Care Quality Commission

Florence House (Staffordshire) Limited

Florence House

Inspection report

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Tel: 01782637354

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Florence House is a residential care home providing personal care and accommodation to 31 people aged 50 and over at the time of the inspection, some of which were living with dementia, a physical disability, sensory impairment or needed support with their mental health. The service can support up to 36 people in a single adapted building.

People's experience of using this service and what we found
Systems were not effective at identifying areas that needed improving in a timely manner. Risks were not always assessed, planned for and mitigated to keep people safe as assessments were not always personalised.

The registered manager failed to ensure that people's care records were accurate and up to date. The registered manager did not undertake audits of people's care records.

Systems were not in place to manage medicines safely. Medication audits had been completed, however, they failed to highlight issues that were found during the inspection.

Ineffective quality assurance systems meant that the provider could not always continuously learn, improve and innovate. We found the registered manager did not complete any audits that focused on accidents and incidents in the service.

The service was clean and free of malodour. There were a number of personal protective equipment (PPE) stations positioned throughout the home and staff wore appropriate PPE.

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

Rating at last inspection
The rating at the last inspection was requires improvement (report was published on 22 August 2019). You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Florence House on our website at www.cqc.org.uk.

Why we inspected
We received concerns in relation to people's personal care and how the service was promoting people's safety. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has remained the same.

Follow up
We identified concerns at this inspection. We will therefore aim to re-inspect this service within the published time scale for services rated requires improvement. We will continue to monitor the service through the information we receive.

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 two breaches. Regulation 12 the registered person failed to ensure risks relating to the safety, health and welfare of people using the service were assessed and managed safely and the registered person failed to ensure the proper and safe management of medicines. Regulation 17 The registered person had not established an effective system to enable them to assess, monitor and improve the quality and safety of the service provided.

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

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not well-led. Details are in our well-Led findings below.	**Inadequate**

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Florence House

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.

Inspection team
This inspection was carried out by two inspectors and one assistant inspector.

Service and service type
Florence House is a 'care home'. People in care homes receive accommodation and nursing or personal care as 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 safety of the care provided.

Notice of inspection
We attempted to contact the provider to announce the inspection, however their telephone service was unavailable due to technical issues. This inspection was therefore unannounced.

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 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
Due to the national pandemic we completed a focused inspection therefore reducing the time we spent at

the service. We spoke with the registered manager, deputy manager, five staff members and six people. During our time at the home we observed staff interactions with people. We looked at people's care records, risk assessments, care plans and accidents and incidents. We requested further information after our visit, this included contact details for relatives and the training record.

After the inspection
We continued to seek clarification from the provider to validate evidence found and we spoke with four relatives. We attempted to contact professionals, however were unable to get a response.

Requires Improvement

Is the service safe?

Our findings

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

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

At our last inspection the provider had failed to ensure risks to people were always fully considered or managed in a safe way. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found not enough improvements had been made by the provider and the provider was still in breach of Regulation 12.

Assessing risk, safety monitoring and management
● At our last inspection we found risks to people were not always appropriately assessed and planned for. At this inspection we found that care files were not person centred and did not given person specific information in relation to how to support people with their needs. For example, one person's cognitive needs care plan highlighted, 'sometimes anxious and aggressive to staff, offer reassurance and redirect.' The care plan did not guide staff how they displayed agitation, what their triggers were, or how staff needed to support the person. People were at risk of been supported by staff who did not understand their care needs.
● We found some care plans and risk assessments were out of date and did not meet people's current needs. The registered manager previously reviewed care files monthly as directed on their care plans. We found most care plans and risk assessments hadn't been updated however since April or May 2020. For example, one person had a bedrail fitted. However, there was no care plan or risk assessment in their care file to identify why this was in place.
● One person's nutrition and hydration risk assessment stated they forgot to eat and drink enough. However, they were not on a food or fluid monitoring chart so staff could assess this. This put the person at risk of malnutrition and dehydration.
● We observed one member of staff attaching movement sensors to a person who was sat down. When discussing this with the staff member, they did not know if this was documented in the person's care file and stated they hadn't read the risk assessment or care plan. We discussed this with the registered manager who acknowledged the staff member should not have attached the sensors as this was not an identified need. People's correct care needs were not being met by staff.
● Where people required support to move around, we saw staff were attentive to their needs and used the correct manual handling techniques.

Using medicines safely
● At our last inspection we found that medicines were not managed safely. At this inspection medicines were still not being managed safely, and we could not be sure people were always having their medicines as

prescribed.
● We found medication care plans were not specific to people's needs. For example, one person who received covert medication did not have this documented on their care plan which meant there was a risk they may not receive this correctly.
● People were not always supported appropriately with their covert medicines. We were told that if somebody had been given medicines covertly as a last resort, this would be recorded on people's associated medicine administration record (MARs) charts. However, we found this had not always been recorded on MARs, so we were unaware of how people had been administered their medicines.
● When someone had refused their medicines, there was no evidence this had been safely disposed of. The registered manager was unable to say where the missing medication was and it had not been recorded correctly in the disposal record. There was a risk people's prescribed medicines could have been taken by people who they were not prescribed for. However, the provider had no recorded incidents of where this had occurred.
● There was limited guidance for staff to assist them in administering covert medicines safely. Care plans did not indicate what steps should be taken prior to giving medicines covertly.
● It was not clear if people had received their topical creams as prescribed. Staff had not always signed the associated topical creams records to say this had been given and reasons were not documented to explain why this medicine was not signed for.
● Staff supported people to take their medicines in a respectful way. Staff ensured that people's dignity was maintained when administering medication. People were asked if they were ready for their medicines and were given time to take them.
● We found a prescribed cream in the staff office where the door was unlocked, and people had access. The name of the person who the cream was prescribed for had been rubbed out. We asked the management team who the cream was for and why it was left in the staff room and they informed us they didn't know who the cream was prescribed for. They removed the cream.

Learning lessons when things go wrong
● At the last inspection, the provider did not have robust processes in place to appropriately respond to incidents. Opportunities to learn lessons had been missed. At this inspection, the response to accidents and incidents had not improved.
● There was no clear process to manage risks appropriately. For example, one person had three recorded incidents with other residents, but did not have their risk assessments updated following the incidents. There was no updated guidance on how to support this person in relation to their behaviours that may challenge.
● The registered manager started to look at common themes with accidents and incidents until April 2020 where they then discontinued. They did not have any processes in place to highlight any common themes or required learning.

Systems and processes to safeguard people from the risk of abuse
● People told us about the safety in the home. One person stated, "Yes, always someone knocking about. I use the lift to get to my bedroom, there is always someone to take me up to the room."
● Not all staff had completed their annual training on safeguarding vulnerable adults. The providers training matrix highlighted that 16 staff had not received or updated their safeguarding refresher training.
● However, we found staff had a good knowledge around safeguarding people's needs. Staff told us they had this training every 12 months. One staff member told us "I can recognise different types of abuse, who to report to, who to ring," and, "If I had concerns, I'd go to the manager but if she didn't handle it well, I'd go to safeguarding."
● Effective systems were in place to safeguard people from harm and abuse. All known safeguarding

concerns had been recorded.

Staffing and recruitment
● People felt there was enough staff to support their needs, one person told us, "Yes, I haven't got to wait long. I use my frame which is very good, they help me with getting up. There is always somebody with us."
● We found that people were supported by a sufficient number of staff. We observed people received a timely response when they required support to go to the toilet or support with walking
● There were sufficient staff to ensure people had a positive dining experience. People received their meals when they requested and there was enough staff to support people who required assistance with their food.
● Required staff recruitment checks including criminal checks with the Disclosure and Barring Service were carried out to ensure people were protected from being supported by unsuitable staff.

Preventing and controlling infection
● Not all staff had received infection prevention control training, however they understood what personal protective equipment (PPE) to wear. Staff told us, "I had no training on infection prevention control but it's all common sense. Everyone does wear masks. After giving personal care you should take the apron off in the room, wrap it up and dispose of it?."
● We found that staff were not always bare below the elbow when delivering personal care which is good infection control practice. We highlighted this to the registered manager who told us they would ensure staff would be moving forward.
● 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 using PPE effectively and safely.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks could be effectively prevented or managed.

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.

At our last inspection the provider had failed to have effective governance systems and processes in place to prevent abuse of service users. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found there had not been enough improvement and the provider was still in breach of regulation 17.

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

- Many of the serious concerns we found at this inspection had been raised with the provider at the last inspection. Most of these areas had not been addressed and we found the same issues were ongoing. This meant risks to people's safety had not been consistently assessed, monitored or mitigated.
- There were limited quality assurance processes in place. We could not be assured the registered manager and provider had processes in place to evidence the quality and performance of the service.
- There was no oversight from the provider, they did not monitor that checks or audits had been undertaken or completed in the service. We were unsure how the provider was supporting the registered manager in their role.
- The registered manager told us they were behind with audits and staff training due to issues they had experienced in the home with staff members and due to the pandemic.
- Medication quality assurance processes in place were not effective. Quality audits had been completed in September and October 2020; the September audit had scored the service at 86%. However, we found that the back page of the audit had not been completed so we were unsure how the provider could give themselves that score. The audit did not identify issues that were found during the inspection with the disposal and recording of medicines and topical cream medication recording.
- The registered manager failed to ensure that people's care records were accurate and up to date. They did not have an accurate understanding of risks associated with people. The inconsistent documentation meant that information was not reflective of people's needs, and this had not been identified by the registered person.
- One person hadn't had their 'mental, psychological, emotional' care plan reviewed since June 2019. People were at risk of being supported by staff who weren't aware of their current needs due to reviews not been undertaken.
- Accurate records were not always maintained or did not accurately reflect the support people were being offered. This demonstrated that changes to people's needs were not being documented appropriately.

There was a risk that any new staff coming to work at the service could provide ineffective and unresponsive care, by following insufficient and contradictory care plans. For example, one person whose file stated they didn't have capacity, had no evidence of mental capacity assessments or a best interest decision being completed.

- The registered manager audits did not highlight when risk assessments did not contain an escalation process to advise staff on how to safeguard people's needs.
- Ineffective quality assurance systems meant that the provider could not always continuously learn, improve and innovate. The registered manager did not have any governance systems for accidents and incidents. There was not a system for them to identify any common themes or risks developing for people in the service.
- The registered manager had no oversight or system to monitor staff competencies within their roles. For example, staff medication competencies were completed by staff members in the same role. Where medication errors occurred, there was no escalation process in place or overview by the registered manager to put improvements into place. The registered manager told us after the visit "Senior medication competencies are overseen by head of care or deputy manager. When medication errors occur, we have a medication error report which contains information of the error. This is investigated."
- The registered manager had ineffective systems to ensure staff had received up to date training. The providers training matrix highlighted that staff training was not up to date. For example, 13 staff had not completed their training in dementia awareness. People were been supported by staff who were not trained effectively to meet their needs. The registered manager told us, "We are currently reviewing the matrix and prioritising new starters and staff with out of date training."

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

- There was a clearly defined management structure within the service. However, there were not effective management systems to promote person-centred care. We found that care plans were not specific to people's needs.
- Staff told us the registered manager supported them well, was approachable and always available to listen to concerns. Staff told us, "The manager has always been nice to me, encouraged me to speak up. Willing to do more that most managers in other care homes I have been to."

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- The register manager did not seek feedback from people on the delivery of the service. We were told, "[Registered manager] has never spoken to me really. If [registered manager] was willing to listen to me I'd have a lot of suggestions to share." The registered manager told us they had not gained feedback from people since the previous inspection.
- The registered manager held staff meetings where staff could raise issues and information could be shared.
- The registered manager told us they spoke regularly to relatives through the pandemic, via Skype or facetime, however they did not have any documented feedback from relatives on service development. Skype and facetime is a way of calling people through an electronic device. However, relatives told us, "They have been marvellous in terms of communication. They have been wonderful with [my relative]." A second relative told us, "They always let us know straight away if there is anything we need to know."

Working in partnership with others

- The service worked well with external professionals. Advice was sought as and when required. For example, we saw in people's care files where external professional had recorded following their visit.

● The registered manager told us the service had close working relationships with district nurses, occupational therapists and pharmacies.

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 registered manager stated they had a duty of candour policy is place , which they followed.
● We found that accident and incident forms had been completed evidencing the date the next of kin had been contacted. Relatives confirmed they had been contacted if any accidents or incidents had occurred.
● The providers last rating was displayed at the front of the service.
● Notifications had been submitted to us (CQC) and the registered manager understood the responsibilities of their registration.

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 At our last inspection the provider had failed to ensure risks to people were always fully considered or managed in a safe way. This was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found not enough improvements had been made by the provider and the provider was still in breach of Regulation 12.

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 At our last inspection the provider had failed to have effective governance systems and processes in place to prevent abuse of service users. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found there had not been enough improvement and the provider was still in breach of regulation 17.

The enforcement action we took:

Impose a condition