The Flowers Care Home Limited

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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
The Flowers Care Home Limited is a residential care home providing personal care to older people and people living with dementia. The Flowers Care Home Limited accommodates 23 people in one adapted building. At the time of our inspection there were 14 people using the service.

People's experience of using this service and what we found

The service had an inconsistent approach that sometimes put people's safety and well-being at risk. The provider did not always manage risks well. Medicines were not always managed safely.

Staffing levels were generally safe although staff were sometimes stretched.

Robust recruitment checks were completed before staff started working at the service. The service had systems which safeguarded people from abuse.

The provider promoted safety through good hygiene practices and the service was regularly cleaned. The provider's approach to visiting did not meet government guidance when we carried out our first site visit because they were restricting visitors. The registered manager took swift action to address this.

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 usually supported this practice.

There was a lack of consistency in how well the service was managed. Care was not always person centred. Systems to assess and monitor the service were not always effective and did not drive the required improvements. Care recording was inconsistent and did not always provide important information about how people's needs were being met.

Feedback about the management team and staff was generally positive.

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 requires improvement (published 10 August 2022). The service remains rated requires improvement. This service was rated requires improvement at the last inspection and the inspection in October 2019. This service was rated inadequate at the inspection in October 2021.

Why we inspected
The inspection was prompted in part due to concerns received about staffing arrangements, and

management of risk and medicines. A decision was made for us to inspect and examine those risks.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Flowers Care Home Limited on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to risk management, medicines management and good governance 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 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.

The Flowers Care Home Limited

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 was carried out by 2 inspectors.

Service and service type
The Flowers 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. The Flowers 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 observed how people were being cared for to help us understand the experience of people who could not tell us about their experience. We spoke with 3 people who used the service, 3 relatives and 7 members of staff including care workers, housekeeping, assistant managers and the registered manager. We reviewed a range of records. This included 5 people's care records and multiple people's medicine records. We looked at 3 staff recruitment files. A variety of records relating to the management of the service were reviewed.

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. The rating for this key question has remained 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.

Assessing risk, safety monitoring and management
- Risks to people were not always assessed and managed safely.
- Some risks had been identified, but actions were not always taken to ensure people were safe. For example, one person was having difficulties when eating and a 'soft diet' was recommended. Care records did not guide staff about what foods were safe and staff were inconsistent when telling the person what they could eat.
- Staff were observed using unsafe moving and handling techniques when supporting one person to transfer from wheelchair to chair. Staff did not follow care plan guidance or use the recommended aid. This was addressed as soon as we brought it to the attention of the registered manager.
- Care records did not always evidence people were receiving safe care. The provider had identified, some people's care required additional monitoring and recording, such as repositioning and when a person became anxious or upset. However, recording was not done consistently which meant the service did not have an accurate overview.
- Premises and equipment checks were completed but these were not always managed to support people to stay safe. For example, in 1 person's room flooring was loose fitting and another person's room was extremely hot because the radiator could not be switched off. The service had 1 shower, but this was out of use. The provider took prompt action to address the environmental hazards.

Systems were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was responsive to the inspection findings and sent information to show they were taking action to address the areas of risk identified at the inspection.

- The service managed some areas of risk well. For example, people's weight was effectively monitored and managed. Advice was requested from other professionals if concerns were identified.

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 usually 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.
● The service judged whether people had capacity to make decisions and usually carried out assessments when appropriate. We saw one example, where an assessment had not been completed. This was addressed as soon as we brought it to the attention to the registered manager.

Using medicines safely
● Medicines were not always managed safely. The service had systems and processes in place for the safe storage, administration, and use of medicines. However, these were not always implemented effectively.
● Systems for administering prescribed topical creams were not safe. Several people had topical creams in their room, but these had been prescribed for other people. Some creams were not stored safely because they were left out in people's rooms.
● One person's care notes stated they had been given 2 pain relief tablets because they were in pain. However, a medication administration record was not completed. The management team did not know where staff had got the stock as the person did not have this medicine prescribed.
● Some medicine stock was incorrect. For example, 1 person had 9 tablets missing. We were unsure if another person's stock was correct because staff were not recording if they administered 1 or 2 tablets.
● One person was prescribed strong pain relief and was in pain. However, we saw they had not been receiving the maximum dose.

Systems were not robust enough to demonstrate medicines were effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was responsive to the inspection findings and sent information to show they were taking action to address the areas of risk identified at the inspection.

Staffing and recruitment
● At times, staff were stretched and sometimes focused on completing tasks. The service had housekeeping staff but did not have catering staff which meant staff on duty were responsible for preparing and cooking meals. Sometimes people sat for long periods with very little stimulation.
● We received mixed feedback about staffing arrangements. One person said, "The staff are run off their feet." A relative said, "They could do with more staff."
● The management team used a tool to calculate staffing levels and the registered manager was confident they had enough staff to keep people safe. They agreed to review how staff were deployed to see if they could do this more effectively.
● Staff were recruited safely. The provider carried out appropriate checks to make sure staff were suitable before they started working at the service.

Preventing and controlling infection
● People were protected by the prevention and control of infection.
● The provider was promoting safety through good hygiene practices. Staff understood their role in relation to infection control and had access to adequate PPE and cleaning supplies.

● Measures were in place to ensure the service was regularly cleaned.

Visiting in care homes
● The provider's approach to visiting did not meet government guidance when we carried out our first site visit because they were restricting visitors. The registered manager took swift action and lifted all restrictions. Relatives told us the arrangements had changed and they no longer had to use a booking system.

Systems and processes to safeguard people from the risk of abuse
● The service had safeguarding systems and usually managed abuse or allegations of abuse promptly. Safeguarding referrals had been made to the local authority and investigated. However, an incident occurred between two people during the inspection which was not appropriately recorded and reported in a timely way. This was addressed by the registered manager.
● Effective systems were in place for monitoring people's personal allowances. Records were well maintained and audited.
● Staff had received safeguarding training and understood how to raise any concerns about poor practice. They were confident the management team would be responsive and deal with safeguarding issues appropriately.
● People felt safe raising concerns with staff and management. One person told us, "I feel safe and know what is right and wrong, and how to stay safe. The majority of the time it is safe for others." A relative said, "Management are very supportive."

Learning lessons when things go wrong
● The service had effective systems for reviewing and investigating safety and events when things went wrong.
● Accidents were well recorded and the management team reviewed individual events and identified how to prevent recurrence.
● The service completed an analysis of events which looked for patterns, trends and lessons learned.

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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

- Governance did not always support the delivery of person-centred care. For example, we arrived at 6.30am and found most people were up, dressed, had eaten breakfast and the breakfast pots had all been cleared away. We observed one person being shaved in the lounge rather than the privacy of their room or a bathroom.
- Record keeping around people's daily routines and well-being was poor. Daily records were very basic and did not contain key information about care that was being delivered. For example, we saw one person was visibly upset on both site visit days but there was no detail to reflect this in their care notes.
- Information to enable monitoring was sometimes unreliable. The service had completed audits, but these did not consistently highlight shortfalls identified during the inspection. For example, during the first site visit we saw people were not offered an alternative dining environment and remained in the same seats; dining audits did not accurately reflect people's experience. This had improved when we carried out a second site visit.

The lack of robust quality assurance meant people were at risk of receiving poor quality care. This was a breach of regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The registered manager was responsive to the inspection findings and sent information to show they were taking action to address the areas of risk identified at the inspection.
- Although systems did not ensure care was always person-centred, staff were observed treating people with kindness and compassion. For example, one member of staff who was serving lunch gave people a choice of meals and spent time making sure they were happy with their selection. The member of staff was caring, friendly and showed genuine warmth towards everyone.
- Relatives told us, when visiting, they were welcomed. One relative said, "We couldn't speak highly enough. They are so, so caring." Another relative said, "The Flowers is good, we're quite happy with it. There's a nice atmosphere."

Working in partnership with others; 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 service contacted health and social care professionals for support and guidance. A health professional said, "In the last six months I've seen improvements, they seem more professional when we are coming, they are interested in people and wanting to know what we are doing."
● The registered manager was aware of their responsibility regarding duty of candour. Duty of candour ensures providers are open and transparent with people in relation to their care.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● The service involved and engaged with people who used the service, relatives and staff. A relative said, "If there's any changes, they tell us and anything new they tell us. They are forth coming with information." One person said, "[Name of care worker] listens, she is tremendous, 100% very good with people." The provider completed annual satisfaction surveys.
● Feedback about the management team was consistently positive. Staff told us they were supportive, approachable and accessible. One member of staff said, "We get good support, and if we need anything we just have to ask."
● Staff felt listened to and attended regular meetings. Staff said team meetings were opportunities to learn and speak out. One member of staff said, "I like how we work as a team and do things together." Another member of staff said in relation to staff meetings, "It's a conversation for everyone."

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 Systems were not robust enough to demonstrate safety was effectively managed. Systems were not robust enough to demonstrate medicines were effectively managed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The lack of robust quality assurance meant people were at risk of receiving poor quality care.