Andrews Court Limited

Andrews Court Care Home

Inspection report

Livesey Branch Road
Blackburn
Lancashire
BB2 4QR

Tel: 01254679525

Date of inspection visit:
24 November 2020

Date of publication:
09 December 2020

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
Andrews Court Care Home is a residential care home providing personal care to 34 people aged 65 and over at the time of the inspection. The care home is in a converted church and can accommodate up to 35 people on two floors.

People's experience of using this service and what we found
People told us they felt safe and well cared for in Andrews Court Care Home. However, we found staff had not always been safely recruited, important checks regarding the environment had not been completed since July 2020 and medicines were not always managed safely. Our findings showed the provider's systems for monitoring the quality of the service had not been effective.

Staff had completed training in safeguarding and knew the correct action to take to keep people safe. The manager used handovers and staff meetings to share any learning from incidents or accidents. Staffing levels were sufficient to ensure people had their needs met in a timely way.

The home did not have a registered manager. There was a manager responsible for running the home, but the provider had failed to ensure they had applied to register with CQC in a timely manner. The manager demonstrated a commitment to addressing our findings during the inspection. They had worked hard to ensure the home was Covid 19 secure and our inspection confirmed staff followed safe infection control practices.

Staff told us they enjoyed working in the home and found the manager to be approachable and always willing to listen to them. People who lived in the home also gave us positive feedback about the manager and told us they would be confident to approach them if they had any concerns about their care.

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 January 2018)

Why we inspected
This inspection was prompted following a number of safeguarding alerts raised with the local authority and whistleblowing concerns raised with CQC during the pandemic. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 coronavirus and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

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 identified breaches of regulations in relation to the recruitment of staff, the administration of medicines, the safety of the premises and the processes to monitor the quality and safety of the service.

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 Andrews Court Care Home on our website at www.cqc.org.uk.

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.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Andrews Court Care 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 Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector.

Service and service type
Andrews Court Care Home 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. A registered manager 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
This inspection was 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 the local Healthwatch team. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also reviewed information from statutory notifications sent to us by the service about incidents

and events that had occurred at the home. A notification is information about important events, which the service is required to send us by law.

We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

We used all of this information to plan our inspection.

During the inspection
We spoke with four people who used the service about their experience of the care they received. We also spoke with the manager and three members of care staff.

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

After the inspection
We spoke by telephone with three relatives to gather their views about the care provided in Andrews Court Care Home. We continued to seek clarification from the provider to validate 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 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.

Staffing and recruitment

- The provider had failed to ensure recruitment processes protected people from the risk of unsuitable staff.
- The provider had not ensured that applicants provided a full employment history and the reasons for any gaps in employment had not been explored or documented. Although the manager told us they had contacted some referees for additional information, this had not been documented. It was therefore unclear whether safe recruitment decisions had been made.
- Checks had been carried out with the Disclosure and Barring Service (DBS). The DBS identifies people who are barred from working with children and vulnerable adults and informs the service provider of any criminal convictions noted against the applicant. However, the provider had failed to ensure risk assessments were carried out regarding the suitability of people to work in the home when these DBS checks had highlighted past offences. Following the inspection, the manager sent us evidence a risk assessment had been completed.

The failure to ensure safe recruitment processes is a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff told there were generally enough staff to meet people's needs and that they did not feel rushed when caring for people. People who lived in the home told us they did not have to wait long if they requested staff support and that staff were always kind and caring. Comments made included, "It's wonderful here because of the staff. They can't do enough for you. The night staff in particular are excellent" and "Staff are pleasant, willing and caring."

Using medicines safely

- Systems were not robust enough to ensure people always received their medicines safely.
- Handwritten medication administration records did not contain full administration details for each medicine. Improvements also needed to be made to ensure staff always recorded accurately when medicines had been given or the reason if they had not.
- Staff had not always completed protocols for people who were prescribed medicines to be given on an 'as required' basis. These protocols should provide information for staff about when such medicines should be given and in what quantity. One protocol we reviewed contained inaccurate information about the administration details and also referred to a different individual other than the one for whom the medicine was prescribed.
- One person was being given their medicines covertly (in food or drink that they were not aware of). However, staff had not followed the correct procedure to ensure this process was in the person's best

interests and that it was safe to give their medicines in this way. The manager took immediate steps to ensure the practice was stopped until the correct legal authorisation was in place.

The provider had failed to ensure the safe handling of medicines. This is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management

● The provider had failed to ensure regular checks were carried out to ensure the safety of the environment. The monthly check on fire doors had last been documented in March 2020 when it had been reported that the seals on two fire doors were damaged. The manager told us they had not been able to arrange for someone to complete the necessary repairs during the pandemic. However, they had not taken action to source advice as to whether they could mitigate the risks the damage on these doors might present to people living in the home until the repairs could be completed. In addition, the weekly check on the stairlift had not been completed since April 2020 and checks on window restrictors, mattresses and water temperatures had not been recorded since July 2020. Following the inspection, the manager sent us evidence that all required checks had been completed. In addition, they sent us the confirmation action had been taken to keep people safe on the advice of the fire service.

The provider had failed to ensure adequate checks had taken place to ensure the safety of the premises. This is a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff completed an assessment of the risks relevant to each individual who lived in the home and strategies were in place to manage the identified risks. Staff reviewed these strategies regularly to ensure they remained relevant to people's needs.
● The manager had completed individual risk assessments both for people living in the home and staff in relation to coronavirus.

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe living in the home and that they were well cared for. Comments made included, "It's wonderful here because of the staff. They can't do enough for you. The night staff in particular are excellent" and "Staff are very good at what they do. I look for standards and they are very good here. Everyone gets good care, that's why I chose to come here."
● The provider had systems to protect people from abuse and avoidable harm. Staff had completed safeguarding training and were confident in how to raise any concerns. One staff member told us, "I would always report any concerns to the senior or manager. We are here to care for people and I do so as if they were my family."

Preventing and controlling infection

● 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 can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Learning lessons when things go wrong

● The provider had systems to review incidents, accidents and any safeguarding concerns raised to see where any improvements needed to be made. Handover meetings were used to inform staff of the outcomes of investigations and any changes made to procedures as a result to reduce the risk of similar events occurring. We saw the manager had introduced changes to the recording system following feedback from a recent safeguarding investigation.

Requires Improvement

Is the service well-led?

Our findings

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 now 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; Continuous learning and improving care
● The provider had failed to ensure there was a registered manager at the home since June 2019. This was a breach of the provider's conditions of registration. The manager working in the home was also registered as manager for another service in a different area. However, they had been working exclusively at Andrews Court since March 2020 due to restrictions in place during the pandemic. Staff told us they felt this had made a positive difference to the way the home was run. A deputy manager had also been appointed to support the manager in running the home.
● The manager told us they had focused much of their efforts since March 2020 on ensuring the home was Covid 19 secure but acknowledged this meant other areas in the home may have slipped. They told us they intended to work closely with the newly appointed deputy to, "Get the home where it needs to be."
● The provider had systems to monitor the quality and safety of the service. However, these had been ineffective as we found shortfalls during this inspection in relation to recruitment of staff, the handling of medicines and checks relating to the environment.

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● The staff team were experienced, knowledgeable and familiar with the needs of the people they supported. People were positive about the quality of service they received. One person told us, "Staff are very good at what they do. I look for standards and they are very good here. Everyone gets good care, that's why I chose to come here." Another person told us how their health had improved significantly since they were admitted to the home.
● Care records were personalised and well-written. They included good information for staff to follow to ensure they provided each person with the care they needed.
● Staff told us they were proud to deliver person-centred care which helped people to achieve positive outcomes. One staff member commented, "People get person centred care here. Everyone is different. We treat everyone as an individual. We know their likes/dislikes and work with that. Its knowing that person and their individual needs. That's how we work here."

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 had a policy which outlined the responsibilities of all staff in relation to the duty of candour. No incidents had occurred that we were aware of, which required duty of candour action.

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

● The provider had developed systems that engaged and involved people, relatives and staff. These involved meetings, face to face discussions and surveys. Although relatives had no concerns about the safety of their family members, two people told us they felt communication between them and the home could be improved.

● Staff told us they enjoyed working in the home and that their views were always listened to by the manager. A staff member commented, "The manager leads a good team. Everyone gets on with it. It's an open-door policy if you want to speak with her (manager). Its better now she is here every day during the week."

● People living in the home spoke positively about the manager and told us they could approach them or any other member of staff if they had any concerns.

Working in partnership with others

● The service worked in partnership with other professionals and agencies to help ensure people received the care they needed. During the pandemic, the manager had taken part in weekly virtual ward rounds with a GP to ensure people's health and medication needs were regularly reviewed.

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 the safe handling of medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment The provider had failed to ensure recruitment processes protected people from the risk of unsuitable staff.

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 there were robust systems to monitor the quality and safety of the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to ensure recruitment processes protected people from the risk of unsuitable staff.