Barchester Healthcare Homes Limited

Florence Court Care Home

Inspection report

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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
Florence Court Care Home (hereafter referred to as Florence Court) is a residential care home providing accommodation and personal care to up to 75 people. The service provides support to older people, some of whom are living with dementia. At the time of our inspection there were 32 people using the service. The home provides purpose-built accommodation over 4 floors with 2 currently in use.

People's experience of using this service and what we found
People and their relatives told us the service provided good care and people's needs were met by caring staff.

Since October 2022 the home had experienced an infestation of flies, and this had posed risks to people's health and wellbeing. We found these risks had not been robustly assessed and this had placed people at risk of harm.

Other risks to people's health and wellbeing had not always been assessed to ensure action had been taken to mitigate these. Where action had been identified to support the management of risks, these had not always been completed.

Skin injuries had not always been recognised or investigated as incidents of possible abuse. Safeguarding incidents had not always been reported to the local authority or to CQC. We found no evidence that people had been abused, but the procedures in place to protect people from abuse were not robust.

People were not always supported to have maximum choice and control of their lives. Staff supported people in the least restrictive way possible. However, it was not always evident decisions had been made in people's best interests in line with the Mental Capacity Act (MCA). We have made a recommendation about the application of the MCA.

The provider has acted to make improvements and was working with the local authority and others, including environmental health, to promote the safety of people using the service.

There were enough staff to meet people's needs. People's medicines were managed safely.

Quality assurance systems were in place but had not been effective in identifying the concerns we found. The governance approach to risk management had been limited and had not involved all stakeholders in a timely way. Decisions about people's care when they lacked capacity were not always recorded to show their best interests had been considered. Whilst relatives we spoke with were happy with the care their relatives received, there was some dissatisfaction with the feedback from the service to concerns raised about the infestation. Not all serious incidents had been reported to the CQC as required.

The registered manager took action to address the shortfalls we found and is engaged in an improvement process, supported by the provider and local authority health and social care professionals.

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 (published 23 December 2022).

Why we inspected
We undertook a targeted inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about risks to people from infection prevention and control concerns. A decision was made for us to inspect and examine those risks. We inspected and found there was a concern with the management of these risks, so we widened the scope of the inspection to become a focused inspection which included the key questions of safe and well-led.

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.

Enforcement and Recommendations
We have identified breaches in relation to safeguarding, risk management, governance, and notification of incidents to CQC 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below

Florence 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 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.

This was a focused inspection to check on a concern we had about the management of a specific risk associated with infection prevention and control.

Inspection team
This inspection was carried out by 1 inspector.

Service and service type
Florence Court Care 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. Florence Court Care 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.

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 4 people and 2 relatives; we used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 12 staff members including the registered manager, deputy manager and 3 housekeeping staff, 5 care staff, head of maintenance and the provider's clinical development nurse (south). We spoke with 4 external health and social care professionals.

We looked at the care records of 9 people and multiple medication records. A variety of records relating to the management of the service were reviewed. These included policies and procedures, records of accidents or incidents, staff training and quality assurance records. Following the inspection, the registered manager provided us with information and other documents to support our inspection.

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 good. At this inspection the rating has changed to requires improvement: 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.

Systems and processes to safeguard people from the risk of abuse

- Staff had not always reported incidents to the local authority safeguarding team or the CQC in a timely manner. This meant safeguarding concerns had not always been investigated, to explore if further action would be required to keep people safe. In addition, multiple safeguarding allegations had been raised with the local authority by healthcare professionals and were being investigated.
- A body map showed bruising to a person's arm which was unexplained. On checking, there was no incident report or account to explain the bruising. The deputy manager told us staff record skin injuries on a body map but do not complete incident forms. There were no records to show where the bruise had come from or if it had been investigated at the time it was identified. A lack of investigation into unexplained injuries meant people could be at risk of recurring harm because the cause of the injuries had not been established.
- We found no evidence that people had been abused however, systems were not robust to demonstrate safeguarding risks were effectively managed. This placed people at risk of harm.

The failure to protect people from abuse and improper treatment and to have effective systems and processes in place to investigate suspected abuse was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Preventing and controlling infection

- Infection control risks were not managed safely, and risks were not assessed. Since late October 2022 there had been an infestation of flies in the home. When we visited in February 2023 risks to people from this infestation had not been assessed. People had continued to be admitted to the service during this time. Whilst the service had taken actions to eliminate the flies. The lack of a robust risk assessment to ensure all the risks to individual people had been considered, evaluated, and mitigated had placed people at risk of harm.
- One person had experienced a significant health risk due to the flies and others were placed at risk of harm to their health and wellbeing. For example, some people had skin wounds which would be vulnerable to a risk of infection from flies. Flies were seen on people's dressed wounds, found in drinks, and seen on people's food. This meant there was a risk food and drink were contaminated, which could cause illness. Some people would not be able to see flies in their drinks or on their food. A staff member said, "Loads of times we find them [flies] in people's drinks; yesterday they were in [person's name] and they can't see the flies"
- It was not evident the actions put in place were robust or timely enough to mitigate the risks to people

from the continuing fly infestation. For example, cleaning was carried out once a day in people's rooms. However, when we visited a person at 11am there were a lot of crumbs in their room. Their relative told us this was because the person had sausage rolls for tea the previous day. This meant there was a risk flies would be attracted to the food crumbs. An electric fly killer had been placed in this person's room to reduce a reoccurrence of an infection risk to them, but this had only just been installed. However, the flies had been prevalent in their room for some time. A relative who we spoke to at the same time as the person living in the service, told us, "2 weeks ago we were clapping them [flies] away. In the last few days, they have decreased." The person then said, "No they haven't [decreased]."

● People we spoke with told us the flies were, 'a nuisance' and one person said, "They [flies] drive me mad, but I put up with them, they go up my nose." Another person after telling us how they brushed flies away from their drinks and food said, "What else can we say – what is the solution?"

● Relatives we spoke with told us they were being kept informed of the actions taken to remove the flies but had little information about the risks posed to their relatives. Some people effected by the flies lacked the mental capacity to make informed choices about how risks to them were managed.

● The provider had completed an infection control (IPC) audit. This did not identify increased infection risks or ensure risk assessment were completed where required.

The failure to assess, prevent, detect, and take action to mitigate infection control risks was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Visiting in care homes

The visiting arrangements in the home aligned to government guidance. Visitors were welcomed into the home and were able to visit people in private in their rooms or in communal areas.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

● The service's approach to assessing and managing risks had placed people at risk of harm. One person had an infectious health condition and staff were following the correct precautions to protect themselves and others. However, a risk assessment had not been completed to identify the associated risks and what action staff needed to take to reduce and control the risk of infection. This placed the person at risk of harm and did not meet the Department of Health code of practice about the prevention and control of healthcare associated infections.

● Safety concerns were not consistently identified or addressed quickly enough. This included skin wounds, constipation, sight loss, and behaviours which placed the person or others at risk. The lack of assessment and clear guidance for staff to support them to manage risks, meant people were placed at risk of harm.

● Information about risks and safety was not always comprehensive or up to date. For one person with a pressure injury, the care records described it was, 'more sore.' There was no further detail to identify the condition of the skin or what action needed to be taken. Their care plan had not been updated with the information about increased risk to their skin integrity. We discussed this with the deputy manager, who told us the person was being re-positioned more frequently. However, the repositioning charts did not always reflect this had happened. This meant the person could be at risk of the pressure sore deteriorating further.

● Information to support the management of risks to people had not always been completed. One person had a wound on their leg and was known to remove their dressing, which placed them at risk of infection. Staff told us on noticing the dressing had been removed they replaced it. However, there was no risk assessment in place to guide staff as to how this risk was to be monitored or what action they should take to reduce the risk. We found another person's fluid input and output records to support the management of a person's catheter, were not always completed. When they were completed, the amount was not added up or reviewed to ensure action would be taken when needed. This meant the management of this risk was

ineffective. A third person was at high risk of falls and had recently fallen. They did not have a falls care plan to describe how risks to them from falls were managed. In addition, this person was on blood thinning medication, which increased the risks to them from falls.

The failure to assess and manage the risks to the health and welfare of service users was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● During our inspection the registered manager and deputy manager acted to put risk assessments in place.

● The service was working with the local authority and environmental health services to improve risk management. Training and support had been provided by the local authority care homes team and other healthcare professionals, including the provider's clinical development nurse. These Improvements were being embedded into the service at the time of our inspection.

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)

● Not all decisions made in the best interests of people who lacked capacity had been recorded to evidence the required process had been completed. For example, decisions for people to move or stay in their rooms during the infestation. The provider did have a process to apply the MCA, but this needed to be applied consistently.

We recommend the provider considers current guidance on the application of the MCA and updates their practice accordingly.

● We found appropriate legal authorisations were in place or applied for to deprive a person of their liberty.

Using medicines safely

● The registered manager acted promptly when we identified areas where some improvement was required in the management of people's medicines. This included ensuring information about anti-coagulants (blood thinning medication) was clearly identified in risk assessments and on information for emergency services, and medicine administration records were promptly updated to reflect a changed prescription.

● Arrangements were still in place for the safe administration, disposal, and storage of people's medicines.

Staffing and recruitment

● The registered manager confirmed there had been no changes to the recruitment process since our previous inspection in November 2022 when we found staff were recruited safely.

● There were enough staff to meet people's needs. The registered manager confirmed the service was fully staffed and staffing numbers continued to be based on an assessment of people's needs.

● Additional staff roles had been created to support people's needs and waking night staff had also been increased.

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

- There had been a lack of a systematic approach to managing the risks to the health, safety, and welfare of people from the fly infestation. No health and safety risk assessment had been developed until 27 February 2023. This was 4 months after the onset of this problem/hazard. The purpose of a risk assessment would be to carry out a robust examination of the hazard, the potential for harm, the actions to mitigate the harm and a review of the effectiveness of those actions. The lack of a systematic approach meant people may have been exposed to the risk for longer.
- Although some mitigation of risks associated with the fly infestation had been completed, this was limited. The service had used a reputable pest control company to investigate the cause of the infestation. However, when the problem had persisted, the service had not sought other external professional/expert advice to assist in making improvements. Following incidents affecting the health and dignity of people at the service, other organisations became involved. Including environmental health and local authority health and social care professionals. This resulted in a more robust analysis of risk and mitigation measures.
- Quality assurance processes were in place and these included heads of department meetings, clinical governance meetings and an audit system. However, these had not been effective in identifying all the concerns we found during the inspection. These have been detailed in the safe question and included identifying and investigating safeguarding concerns, risk assessment and management oversight.

The failure to operate effective systems to assess, monitor and mitigate the risks relating to the health, safety, and welfare of people, was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager told us they had learnt from this experience, had made improvements, and would ensure other improvements needed would be completed. They said "Yes, absolutely [I have learnt] it has made me think differently about risk assessment."

- The registered person must notify the CQC without delay of some incidents that occur in the service. This includes any abuse or allegation of abuse in relation to a service user and serious injuries. We found 3 incidents of a serious injury and 3 allegations of abuse had not been notified to CQC as required.
- The provider's system in place to alert the registered manager of incidents that required notification needed to be reviewed to ensure notifiable incidents at the service were identified and submitted without delay.

The failure to notify the Commission without delay of incidents that occurred whilst carrying on a regulated activity was a breach of Regulation 18 (Notification of other incidents) of the Care Quality Commission (Registration) Regulations 2009.

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

● Feedback was not always acted on in a timely way. In January 2023 we received two complaints from relatives about the fly infestation who did not feel their concerns, raised over preceding months, had been acknowledged or acted on. On checking, the registered manager had not informed families in writing of the actions being taken to deal with the fly infestation. The registered manager said they had conversations with relatives; however, this had not been effective in satisfying people's concerns. Following this they did email the complainants, provide a written update, and arrange a meeting for relatives.

● The process for obtaining the views of people and or their representatives about decisions affecting their care and treatment, was inconsistent. For example, decisions about moving to other less affected areas of the home were not clearly documented. This was important to demonstrate people's best interests had been considered when they lacked capacity to make the decision. When plans to move people to reduce the risks from the fly infestation were agreed, these did not always happen and there was no clear rationale for this decision. Relatives we spoke with told us they would have agreed to a move if their relatives were at risk, however the risks had not been fully explained to them.

● Residents meeting were held, and we saw the minutes of the meeting held in February 2023. This showed people attending had been given feedback about progress with the infestation and asked if they would like to move rooms. People agreed the flies were a 'nuisance' but it was recorded nobody at the meeting expressed the wish to move rooms. Other matters such as events, food and activities were also discussed.

● It was clear from talking to staff, the flies had created a very unpleasant environment to be living and working in. A staff member said, "It's not ok, it's not nice for the residents [people]. Flies in your face it's not pleasant. We don't like it for the 12 hours we are here, it's not at all nice for them." Staff told us they were kept informed of actions taken and were able to tell us about what they did to minimise the impact on people.

Working in partnership with others

● The local authority and care homes team who support best practice in care homes, had been working with the service prior to our inspection. The service was engaging in this improvement process supported by a range of health and social care professionals. The care homes team had delivered training, practice observations and guidance for the service and they told us staff had engaged well in this process.

● The service worked with the GP surgery and community nursing team who regularly visited to provide healthcare to people in the service. The relationship with the community nursing team was being strengthened as part of the improvement process.

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

● People and relatives, we spoke with told us the service provided good care. People's comments included, "Very good, good food and attention and look after me well" and "I am cared for very well, no complaints at all. They [staff] are prompt at answering calls." A relative said, "There are always staff, plenty and [person] has a call bell. [Person] eats well. We were told [person] was palliative [end of life], but now they are eating really well."

● We observed staff were kind, attentive and caring in their approach with people.

● Staff we spoke with were knowledgeable about people's needs. However, as described in this report records did not always provide up to date, comprehensive information about peoples care and treatment

needs. This is important so that staff, have consistent guidance to follow.

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 understood the requirements of the duty of candour and acted on this in relation to notifiable incidents.

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 18 Registration Regulations 2009 Notifications of other incidents How the regulation was not being met: The provider had failed to notify the Commission without delay of incidents that occurred whilst carrying on a regulated activity. Regulation 18 (1) of the Care Quality Commission (Registration) Regulations 2009.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: The provider had failed to assess and manage the risks to the health and welfare of service users, including the risk of infection. Regulation 12 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment How the regulation was not being met: Systems were not robust enough to demonstrate safeguarding risks were effectively managed. Regulation 13 (1)(2)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

How the regulation was not being met:
The provider had failed to operate effective systems to assess, monitor and mitigate the risks relating to the health, safety, and welfare of people.

Regulation 17(1)