Care UK Community Partnerships Ltd

Francis Court

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Francis Court is a residential care home providing personal and nursing care for up to 87 people in purpose-built accommodation. The service provides support to older people, many of whom have dementia, and younger people with disabilities. At the time of our inspection there were 50 people using the service.

People's experience of using this service and what we found
There were insufficient staff to support people's needs. Sometimes people had to wait longer then they should expect for support from staff. People told us staff answered call bells quickly but would sometimes come back later to deliver care. This had a negative impact on people's quality of life, but this had not been identified by the provider's quality monitoring systems which only measured the response time for call bells.

People's need for social stimulation was not consistently supported. People did not always have enough to occupy them, and staff were not spending quality time with people. The provider's system for monitoring quality had identified this shortfall but improvements had not yet been made.

People who were receiving care at the end of life had not always received the support they needed. Shortfalls had been identified following a complaint and the registered manager had implemented additional training for staff and amended systems to address these concerns. These improvements were not yet fully embedded and sustained in practice.

Since the last inspection improvements had been made in the assessment and management of risks and the administration of medicines. Care records were being maintained consistently and reflected the care provided to people.

People told us they felt safe and staff were kind and caring. One person said, "They are all so kind." A relative said, "The care assistants are very good, genuinely caring and supportive." Staff demonstrated a clear understanding of their responsibilities for safeguarding people and knew when to report concerns.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People, relatives and staff spoke highly of the management of the service. One staff member said, "It has been a difficult time, but we have been well supported." The registered manager was open and transparent about challenges the service had faced and demonstrated the improvements that had been made since the last inspection.

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 requires improvement (published 12 February 2020) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection we found the provider remained in breach of regulations. The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe, Responsive and Well-led which contain those requirements.

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

For those key questions not inspected, we used the ratings awarded at the last comprehensive inspection to calculate the overall rating. The overall rating for the service has remained requires improvement based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the Safe, Responsive and Well led sections of this full report. 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 Francis Court 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 staffing, personalised care and monitoring and improving the quality of the service at this inspection. Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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?

Requires Improvement

The service was not always safe
Details are in our safe findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Francis Court

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 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 team consisted of four inspectors.

Service and service type
Francis Court 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. Francis Court is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was a registered manager in post.

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 professionals who work with the service. 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. We used all this information to plan our inspection.

During the inspection
We spoke with 13 people and 5 relatives to gain their views on the care provided. We spent time in the home whilst people were relaxing in the communal lounge, dining area and receiving support from staff. This gave us an opportunity to observe staff interactions with people. We spoke with 13 members of staff including the registered manager, two nurses, one team leader, one unit manager, one housekeeper and seven care assistants. We reviewed records that included care plans, risk assessments and medicine administration records. We also looked at records relating to the management of the service, including policies and procedures, quality assurance systems and staff rotas.

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 our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant people were not consistently safe and protected from avoidable harm.

Staffing and recruitment
At the last focussed inspection on 17 December 2019 there were not always enough staff deployed to meet the needs of people. This was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection not enough improvement had been made and there continued to be a breach of regulation.

- There were not always enough staff to support people's assessed needs.
- People told us how their call bells were answered quickly, but the staff did not always support them and often came back later. One person told us, "I have noticed the difference with less staff. It still feels safe, but you have to wait longer, which is difficult at times when you need the toilet." Another person told us they would like to do some exercise, but the staff were too busy to support this. They said, "Nobody has time to support me with it. They always say they are needed with someone else, the staffing issue is not recent." A relative explained how people were having to wait longer then they should expect for support. "They have waited, sometimes for up to an hour, for support at breakfast time because staff have to prioritise getting other people up."
- The provider used a tool to determine safe staff levels based on people's needs. There was a heavy reliance on agency staff to maintain staffing levels. The registered manager explained they were actively recruiting to vacant posts to reduce reliance on agency staff. Staff told us they had opportunities to work additional hours and this supported continuity for people living at Francis Court.
- People and relatives spoke highly of the staff but said they felt staff were stretched. One person told us, "They (staff) are very busy, but they do their best." A relative said, "They could do with more staff but that's the same everywhere at the moment." Our observations were that staff were task focussed and did not have time to spend with people providing person centred support.

There was a failure to deploy sufficient staff to support people's needs. This was a continued breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider's system for recruitment were designed to ensure staff were suitable to work with people. This included checking references and employment history as well as Disclosure and Barring Service (DBS) checks. DBS checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Assessing risk, safety monitoring and management
At the last focussed inspection on 17 December 2019 risks to people were not managed consistently to ensure that people received safe care and treatment. Medicines were not managed safely. 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 management of risks and administration of medicines had improved and there was no longer a breach of regulation 12.

● Risks to people were identified, assessed and monitored effectively. Care plans included guidance for staff in how to manage risks and support people in the way they preferred.

● For example, some people had risks associated with skin integrity. Staff were knowledgeable about how to care for a person who was assessed as having a high risk of developing pressure sores. Staff told us how they used equipment to support the person to move and reported any changes in the condition of the person's skin. Records confirmed appropriate monitoring systems were in place and we observed how staff were checking the settings of the pressure relieving mattress to ensure they remained correct for the person.

● Other risks to people were monitored and assessed, including for health conditions. For example, a person had diabetes and an assessment identified the level of risk for the person and how they were supported to manage their condition. Another person had risks associated with moving around and falls. Their risk assessment identified they were at high risk of falls and needed support from staff to move around. Equipment was in place to mitigate risks to the person including a bed sensor to alert staff when the person was mobilising. Issues of consent had been considered as part of the assessment process for putting a bed sensor in place.

Using medicines safely

● People were receiving their medicines safely. Staff were trained and had completed medicines competency checks to ensure they administered medicines safely.

● Medicines were stored securely, and systems were in place to ensure people had access to the medicines they were prescribed. A staff member explained how some recent issues with supply of medicines had been resolved by changing to a more local pharmacist. They said, "We have a good relationship with the pharmacy now and they provide a prompt and reliable service."

● Staff had a good rapport with people when administering their medicines. Staff knew people well and were supporting them to have their medicine in the way they preferred. For example, one staff member explained how they adapted their approach for a person with dementia who could be reluctant to take their medicines. They ensured the process was kept low key by keeping the medicine trolley out of sight and bringing the medicine to the person quietly and with a drink they preferred. We observed this person-centred approach and noted how the staff member approached the person in a discreet way, with gentle persuasion so that the person felt comfortable to have their medicines.

● Systems for monitoring administration of medicines were described by staff as being robust and stringent. One staff member explained how the high number of agency staff, including nurses who give medicines, increased risks of errors when managing medicines. They described how a recent error had been identified and what they had done to ensure the person's safety. This had included contacting the GP for advice, informing the person and their family of the error and ensuring the staff member completed additional training to prevent them from repeating the error.

● Some people were prescribed PRN (when required) medicines. There were clear protocols in place to guide staff in when to offer these medicines.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)
● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.
● Where people lacked capacity to make specific decisions records showed how decisions had been made in their best interest in accordance with the MCA.

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.

Visiting in care homes
● The arrangements for visitors were in line with current government guidance. There were no restrictions in place at the time of the inspection.

Systems and processes to safeguard people from the risk of abuse
● People were protected from risks of abuse. People told us they felt safe living at Francis Court. One person said, "They look after us well here, I do feel it is safe." Another person told us, "I feel very safe, it's secure and the staff are very good."
● Staff demonstrated an understanding of how to recognise potential abuse and knew how to report any concerns. A staff member told us, "If I had a concern about abuse, I would intervene immediately and then report to the manager."
● Incidents were recorded and monitored to ensure that indicators of abuse were reported and investigated appropriately. For example, when staff noticed some bruising on a person this was recorded and reported in line with the provider's safeguarding policy. An investigation showed the person had rolled off the bed and this was the likely cause of the bruising.

Learning lessons when things go wrong
● Systems were in place to identify when things went wrong. Incidents were recorded and analysed to determine the cause and identify changes that would prevent a reoccurrence. For example, a person had fallen twice, staff completed incident forms that did not identify a particular cause. A referral was made to the falls prevention team for advice and as a result a chair sensor was put in place to alert staff when the person needed support to move.
● The registered manager explained how root cause analysis was used to identify possible trends or patterns. For example, when a number of people developed urinary infections staff considered whether dehydration could have been a contributory factor. Improving levels of hydration across the home became a focus for all staff in an effort to reduce the number of infections.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At our last comprehensive inspection on 14 May 2019 we rated this key question good. At this inspection the rating has changed to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were not receiving a consistently personalised service to meet their needs. People's social needs were not always met. People told us the staff did not have time to spend with them and our observations confirmed that staff were often task focussed and did not spend time with people other than when providing care.
- One person told us, "The staff are very busy, we do have activities and entertainment sometimes, but it's not a regular thing." Another person said, "Activities are poor, they don't stick to the programme, and it's very repetitive." A relative told us how their relation had said they were bored, "They said they were bored and wanted more activities."
- During the inspection we did not see staff supporting people with activities or providing opportunities for occupation. Some people had gone on a day trip to Brighton for fish and chips, but those who did not go, had little to occupy them.
- Some people were able to follow their own interests and told us they were content. However other people needed support from staff. We observed staff were engaging with people in a warm and natural way and knew them well, but they did not have time to sit and have a meaningful chat or to support people with an activity of their choice.
- We discussed the lack of occupation for people with the registered manager. They were aware this was an area of practice that needed to improve.

Meeting people's communication needs

Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carer's, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- People and their relatives had been involved in developing care plans that were holistic and provided personalised detail about people's needs and preferences.
- People's communication needs were identified as part of the risk assessment and care planning process. Individual communication care plans provided clear guidance for staff in how to support people with their communication needs.
- Staff were aware of people's individual needs. For example, we observed how a staff member checked that a person who was hard of hearing was wearing their hearing aid before asking them about their meal choice.

End of life care and support

● People were not consistently supported to have a comfortable, dignified and pain free death. The registered manager had received a complaint about end of life care. They explained how they had investigated and confirmed care provided had fallen short of the standards that people had a right to expect. The registered manager told us they were passionate about ensuring that these shortfalls were addressed and people always received a high standard of care. They explained the measures they had already taken to make improvements including, providing additional training for staff and improved systems for oversight of care provided to people at end of life.

● We observed staff were gentle and caring in their approach to people and their families. One person told us, "All the staff who deal with me a very kind and caring people." A relative told us, "The staff are really very caring, genuinely caring in a very nice way."

● Staff were proactive in contacting the GP for a person whose condition was deteriorating. Staff were supporting family members in a considerate and compassionate way, ensuring they were included in discussions, protecting their privacy, the person's dignity and working with health care professionals to ensure appropriate medicines were in place to keep the person comfortable.

● Records included planning for end of life care and considered people's diverse needs and beliefs. Staff spoke with compassion about caring for people at the end of life. One staff member told us, "It's very hard, you get fond of people and then if they die it's hard, you have to be professional but it can take its toll if you are grieving too."

● Following this inspection the provider sent us confirmation of training sessions that had been arranged for staff, including team leaders and nurses who were responsible for leading staff. The positive actions already taken to make improvements in end of life care had not yet had time to become fully embedded and sustained in practice. This is an area of practice that needs to improve.

The lack of support to meet people's social needs and inconsistency in provision of end of life care meant there was a breach of Regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Improving care quality in response to complaints or concerns

● The provider had a system for managing complaints and concerns and people and their relatives were aware of how to make a complaint if they needed to.

● People told us they felt comfortable to raise concerns, one person said, "I have complained to the manager in the past." Another person told us, "I can always tell the staff and things get sorted out, I feel lucky to be here."

● Records showed that complaints had been investigated and a full response had been provided with an apology where appropriate.

● The registered manager spoke about learning from complaints and gave examples of how improvements were made following complaints, including additional training for staff.

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 requires improvement. At this inspection the rating has remained 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.

At our last focussed inspection on 12 December 2019 there was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. There was a continued failure to assess, monitor and improve the quality and safety of the service and records were not always accurate. At this inspection there was an improvement in the accuracy of records, however, the provider's quality monitoring systems had not identified shortfalls that had an impact on people's quality of life. This meant there remained a continued breach of the regulation.

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

● Management systems were not always effective in identifying shortfalls in the quality of the service. The provider's system for monitoring call bells identified how quickly staff responded to a call bell. The registered manager was able to identify and investigate when call bells had not been answered within an acceptable time frame. However, this system had not identified that some people were waiting longer then they should have to for care to be provided. This was because the call bell was answered, but staff then went away and came back later to support the person. This called into question the effectiveness of the monitoring system. Following the inspection, the provider confirmed they had introduced additional measures for call bell monitoring to ensure people's needs were fully met.

● The lack of staff deployed to support people's social needs had a negative impact on the quality of life for some people. Staff told us it was rare that they were able to spend time engaging in activities with people and this was observed during the inspection. A recent governance review by the provider had identified similar issues, but actions had not yet been taken to make improvements. The registered manager confirmed they were aware of this shortfall and acknowledged this was an area of practice that needed to improve.

● Failures in oversight and governance had not identified shortfalls in the provision of end of life care, including ensuring that just-in-case medicines were in place. The registered manager had amended systems to improve over-sight but this was not yet embedded and sustained.

There was a continued failure to monitor and improve the quality of the service, this was a continued breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff were clear about their roles and described being supported and encouraged to improve their

practice. One staff member told us, "I have been very well supported and I have learned so much since starting here." Another staff member said, "The management have been the best I've ever had, both the deputy and the registered manager."

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

● The registered manager was open about the challenges facing the service and demonstrated an awareness of the day to day culture in the home, including the frustration and low morale expressed by some staff. The registered manager explained how they continued to prioritise recruitment and retention of permanent staff to strengthen and support the staff team and to improve outcomes for people.

● Staff described the main challenge for the service as being the staffing issues at the home. Staff comments included, "We have lost so many staff, agency staff are not all familiar with people and their needs." Another staff member said, "The number of agency staff has an impact because it takes us away from people when we have to show them what to do."

● Staff expressed mixed views about the support their received and the culture and leadership of the service. Some staff described feeling well supported and valued, whilst other staff were more reticent in their views. One staff member told us, "We all want to do the best we can for people here, that's why we do the job , it can be difficult to remain positive when things don't feel like they are getting better but I love the job."

● People and their relatives spoke positively about the management of the home and described the service as being well-led. One person told us, "The manager has a difficult job but she's definitely up to it." A relative said, "The home is not perfect, but the management is brilliant, and they are doing their best to sort things out. I would recommend the place, all the staff are very kind and caring."

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; Continuous learning and improving care

● The registered manager understood their responsibilities to comply with the duty of candour. They described their commitment to openness and transparency and how this had enabled learning when things had gone wrong.

● Daily meetings and handover meetings provided opportunities to discuss practice and support improvements. For example, when areas for improvement were identified through the auditing process this was discussed and noted at daily meetings to ensure staff were aware and could focus of the required improvements. One staff member told us how increased cleaning of touch points around the home had been improved through this focus in daily meetings.

● Continuous learning supported improvements at the home. For example, a staff member had completed training to become a dementia coach. They described how this had supported their practice saying, "It was detailed training and I felt highly skilled afterwards." They explained how this had enabled improvements in practice by offering alternative strategies for staff when supporting people. We observed how staff were working with people who had dementia in a gentle and caring way, staff appeared confident in their approach and the atmosphere was calm.

Working in partnership with others; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Staff had developed positive working relationships with other health and social care partners. A relative told us how staff had been proactive in contacting the GP if people were unwell. A person said, "They (staff) have been working closely with the doctor to sort out my medicines, because I have a lot of them."

● Records confirmed that staff worked collaboratively with a range of health and social care professionals including Speech and Language Therapist, Parkinson's nurse, Occupational Therapist and Tissue Viability Nurse. One staff member described how an advocate was involved with a person who needed support to

express their needs and preferences.

● People and their relatives spoke positively about communication and engagement with the service. One person told us, "We have meetings and discuss how things are going. We talked about the staffing issues and they are doing their best to recruit more staff." A relative said, "I can come and speak to the manager at any time, she is very open to discussions about the place."

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive a responsive service to support their individual choices and to meet their need for social stimulation and interaction.

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 There was a continued failure to monitor and improve the quality of the service

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 There were not always enough staff deployed to support people's choices and to meet their needs.