Florence House Limited

Florence House

Inspection report

17 Church Road
Wanborough
Wiltshire
SN4 0BZ
Tel: 01793 790727
Website: www.example.com

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Inadequate**
Is the service effective?	**Requires improvement**
Is the service caring?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

We inspected Florence House on 22 and 29 of May 2015. Florence House provides nursing care for up to 30 older people with a range of conditions. At the time of our visit there were 22 people using the service. We carried out an unannounced visit.

People's medicines were not managed safely. Medicine records were not always accurate and there were no effective systems in place to monitor medicines coming into the home. This put people at risk of not receiving medicines as prescribed.

People's needs had been assessed and where risks were identified risk assessments were in place. However, staff were not always knowledgeable about people's needs and care was not always provided in line with care plans.

The provider was not always adhering to the principles of the Mental Capacity Act 2005 Code of Practice. The Mental Capacity Act 2005 ensures that where people lack the capacity to make decisions, any decisions made on the person's behalf are made in their best interest.

There was a registered manager in post. A registered manager is a person who has registered with the Care

Summary of findings

Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run

People and their representatives were complimentary about the care provided at the home. We saw some kind and caring interactions and people were given choice in relation to their care.

People and their representatives spoke positively about the approachability of the registered manager and provider. However, there were no effective methods in place to enable the provider to gather feedback from people or their representatives. Quality assurance systems were not effective in making improvements to the service.

Staff did not receive supervision or appraisals as required by the organisation's policy. However, staff were positive about the support they received from the management team and felt improvements were being made.

There were enough staff to meet people's needs on the day of our inspection. People and staff had mixed views on whether there were always enough staff to meet people's needs. The registered manager had no system to assess how many staff they needed to ensure people's needs were met and the number of staff on duty often varied. We have made a recommendation about the assessment of staffing levels to meet people's needs.

The provider was not always sending notifications to CQC as required by the conditions of their registration.

We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Care Quality Commission (Registration) Regulations 2009. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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 always safe.

People's medicines were not managed safely.

Staffing levels were not consistent. There was no system in place to monitor staffing levels required to meet people's needs.

Staff were not always aware of their responsibilities in relation to recognising and reporting suspected abuse.

People's care plans contained risk assessments. Where risks were identified risk management plans were in place.

Is the service effective?

Requires improvement

The service was not always effective. The provider was not meeting the requirement of the Mental Capacity Act 2005.

Staff did not receive regular supervision.

People received sufficient food and fluids to meet their needs.

Is the service caring?

Requires improvement

The service was not always caring. People were not always treated with dignity and respect.

People were supported by staff who knew their needs.

People were involved in decisions about their care.

Is the service responsive?

Requires improvement

The service was not always responsive. People did not always have access to activities that interested them.

People and their relatives felt involved in their care.

Complaints were dealt with in line with the providers complaints policy.

Is the service well-led?

Requires improvement

The service was not always well led. Quality assurances systems were not always effective in driving improvements to the service.

The provider was not notifying CQC of all notifiable incidents.

The provider was implementing measures to improve staff retention.

Florence House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 22 and 29 May 2015 and was unannounced. The inspection team consisted of three inspectors.

Before the visit we looked at notifications we had received. Providers tell us about important events relating to the care they provide using a notification. This enabled us to ensure we were addressing potential areas of concern. We spoke to two health and social care professionals.

We spoke with nine people who lived at Florence House and five people's relatives. Not everyone we met was able to tell us their experiences, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with the provider, the registered manager, the deputy manager, one nurse, five care workers, the chef and a housekeeper.

We looked at 12 people's care records, ten records relating to medicines and at a range of records about how the home was managed. We reviewed feedback from people who used the service and a range of audits.

Inadequate

Is the service safe?

Our findings

Medicines were not managed safely. Systems in place did not ensure there was an accurate record of people's medicines. There was no effective system to check the amount of medicines held in the home. Where balances were recorded these were often incorrect. For example the balances of six medicines for one person were incorrect. The balances of these medicines had been recorded on the medicine administration record (MAR) two days before our inspection. Medicines received into the home were not always recorded on to the MAR. MAR were not always completed accurately. We could not be sure people were receiving their medicines as prescribed.

People's medicines were stored in individual trays in the medicines trolley. Trays were not always labelled to enable identification of people's medicines and medicines were not always in the tray for the correct person. This put people at risk of not receiving their prescribed medicines. Tablets were not always in the dispensed packaging, for example there was a strip of tablets in a person's tray with no name of who they were prescribed for. The medicine was not listed on the person's MAR. The nurse responsible for administering the medicines did not know who the medicine was prescribed for.

Controlled drugs were stored in a controlled drugs cupboard. There was a controlled medicine for one person that was not in the dispensed packaging. There was no administration instructions from the pharmacy and the nurse administering the medicines could not be sure the medicine had been prescribed for the person. We raised this with the registered manager who took immediate action.

The home had a policy for the administration of homely remedies. A homely remedy is a non-prescription medicines available over the counter in community pharmacies. Homely remedies were stored in the medicines stock cupboard. However, there was no system in place to monitor the balances of homely remedies. Some homely remedies were not in the original packaging and contained no administration instructions.

These issues are breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not protected from abuse as there were not effective systems in place to identify and respond to concerns. Some staff we spoke with told us they had received safeguarding adults training. However, staff did not have a clear understanding of the different types of abuse or their responsibilities in relation to safeguarding adults. Staff told us they would report any concerns about abuse to the registered manager, however they were not aware of where to report issues outside of the organisation. The provider's safeguarding policy did not include contact details of the local authority safeguarding team.

The provider's safeguarding policy stated staff would receive safeguarding training annually. The training matrix showed that not all staff had received safeguarding training and staff had not received an annual update.

The provider had not always raised safeguarding concerns with the local authority. We saw incident forms that indicated a safeguarding concern should have been raised. For example one person had an unexplained skin tear.

These were breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us people were safe. One relative said, "Yes [relative] is very safe".

There were sufficient numbers of staff to meet people's needs on the day of our inspection. People told us there were usually enough staff to meet their needs. One person told us, "They [staff] come in and have time to sit and have a chat". One relative we spoke with said, "They occasionally need more staff, but it is much better now".

Staff told us there were not always sufficient staff to meet people's needs. One care worker told us, "Today it's five so that's good. It's not always like that". Staff told us agency staff were used when staff were on leave or off sick. We looked at the staff rotas for a four week period and saw that staffing levels for the morning varied between four and seven. We spoke to the provider about staffing levels. The provider told us there was no dependency tool for assessing the number of staff required to meet people's needs. This meant there was no accurate way to determine the levels of staff required to meet individual needs.

Inadequate

Is the service safe?

During our visits call bells were answered promptly and requests for assistance responded to in a timely manner. Staff were not rushed and had time to chat with people and their relatives.

People's needs were assessed prior to admission to the home. Where risks were identified risk assessments were completed and risk management strategies put in place. Risk assessments included information relating to the use of bed rails, falls, skin pressure damage and nutrition. One person had a specific condition requiring prompt intervention. The person's care plan contained a detailed risk assessment and action required to reduce risk of harm. However people who were staying at the home for a short period were not always protected from risk as care plans did not contain detailed information about risks associated with their care or how to minimise these.

Records relating to recruitment of new staff contained relevant checks that had been completed before staff worked unsupervised in the home to ensure they were of good character. These included employment references and disclosure and barring checks (DBS). DBS checks enable employers to make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

We recommend the provider finds out more about the use of dependency tools to assess staffing levels, to ensure people's needs are met.

Requires improvement

Is the service effective?

Our findings

We found the provider was not adhering to the principles of the Mental Capacity Act 2015 (MCA) and associated codes of practice. The Mental Capacity Act 2005 protects people who can't make some or all decisions for themselves.

Care plans contained conflicting information regarding people's capacity to make decisions. Where people were assessed as lacking capacity there was no record of decisions being made in the person's best interests. One person's care plan contained a bed rail assessment which had been signed by a relative. There was no indication the person lacked capacity to make the decision regarding the use of bed rails. There was a consent form signed by the person giving consent to share information.

Staff had little understanding of the MCA. They were unaware of the principles of the MCA and associated codes of practice. Staff we spoke with had not received training relating to the MCA. Staff had no understanding of the Deprivation of Liberty Safeguards (DoLS). DoLS provide a lawful way to deprive someone of their liberty, provided it is in their own best interests or is necessary to keep them from harm.

These were breaches of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they did not receive regular supervision and had not had an annual appraisal. One care worker told us they had received supervision when they first started working at the home and had "Found it really helpful". The providers supervision policy stated staff would receive supervision every two months. We spoke to the provider about staff supervision. The provider stated they are supervising and appraising staff in an informal way while they review their supervision process. There were no records of staff supervisions.

Care staff were not always knowledgeable about people's needs and how to support them. For example staff we spoke with were not aware they were supporting people who experienced seizures.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was aware of their responsibilities in relation the DoLS and had made applications to the supervisory body as required.

Staff told us they had completed training in moving and handling, fire safety, infection control, dignity and respect and pressure care. One member of staff told us, "The training is good". This member of staff was currently completing end of life training provided by a local hospice. Staff had access to development opportunities. Two staff were working towards a level two diploma in social and health care. One member of staff had completed their level three national vocational qualification in social and health care.

The provider told us they were currently reviewing their training plan. The training plan included 'back to basics' training for all staff. This included the use of an 'Old Age Simulator Suit', to enable staff to experience some of the difficulties people living in the home faced.

The provider had recently appointed a training officer to oversee the implementation of the training plan. The provider told us, "Our training officer is responsible for the induction programme, shadowing new staff and ensuring the individual training plans are followed".

People told us they enjoyed the food. Comments included; "The food is very good" and "Food is nice, plenty of it". Relatives were complimentary about the food. One relative said, "On the whole the food is good".

The home did not have a dining room. People were supported to eat in the lounge areas or in their rooms. Where people required support, care staff sat with people and supported them to eat and drink at their own pace. The atmosphere during lunch was calm and relaxed. People were offered choice and where they did not like the choice on offer, alternatives were available.

The chef had recently completed a survey with people in the home, regarding their likes and dislikes. As a result a new four week menu had been planned and was due to be introduced in the next few weeks.

Care staff had a clear knowledge of people's special dietary requirement's. For example one person required a pureed diet and thickened fluids. Staff we spoke with were able to tell us about this person's needs. We saw this person received appropriate food and fluids.

Requires improvement

Is the service effective?

Relatives were complimentary about the way the provider worked with health professionals. One relative told us, "They have good contact with the GP. They are very good at getting professional help". People had access to health professionals when their condition changed. The GP visited the home weekly and reviewed people where there were any changes to their health. Health and social care professionals we spoke with were complimentary about the service referring people for review. The home worked closely with the local hospice and contacted them for guidance and support.

Requires improvement

Is the service caring?

Our findings

People's personal information was not always kept confidential as people's care plans were kept in the office where the door remained open when the office was unoccupied.

People told us staff were caring. Comments included; "Staff are lovely, really nice", "They [staff], are all very good, they listen to you". Relatives we spoke with were complimentary about the staff. One relative said, "Care is good, it's the human interaction as well as the care that makes the difference". One visiting social care professional we spoke with was complimentary about the care people received. They told us staff were good at human interaction and that the home had a caring ethos. However, our observations did not always support the positive comments we received.

We saw that most people were treated with dignity and respect, for example people were addressed by their chosen name. However one person removed their clothing from the top half of their body in a communal area of the home. Staff entered and left the room several times before supporting the person to put on clothing.

We observed many kind and caring interactions. For example one care worker sat with a person, reassuring them in a supportive manner. However, we heard staff supporting a person to change their clothing, staff spoke to the person in an abrupt manner saying, "Stop shouting [name], it's not hurting".

Staff took time to speak with people and explained what they were doing before supporting people. For example two care staff were supporting a person to transfer from their wheelchair to a chair in the lounge using a hoist. Care staff explained what was going to happen and reassured the person throughout the transfer. The care staff made sure the person was comfortable before leaving them.

Staff showed knowledge about people's backgrounds and families. Staff spoke to people about things that interested them. We saw one care worker talking to a person about a recent visit from a family member.

People were involved in decisions about their care. One person told us how they had been involved in the decision regarding a new chair to enable them "To be more comfortable".

Requires improvement

Is the service responsive?

Our findings

Care records did not always contain accurate information. For example, two care plans we looked at contained different people's names. Care records did not always contain up to date information. For example one person's care plan identified the person walked with walking sticks, however staff told us the person used a walking frame and we saw the person walking with a frame. Care records were not always stored securely.

Some care plans contained documents detailing people's likes and dislikes. The document included what was important to the person. For example one person liked to have their hair done every week. The person's relative told us the person had their hair done as requested. However care plans that did not contain people's likes and dislikes meant information was not available to enable staff to provide individualised support.

These are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were complimentary about the home and felt listened to. One person told us, "It is all very good, they really listen to you". People's relatives were positive about the home and told us staff knew people's likes and dislikes. One relative told us, "I know [relative] is looked after really well. They know what's important to her".

People were able to spend their day how they chose. People who preferred to remain in their room were supported to do so. One person told us they liked having their own possessions around them.

The provider employed an activity co-ordinator. We saw people being encouraged to play games and take part in craft activities. People were laughing and enjoying themselves. The evening of our inspection people were having a 'fish and chip supper'. People told us about the event and were looking forward to it. However, some people told us they did not always have access to activities that interested them. Comments included: "I love it here, it's nice but there's not always a lot to do"; "We do things when the girls have the time"; and "We do games and things, but not every day".

People we spoke with were aware of their care plans and felt involved in their care. Relatives were involved in developing people's care plans. One visitor, who's relative had died in the home told us, "The manager always kept me involved in the end of life decisions and was very supportive". Care plans showed people had been involved in their care plan and contained people's views.

Where risks assessments had been completed and a risk identified, plans were in place to manage the risk. For example where people were at risk of pressure damage to their skin pressure relieving equipment was in place. One person's care plan identified the person experienced seizures. The person's care plan included a risk assessment and care plan detailing the action needed should the person experience a seizure.

People felt confident to raise concerns and felt they would be listened to. One person said, "I would say if I'm not happy". Relatives told us they would feel comfortable to make a complaint and that it would be dealt with promptly. Comments included: "I raised a complaint a few months ago and the manager and owner were very responsive"; "I have no doubt that the manager would respond appropriately to any concern" and "I have no concerns at all. They would put it right if I did".

Complaints records showed that complaints had been fully investigated and responded to in line with the homes complaints policy. Records showed people were satisfied with the outcome of the complaint.

Requires improvement

Is the service well-led?

Our findings

There was a registered manager in post. The provider and registered manager did not have effective systems in place to monitor the quality of service. The registered manager carried out a series of audits which included care plans, infection control and kitchen audits. However, audits were not always effective. For example, a monthly care plan audit was completed. The audit contained no details of any issues identified during the audit or action required as a result of the audit. The audit had not identified issues we found during the inspection.

Relatives told us there was no formal form of communication within the home. Relatives had not completed any satisfaction surveys and there were no regular meetings arranged to enable the provider to gain feedback about the service.

The registered manager told us they had started a quality assurance survey with people using the service. However, the survey was not effective. The survey was completed by staff supporting people to answer the questions. It was not clear from the completed surveys what element of the service people's comments referred to.

These are breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Records showed that the provider had not notified CQC of all notifiable incidents. A notification is information about important events which the provider is required to tell us about by law. For example safeguarding concerns had not been notified to CQC.

This is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

The provider and registered manager promoted a positive and caring culture in the home. Staff told us they felt valued and listened to. The provider had recruited an administrator to support the registered manager to enable them to spend more time with people and supporting staff.

People were complimentary about the registered manager and provider. Relatives told us the registered manager and provider were approachable. Relatives said they thought the service was improving. One relative told us, "Things have improved in the last few months. It just feels better".

Staff felt supported by the registered manager and provider. Staff had completed a survey and the results had been shared at a recent staff meeting. The provider shared plans about introducing incentive schemes to improve staff retention.

Staff we spoke with were clear about their role and responsibilities. A nurse we spoke with told us they were responsible for the allocation of duties and monitoring of the staff. Staff understood who they should report to and were aware of the structure of the organisation.

Staff were confident to raise any concerns with the manager or provider. They were aware of the whistleblowing policy and how to use it.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The provider was not protecting service users from abuse and improper treatment because systems and processes were not operated effectively to prevent abuse of service users. Systems and processes were not operated effectively to investigate evidence that indicates abuse could have occurred. Regulation 13 (1) (2) (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure that persons employed by the service provider in the provision of a regulated activity received supervision and appraisals as required by the providers supervision policy. Regulation 18 (1) (2) (a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not assess, monitor and improve the quality of service. The provider did not seek and act on feedback from relevant persons. The provider did not maintain accurate records in respect of all service users. Records were not stored securely. Reg 17(2)(a)(c)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents

This section is primarily information for the provider

Action we have told the provider to take

The provider was not notifying the commission of all notifiable incidents. Regulation 18

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider was not following the principles of the Mental capacity Act 2005. Regulation 11(1) (2)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Care and treatment was not provided in a safe way as there was not proper and safe management of medicines. Regulation 12 (1) (2) (g).**