K N Bhanji

Clair Francis Retirement Home

Inspection report

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Date of inspection visit:
24 January 2022
27 January 2022
04 February 2022

Date of publication:
21 March 2022

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Clair Francis Retirement Home provides accommodation and personal care for up to 28 older people, some of whom are living with dementia. At the time of the inspection, 20 people were living in the home.

People's experience of using this service and what we found
Risks to people were not always identified, managed or reviewed to ensure people were safe and protected from harm. People were not always protected from the risk of cross contamination of infection due to some poor infection prevention and control practices. Incidents and accidents were not always reported in a timely way to the registered manager.

Analysis of incidents to identify patterns to learn lessons and prevent reoccurrence had not always taken place, thus placing people at further risk. The provider, registered manager and provider's consultant responded positively to our feedback and took action to mitigate the risks to people.

Oversight of the quality of the service provided and audits carried out had not always been effective in identifying areas for improvement and ensuring they were completed in a timely manner. Processes to monitor people's standards of care were not clear and we found gaps in recording and or monitoring that had not been addressed. This increased the risk that people would not receive the care they required.

People, their relatives and staff had been asked for their feedback on the service being delivered. The staff worked well with outside agencies to ensure people received the care and support they needed. Staff felt supported in their roles. Relatives of people living in the home told us that the registered manager was approachable and kept them up to date with how their family member was.

New staff had been recruited safely to ensure the right people were employed. There were sufficient number of staff working in the home to meet people's needs in a timely manner.

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 good (report published 09 October 2019.) The rating has changed to requires improvement.

Why we inspected
As part of CQC's response to care homes with outbreaks of COVID-19, we are conducting reviews to ensure that the Infection Prevention and Control (IPC) practice is safe and that services are compliant with IPC measures. This was originally a targeted inspection looking at the IPC practices the provider has in place. Due to IPC concerns identified during the inspection we widened the scope of the inspection to become a focused inspection including the Safe and Well-led key questions. We also asked the provider about any

staffing pressures the service was experiencing and whether this was having an impact on the service.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of this full report. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Clair Francis Retirement 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 monitor the service and will take further action if needed.

We have identified breaches in relation to reducing risks to people's safety and quality assurance of the service being provided at this inspection. Please see the action we have told the provider to take at the end of this report.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service well-led?

The service was not always well-led.

Details are in our well-led findings below.

Requires Improvement

Clair Francis Retirement 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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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
Two inspectors carried out this inspection over three days.

Service and service type
Clair Francis Retirement Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Clair Francis Retirement Home is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Notice of inspection
The first part of the inspection was announced. This was because it is a small service and we needed to be sure that the registered manager would be in the office to support the inspection. However, we returned for a second day and this visit was unannounced.

What we did before the inspection

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

During the inspection-
We spoke with one person who lives at Clair Francis Retirement Home. We also spoke with two relatives and one friend of person who lives in the home. We spoke with the provider, the registered manager, the provider's consultant, and four members of care staff.

Inadequate

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to Inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- Not all risks had been mitigated where possible.
- Effective procedures to prevent pressure sores to people were not in place. This placed people's health at risk.
- The annual fire risk assessment for the home had not been reviewed since November 2020. Not all recommendations in the action plan had been completed. Not all fire records were up to date and accurate. The checks of the smoke seals on doors had not been completed as planned in December 2021. This placed people's health and safety at risk in the event of a fire. We shared our concerns and findings with the fire service and asked them to carry out a review of the home.
- Effective procedures to ensure people at risk of dehydration were drinking enough were not in place. Targets for intake were not always set and fluid charts were not always being reviewed. This placed people at risk from dehydration.
- Not all risk assessments had been reviewed to ensure they were still accurate or if any other action was needed. This meant that staff might not be aware of changes to people's care and support needs.
- Although new window restrictors had been purchased to replace the chain type restrictors already fitted, they had not all been fitted to ensure people's safety. One window did not have a restrictor fitted to it.

Learning lessons when things go wrong

- The system to monitor incidents and accidents was not effective. Action had not been taken in response to one person's repeated falls. This placed them at ongoing risk of harm.
- The registered manager and provider's consultant confirmed that there had not been recent analysis of the accidents and incidents that had occurred in the home. This had meant that patterns and themes had not been identified so that actions could be taken to reduce any risks to people.

Preventing and controlling infection

- Staff were not always following the providers procedures to prevent and control the spread of infection.
- During the first day of the inspection we found several unnamed electric razors all stored together in a plastic box in a downstairs bathroom. We also found unnamed toiletries and a hairbrush in the same bathroom. This is not good infection control practice and increases the risk of cross contamination.
- Staff were wearing personal protective equipment however; this had not always been disposed of appropriately.

Using medicines safely

- Administration of medicines was not always safe.

● Procedures for administering controlled drugs was not always followed. Evidence of staff's annual medication administration competency assessments could not be provided. Competency assessments check that staff trained to administer medicines continue to do so safely
● Not all staff who were responsible for the administration of medicines were aware of where the procedures of "when required" medicines were kept.

Systems and processes to safeguard people from the risk of abuse
● Staff were aware of the procedures to be followed if they thought anyone had suffered abuse. However, we found that these procedures were not always followed by staff.
● During the inspection we identified an incident that had happened between two people that had not been reported to the registered manager and a safeguarding referral had not been made. As a result of this we made a safeguarding referral to the local authority safeguarding team.

The provider had failed to mitigate risks to people where possible. This was a breach of Regulation 12 Safe care and treatment of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● As a result of our feedback the provider, registered manager and providers consultant told us they had taken action to mitigate the risks to people where possible. We will check this at out next inspection.

Staffing and recruitment
● Staff were recruited safely. Appropriate checks including Disclosure and Barring checks (DBS) had been made to ensure staff were safe to work with people. (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● Staffing levels were sufficient to meet people's needs in a timely manner.

Visiting in care homes
At the time of the inspection the home was experiencing a Covid-19 outbreak. This meant that there were restrictions in place for visitors apart from anyone receiving end of life support. There were no essential care givers at the home however the registered manager was going to promote this to the family/friends who may be interested.

Care homes (Vaccinations as Condition of Deployment)
From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an emergency. We checked to make sure the service was meeting this requirement. The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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; Continuous learning and improving care

- During the registered managers recent sick leave the providers consultant had been covering both their own and the registered managers role. This had meant that there was not adequate management cover and not all tasks had been completed as planned.
- Although there were quality assurance systems in place, they had not identified all of the areas for improvements that we found during the inspection. Audits had not always been effective in identifying areas for improvements. For example, a recent check of the window restrictors in the home had not identified that one person's window did not have an appropriate restrictor fixed to it. Action plans did not always identify who was responsible for making improvements or by when. There was not always evidence on the action plans that the necessary action had been completed. We found significant shortfalls in the safety of the service provided.
- Lack of management oversight meant that the registered manager and provider's consultant had not been aware of all accidents/ incidents that occurred in the home. This had put people's health and safety at risk as accidents had not been reviewed in a timely manner to identify any action to take to prevent a reoccurrence.
- The quality assurance system had not identified that records being completed to support people's health and well-being such as the recording of people's food and drink intake or repositioning were not being completed as expected. The systems in place had not identified named staff members to regularly check charts to ensure any action needed to maintain a person's well-being was taken without delay.
- Risk assessments and care plans had not always been reviewed to ensure they were updated when changes occurred. The need for improvements to risk assessments and care plans had been identified by the providers consultant. Staff appointed to carry out these improvements had not been successful in making the improvements. So further action was being taken to ensure they reflected people's current needs.
- Action had not been taken to ensure that the fire risk assessment had been reviewed annually and action completed where necessary to reduce the risks to people in the event of the fire. The quality assurance system had not identified that not all fire records were available and up to date such as fire drills and people's emergency evacuation plans.

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 was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider, registered manager and provider's consultant all responded positively to the inspection findings and took action to ensure people were safe.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● People were supported to achieve positive outcomes from their care. There was an open and inclusive culture in the home. We observed a relaxed atmosphere, in which people and staff engaged and interacted with one another.
● People, relatives and staff told us the culture was positive and they could approach the registered manager with any concerns.

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 and registered manager were aware of their duty of candour and legal responsibility to notify the Care Quality Commission of any allegations of abuse, serious injuries or incidents involving the police.
● The registered manager was open and transparent to people and relatives when things went wrong. Relatives told us they were contacted and kept up to date by staff.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People could give their feedback about the home. Information about developments in the home were shared with people and their relatives to keep them updated.
● Staff were given the opportunity to provide their feedback about working for the provider by completing a survey, which was analysed to identify any issues.

Working in partnership with others
● The provider worked in partnership with professionals to support people in the home.
● The provider had established links in the community with local authorities, public health and other services. They kept up to date with new developments in the care sector and with government guidance on protecting people from COVID-19.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that where possible risks to people were mitigated.

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 17 HSCA RA Regulations 2014 Good governance The provider had failed to ensure that there was an effective system to assess, monitor and improve the quality of the service.

The enforcement action we took:

We served a warning notice on the provider which required them to make the necessary improvements by 1 April 2022.