cause harm were identified, for example, missing bedrail assessments. Accident and incident forms were completed but it was not always clear whether lessons had been learnt or families had been notified.

People were supported by enough staff but felt there were times when more staff were needed. People felt safe and were supported by staff who had been trained in recognising abuse.

Medicine guidance and information was not always complete, and staff felt they were not always given clear instructions for administering people's medicine.

Infection, prevention and control measures were in place but not all of the government guidance was being met. Indoor visits to the home were yet to be facilitated.

The provider was open to the concerns raised and was already taking action to improve the care people received.

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

Rating at last inspection
The last rating for this service was good (published 19 November 2019).

Why we inspected
The inspection was prompted in part due to concerns received about the overall governance within the service. A decision was made for us to inspect and examine those risks.

We looked at infection prevention and control measures under the safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

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 and the overall governance of the home at this inspection.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will 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.

Cloverfields

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
This inspection was carried out by two inspectors.

Service and service type
Cloverfields 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 provider was in the process of recruiting a new manager. The provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before 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. 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.

During the inspection
We spoke with five people who used the service and three relatives about their experience of the care provided. We spoke with eight members of staff including the quality and compliance team, nurses, care workers and maintenance person. 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 five people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. 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. We looked at training data and quality assurance records. We spoke with one further relative and received email feedback from three more. We also liaised with two external professionals in connection to the 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 good. At this inspection this key question has deteriorated to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
• The provider had not ensured known risks within the property were fully mitigated. We found window restrictors were in place, but several did not meet the required standard. We told the provider to take urgent action to ensure the appropriate restrictors were being used. The provider responded to this request and new restrictors have now been installed.
• The provider had not ensured actions highlighted on the fire risk assessment were completed. The fire risk assessment indicated several actions remained outstanding. We shared this intelligence with the local fire service as they were in communication with the home.
• Risks to people's safety were not always considered and action was not consistently taken to reduce the potential for harm to occur. For example, one person had become trapped in their bedrails. An incident form had been completed, and no injuries were sustained. However, we found no evidence of a bed rails assessment or update in the persons care plan to ensure staff knew how to prevent this from happening again. The provider took immediate action to review bedrails assessments for all those who use them as we found these were missing from other people's care files.
• People were not always able to request help when needed. We observed one person in bed and their call bell was out of reach, underneath the bed. We alerted staff who took immediate action to ensure the person was safe.
• The provider had not ensured risk assessments needed to comply with COVID-19 guidance were completed. Assessments around staff's health issues and ethnicity were recommended but had not been actioned. The provider told us they would ensure these were completed.

Using medicines safely
• People did not always have up to date protocols in place for the medicine they were prescribed. One person's prescription changed during a recent admission to hospital. However, their medicine protocol had not been updated following their discharge back to the home. This meant staff were having to deviate from the instructions in place. Following our inspection, the provider confirmed they had contacted the relevant health team to request an updated protocol.
• One person was prescribed topical cream but there was no guidance to say how often or where the cream should be applied. This placed the person at risk of not receiving their cream at the correct frequency or to the correct area of their body.
• Staff were not always confident using all routes of medicine administration. Most people took their medicine orally and some people required a different route of administration. Staff told us they had not received training from the provider to support alternative routes of administration, and we found no evidence of formal training being delivered. The provider has shared evidence confirming this training has

now been requested.

Preventing and controlling infection
• We were not assured that the provider was using PPE effectively and safely. We observed incidents of staff not wearing gloves and aprons when hoisting people and supporting people to eat. This placed staff at risk of being exposed to bodily fluids. Staff wore PPE correctly at all other times.
• We were not assured the provider was promoting safety through the layout and hygiene practices of the premises. We observed the staff were not wiping down the hoists between uses and found maintenance records had frequent references to equipment needing further cleaning. Other areas of the building were clean and hygiene practices were promoted. The provider has since taken advice from the local Infection, prevention and control team and introduced a new system to monitor the cleaning of equipment.

We found no evidence that people had been harmed however, we found incidents where there was the potential for harm to occur. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• We were not assured the provider was facilitating visits for people living in the home in accordance with the current guidance. The home had recently recovered from an outbreak of COVID-19 where they had needed to lock down. The outbreak had since passed however, the provider was still to take action to enable visitors to come in to the home. We spoke with several relatives who told us they were still only permitted to have window visits. One relative said, "It is so unfair, I want to see my [relative] and I'm sure we should be allowed to, but we have heard nothing. I don't want my [relative] to feel abandoned." Another relative told us, "When we get to visit, I know my [relative] will perk up and be more responsive. The staff do their best, but they need their family in their lives more." Following the inspection the provider confirmed they had reviewed their indoor space and were making plans to facilitate indoor visits.
• We were somewhat assured that the provider's infection prevention and control policy was up to date. This was because not all the required actions had been completed.
• We were assured that the provider was preventing visitors from catching and spreading infections.
• We were assured that the provider was meeting shielding and social distancing rules.
• We were assured that the provider was admitting people safely to the service.
• We were assured that the provider was accessing testing for people using the service and staff.
• We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

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

Staffing and recruitment
• We saw there was enough staff to meet people's needs. However, feedback from people and the staff team suggested there were times when this was not always the case. One person told us, "There are always carers around but sometimes we do have to wait." Another person said, "At present it doesn't feel like there are many carers, but I can help myself."
• People's relatives told us communication during the pandemic had sometimes been poor because there was not always staff free to support communication. One relative said, "Sometimes no one is available to support [relative] use the phone which means we can't always communicate."
• People were supported by staff who had been recruited following safe recruitment practices. These included checking candidates background, qualifications and character. In most files all checks were complete however, we did find one staff file where a full employment history had not been recorded. We recommended the provider audited the staff files to reassure themselves all checks had been completed in full.

Systems and processes to safeguard people from the risk of abuse

• People told us they felt safe in the home. One person said, "Yes I feel safe, never have to worry about that." Relatives also told us they felt people were safe. One relative told us, "I know my [relative] is safe and well looked after even though I get frustrated sometimes about a few things." Another relative said, "I believe [relative] is in safe hands with caring staff in these difficult times."

• People were protected from the risk of abuse. Staff had received training in recognising and reporting signs of abuse and were confident in reporting although some did say they were not sure who they would go to within the organisation. One staff member told us, "There has been a lot going on in the home, we have new managers, staff have left and everyone is a bit unsettled but I would speak to someone if I thought anyone was at risk."

• Staff had access to the provider's policies on safeguarding as well as the Local Authority referral process. This meant staff could access external support for people if necessary.

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 good. At this inspection this key question has deteriorated 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.

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

• The provider's governance systems within the home were not robust. Recent audits completed by the provider highlighted poor compliance with their own standards as well as some regulatory requirements. Therefore the quality of care had not been maintained and improvements were required.

• The systems in place had not been effective at ensuring risks to people safety were assessed and appropriate mitigation strategies were being implemented. We found concerns with the building, the use of bedrails, people's medicine and infection, prevention and control. We noted some inaccuracies in documentation and record keeping. For example, there were several gaps in people's daily records.

• Staff were not always given enough training or information to ensure they knew how to fulfil their role. One staff member told us, "I have had some training, but I often have to rely on others telling me what needs doing." Another staff member said, "Sometimes you have to figure things out for yourself which is not ideal." This could potentially put people at risk because staff were not always aware of how to meet the required standards.

We found no evidence people had been harmed however, the governance systems in place were not robust enough to ensure people remained safe. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

• The previous inspection rating was displayed in line with legal requirements.

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

• We found a poor culture within the home had begun to develop. The impact of the COVID- 19 pandemic and recent changes within the staff team were reported as the catalyst for this change. Staff told us, "It's not great at the moment, it's a lovely place to work but so much has happened and we need to pick ourselves up."

• Relatives told us previous to the COVID-19 pandemic they found the home approachable and were complimentary of the care delivered. However, some said they were becoming increasingly frustrated at the lack of phone signal which made calls difficult. There was also a lack of direct communication and delays at increased visiting.

• People were supported to engage in activities together and form social relationships with one another.

One person told us, " I do enjoy what we do and I have made lovely friends."

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 was aware of and acted upon their duty of candour. We reviewed accident and incident forms and saw in most instances staff had recorded when families had been notified. However, on some forms we found blank sections meaning we could not be sure whether family had or had not been told. We brought this to the attention of the provider who told us they would explore this further as part of their review of the homes record keeping processes.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• The provider had not completed any recent quality assurance questionnaires and staff supervision and team meetings had all reduced in recent months. This was recognised by the provider who told us this was an area that needed attention to ensure everyone was able to contribute to the service and be on board with what needed doing.
• People were engaged in conversation with staff and staff were responsive to their requests. For example, people were asked what meal they wanted before the meal was prepared and were able to change their mind about what they wanted.

Continuous learning and improving care
• The quality and compliance team who were overseeing Cloverfields were aware of there being issues in the home. However, they were having to work in a reactive manner having not yet had time to establish the priorities and where to focus their attention. They were responsive to our findings and acted upon the points raised.

Working in partnership with others
• We found the provider had engaged in working with others to improve the service provision. Support had been requested from various agencies including local health teams, infection, prevention and controls teams and the fire service.

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 17 HSCA RA Regulations 2014 Good governance The governance systems in place were not robust enough to ensure people remained safe.

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 Risks to people's safety were not always mitigated

The enforcement action we took:

A warning notice was issued to the provider.