Care UK Community Partnerships Ltd

# Pear Tree Court

## 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
Pear Tree Court is a residential care home providing personal and nursing care to 46 people at the time of the inspection. The service can support up to 72 people. The service was purpose built and accommodation in en-suite bedrooms is arranged over three units on different floors. Gale unit provides residential care, Napier unit provides care and support for people living with dementia and Murray unit provides nursing care. Each floor has its own lounge, dining room and TV lounge. Other facilities include a café, hair salon and cinema.

People's experience of using this service and what we found
Risks to people were not always assessed or managed safely and records relating to risk management were not always accurate or consistent. Actions were being taken to improve risk management, however the provider needs to check these are effective.

The management of people's medicines was not always safe. We did not find any harm to people, but improvements were required in the management of controlled drugs, medicine storage, topical medicines (applied to the skin) and decision making.

We received mixed feedback about staffing levels from staff, relatives and people. The provider used a dependency tool to calculate how many staff were required to meet people's needs and this showed enough staff were available. The provider had acted on concerns about staff deployment to use staff resources more effectively.

The manager and staff understood their responsibilities to keep people safe. Incidents including safeguarding were reviewed to ensure appropriate action were taken. The provider was acting to make improvements to the safety of care people received following concerns identified by the local authority safeguarding team.

Quality assurance systems had not always been effective in identifying the concerns we found at this inspection and bringing about improvement. We observed staff did not always treat people with dignity and respect, the manager acted on this immediately. There had been difficulties in establishing a positive culture in the staff team, we have made a recommendation about this. We received positive feedback about the new manager.

There was a limited approach to obtaining the views of staff, relatives and people who use services to show how they are involved in shaping the service. The provider told us this was because their priority had been to embed government guidance about safe working practices in relation to COVID-19. The service had received compliments and a high score on a care home review website for the care provided.

Rating at last inspection

The last rating for this service was Good (published 2 May 2019).

Why we inspected
The inspection was prompted in part due to concerns received about neglectful care and treatment, how people were protected from the risk of harm and abuse and a lack of leadership. A decision was made for us to inspect and examine those risks. We undertook a focused inspection to review the key questions of safe and well-led only. Ratings from previous comprehensive inspections for those key questions not inspected were used in calculating the overall rating at this inspection.
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 have found evidence that the provider needs to make improvements. The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection. Please see the safe 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 Pear Tree 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.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**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.

# Pear Tree 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 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
This inspection was carried out by two inspectors, an assistant inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Pear Tree Court 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 had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. At the time of the inspection the registered manager was absent from the service. A relief manager was temporarily managing the service with support from the providers operations support manager. We have referred to the relief manager as 'the manager' throughout the report.

Notice of inspection
We gave the service 30 minutes notice of the inspection visit as we needed to be sure the inspection could be undertaken safely.

What we did before the inspection
We reviewed information we had received about the service since the last inspection including notifications. Notifications are information about specific important events the service is legally required to send to us. 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 received feedback from the local authority and professionals who work with the service. We used all of this information to plan our inspection.

During the inspection
We spoke with twelve members of staff, including the quality development manager, the deputy manager, the regional relief manager, the operations support manager, two unit managers, the regional director, a volunteer, two care staff, 1 nurse and a dining assistant. We spoke to five service users (four via a video link) and one staff member and we spent time observing the support and interactions between people and staff. We also reviewed the environment and equipment in place. We reviewed a range of records. This included three staff recruitment records, governance and training records and multiple medication records on Napier and Murray units.

After the inspection
We spoke with a further five care staff members by phone. We reviewed care records for seven people. A variety of records relating to the management of the service, including policies and procedures were reviewed. We continued to seek clarification 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 Good. At this inspection this key question has now deteriorated 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.

Assessing risk, safety monitoring and management
People and the relatives we spoke with told us the service provided safe care however, we found risks to people were not always managed safely.

● Equipment to keep people safe was not used correctly. For example, we observed a person attempting to get out of bed. A sensor mat was in place to alert staff if they got out of bed as they were at risk from falls, but the sensor mat was not turned on. There were no staff present and when questioned two staff told us it should always be turned on whilst a nurse said it should only be used at night. The persons care plan did not refer to a sensor mat and there was no risk assessment in place. A crash mat was in place, but this was not by the person's bed. This meant the person could be at risk of injury from a fall.

● People's falls risk assessments were not always reviewed following a fall. For example, a person's falls risk assessments or care plan did not include details of the number of falls they had experienced but referred to "multiple falls". This information helps to identify any factors to support effective evaluation of people's needs at review. Records for another person who was assessed as high risk of falls and had experienced two recent falls were not clear about how their needs had changed following a review and why they now required less support to mobilise. In addition, the information about the support they required was not consistent in their records.

● Risks identified such as choking and weight loss had not always been assessed. For example, two people at high risk of choking chose to eat foods which could cause them harm. It was not clear from the records these people had all the information required to make this decision or that alternative measures to reduce the risk of choking for them had been fully considered and was acted upon by staff. . The lack of effective assessment meant measures to help reduce the risk to these people had not been considered.

●It was not clear how people's weight loss was managed. Some people's records showed they had lost weight. The manager told us the weight tracker for people was reviewed weekly. However, care plans did not always show the actions taken as a result of weight loss. According to a person's malnutrition risk assessment they had lost 6kg between July 2020 and December 2020, their risk score was high. However, the persons care plan stated they were medium risk, ate independently and if weight loss occurred, they would resume a food chart to monitor what the person ate, this was not in place. For another person we were given one set of records which showed they had lost 4.5KG. We were subsequently given another set of records which gave different information. One person who was a new admission had lost 2.4KG within 3 weeks their MUST score had changed from medium to high but there was no record of any actions taken to address this.

● Food and fluid intake were monitored for one person to mitigate risks to them from malnutrition and dehydration. However, these records were not completed to enable effective monitoring. Fluids were consistently under target with no recorded action. Food charts did not provide information about portion

size or the content of the meal therefore the calorie value would not be known.
● Repositioning records were not always completed to show the person had been supported with their needs as their care plan described. This can increase the risk of pressure areas and other skin injuries developing.

Information about risks and actions to mitigate such risks to people was not always consistent in people's care records. This meant guidance for staff on how to meet people's needs was not always up to date or accurate which meant people could be at risk of receiving inappropriate care and treatment.

The failure to assess risks to the health and safety of service users and to do all that is reasonably practicable to mitigate those risks placed people at risk of harm and was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider has told us what they are doing to improve risk management, and this was in process. This included staff training, meetings and reviews of people's care plans and risk assessments, staff supervision and deployment and analysis of incidents.
● We saw an example of how a person who had been at risk from the care they were receiving had been supported to make improvements once the risks were identified by the new deputy manager and positive changes had been made.
● Checks of the building and equipment including fires safety were undertaken and a business continuity plan was in place in case of emergencies.

Using medicines safely
● We saw no evidence of people being harmed however, medicines were not always managed safely. Some medicines have legal controls, we looked at the stock of 'controlled medicines' on Murray unit and found some recording errors relating to one person. Recording errors included inaccurate recording of stock and dose and one inaccurate record of a dose given. On Napier unit we found controlled drugs were managed safely.
● We found for one person, who was supported with their medicines covertly , they had a mental capacity assessment and best interest decision in place to show this was being done in the person's best interests. However, there was no evidence of consultation with the pharmacist about this decision. This is important to ensure that the manner in which medicines are administrated covertly do not impact on the effectiveness of the medicines.
● Most medicines were stored safely. However, on Napier unit we found examples of liquid medicine and topical medicines (applied to the skin) that were not dated when opened. This is important to ensure medicines in use remain effective. Medicines for disposal were stored separately, however, not all medicines for disposal were recorded which is important to ensure unused medicines are accounted for.
● Records to show people's topical creams were applied as prescribed were not always completed. To make sure people are kept safe staff need to complete records to show when these medicines were applied, where and by whom.

The failure to ensure the proper and safe management of medicines was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

●Temperature checks of storage were taking place.
● For medicines to be administered 'as required' (PRN) guidance was in place to help staff understand when to give them and in what dose.
● Medicine Administration Records (MAR's) were fully completed to show people had received their

medicines as prescribed.
● Medicines were administered by registered nurses or suitably trained staff who had been assessed as competent to do so safely. Staff responsible for administering medicines completed training and were assessed as competent on an annual basis or following a medication error.
● Following concerns identified by the local authority safeguarding team the provider had acted to improve medicine management. Medication audits showed improvements had been made and medication errors had decreased substantially.

Systems and processes to safeguard people from the risk of abuse
● The registered manager had failed to notify the local authority safeguarding team in a timely manner of safeguarding incidents. When this was identified the provider took prompt action to address this. We have referred to this in the Well-Led domain.
● People's relatives told us their family members were safely cared for at the service, although some relatives commented they had not been able to visit the service for some months due to COVID-19. People told us they were safely cared for and their comments included, "Most safe, staff are absolutely lovely, look after me well" and "It's lovely living here, definitely feel safe."
● Staff we spoke with understood their responsibilities to safeguard people and how to report their concerns.
● Staff were trained in safeguarding and the manager understood their responsibilities regarding safeguarding.

Staffing and recruitment
● Due to visiting restrictions to all care homes, set out by the government during the COVID-19 pandemic not all the relatives we spoke with felt they were able to comment on staffing levels. People's comments included "Is there ever enough staff, I believe it's quite a problem now" and "Staffing – sometimes short but very difficult to organise especially during a pandemic." People and relatives commented there could be a wait for call bells to be answered, people's comments included, "Sometimes it takes a while to answer call bells" and "Answering the call bell rather depends on the length of the emergencies in the rest of the home." A staff member said "If I have to be honest, I think they are really poor [staffing levels] because of the staff illness. Very often we have agency and it's like we have to look after agency as well." Another staff member said, "Some days it's easy but some days it's not enough – all care is given but it can be good to have an extra pair of hands."
● During the inspection the evidence we found did not support the above statements and we observed there were enough staff to meet people's needs.
● The provider used a dependency tool to calculate the number of staff required to meet people needs. This showed the home was staffed above the number of hours calculated to meet people's needs.
● Following feedback from the local authority safeguarding team the provider was regularly reviewing staffing levels and acting on staff deployment to ensure staffing resources were used more effectively such as staff not taking breaks together and this was monitored
●People were protected against the employment of unsuitable staff as the provider followed safe recruitment practices.

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 admitting people safely to the service.
● 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. Policy references Covid-19 and related guidance is available.
● We have signposted the provider to guidance to develop their approach to personal protective equipment and social distancing.
● Agency staff were used when required. The provider aimed to block book agency staff so they were not also working at other homes during the COVID-19 pandemic. This was not always possible; however, a screening process was in place to check agency staff were safe to work in the home at the time of their shift.

Learning lessons when things go wrong
● A system was in place to record and monitor incidents to ensure the appropriate actions were taken.
● An action plan had been developed to make improvements to processes that supported the safety of people using the service following concerns identified by the Local Authority safeguarding team.
● A review of progress in December 2020 showed improvements had been made with further work to do.

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 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

● People's records and care plans were not always accurate, or complete. The inconsistent documentation meant that information was not always reflective of people's needs, and this had not been identified by the registered person. We found that accurate records were not always maintained or did not accurately reflect people were offered the support described in their care plan. This potentially placed people at risk and could compromise the quality of the care being delivered.

The failure to ensure effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of people and others, and to ensure records were accurate and complete was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Quality Performance reports were produced monthly these collated data to give oversight of performance indicators and an internal regulatory rating. Data included; pressure sores, MUST scores (malnutrition), hospital admissions, as well as governance information such as audits completed and audit scores. The last report for October 2020 showed the homes internal regulatory rating was Requires Improvement.

● The provider produced a report showing a breakdown of accidents and incidents. This information was used to identify trends over three months. In the report for September – November 2020 Improvements had been made in medications errors and number of infections and a reduction in falls.

●A daily manager walk around was in place to assess the measures in place to protect and support people in relation to COVID-19. Specific risk assessments had been carried out to mitigate risk to people from COVID-19 such as visiting arrangements and workplace safety.

● At the time of the inspection a registered manager was in post but had been absent from the service since September 2020. Following the inspection, we were notified the registered manager would not be returning to the service and has cancelled their registration with CQC. The regional director, the regional operations support manager, the regional clinical lead and the regional quality development manager had provided on site management support between October 2020 and December 2020 when a relief manager was appointed who has subsequently been confirmed as the permanent manager and has applied for CQC Registration.

● People and relatives were not clear about who was managing the service. A relative said "Not a strong leadership because it changes all the time, initiatives start then go out the window" A person said "I don't think I can answer that, day to day staff are brilliant but I don't know about management"

● Systems had not always been effective to ensure when there were allegations of abuse these were referred to the local authority safeguarding team in a timely manner. Following investigation of these incidents the provider has developed an action plan to make improvements to several areas to prevent a reoccurrence. It was evident they had taken positive action to respond to these concerns. The action plan showed improvements had been implemented with work still to be completed.
● The provider had not always notified us of incidents without delay as required by the regulations. We were notified retrospectively.

We recommend the provider ensures an effective system is in place to notify the Commission without delay of any relevant incidents.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● We observed people were not always treated respectfully by staff. On one occasion we heard a staff member use disrespectful language and they were not corrected by the unit manager. On another occasion a staff member's behaviour caused a person to become upset when their repeated requests to move were dismissed. When the person had been supported with their request the staff member continued to cause the person distress by loudly challenging the support they had received. Whilst we saw many other interactions that were positive, it was of concern to witness staff behave in this way. We spoke to the manager about this who acted on this feedback immediately.
● People's relatives told us they knew how to raise concerns however, we received some mixed feedback about whether concerns were listened to and acted on. A relative said "My sister is main contact; home is quick to contact her. Any issues, they listen to us." Some relatives felt they had to 'push' for a response, it was not always easy to contact staff and some staff had an unhelpful attitude.
● From staff meeting minutes and communications to staff it was evident there had been difficulties in establishing a positive and open culture. Leadership and management had been inconsistent and at times ineffective. A staff member said, "I feel like there was a bit of bullying going on, it's quite cliquey with some staff." Three staff members told us they did not feel all staff were treated equitably. A staff member said, "Some staff have to follow the rules and others get away with stuff which I don't think is the right culture." Another staff member said, I would just like it to be stable [leadership]." A new manager was now in post and we received positive feedback from staff about their approach. "She seems very confident that she knows what she's doing" and "Our manager is quite new, but she does seem very nice. I feel if I had a concern, (which I did raise), she seems very welcoming and didn't have a problem in listening in what I had to say."
● Staff supervision had not been regularly completed over the past year. This was being addressed by the manager who told us these sessions would offer staff, "Meaningful supervisions and capture support conversations." We saw an example of how a staff member was being supported to improve their performance.
●The safeguarding action plan showed the steps the provider was taking to improve staff support. This included; supervisions, increased communication, meeting and training.

We recommend the provider consider current guidance on promoting a positive culture and act to update their practice accordingly.

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 understood their responsibility under the duty of candour, and we saw an example of an investigation and apology into a notifiable incident.

● A duty of candour audit had been carried out in February 2020. This audit enabled the home manager to check the duty of candour was consistently applied to meet the Regulations. The audit identified areas for improvement including; staff knowledge of the duty of candour and learning from incidents. The action plan did not include staff understanding as an improvement action and the action to improve shared learning had not been reviewed since February 2020. We raised this with the manager who said they would take this action forward immediately.

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

● We asked people and relatives if they had been asked for their feedback, views and concerns about the service. People's comments included "Not been asked for feedback" "Did do a survey once, but that was for the benefit of the management" and "Done surveys from time to time." Relatives comments included; "Feedback, never been asked" "Resident of the day, always call me on that day, ask if I want any changes made to the Care Plan, which is really difficult because I haven't seen relative's Care Plan since February" Other relatives told us they were asked for feedback as part of resident of the day. We did not receive any evidence that feedback about the service had been collected from people and relatives and analysed to identify improvements.

● An engagement audit had been carried out on Napier in September 2020 which looked at resident engagement and wellbeing. An action plan had been produced and with some completed and others underway.

● No staff survey had taken place in 2020. The provider told us this was because their priority had been to embed government guidance about safe working practices in relation to COVID-19.'The manager told us staff were asked for feedback on specific questions and had recently been asked for their feedback on having the COVID-19 vaccination. However, it was not evident the service proactively engaged staff to ensure their views were heard and acted on to shape the service.

● We saw the regional operations support manager had introduced regular updates and information emails to staff. The new manager planned to organise team meetings and continue with information emails. A staff member said "We get lots of emails with updates that's good for me"

● People's relatives told us they had been kept well informed about visiting and arrangements during the COVID-19 pandemic.

● We saw examples of compliments received by the home for the quality of care people received and the home had achieved a positive rating on a care home review website.

Working in partnership with others

● The service was working with the local authority care homes team and the GP surgery to embed improvements to the care and treatment people receive at the service.

● The service was working with the local authority safeguarding team and CCG to monitor the progress of their action plan.

● The service worked with a range of other healthcare professionals to meet people's needs including; falls team, older people's mental health team, pharmacist, opticians, speech and language therapist, chiropodist and diabetes nurses.

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<br><br>Treatment of disease, disorder or injury | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment<br><br>How the regulation was not being met: The failure to assess risks to the health and safety of service users and to do all that is reasonably practicable to mitigate those risks placed people at risk of harm.<br>Regulation 12 (1)(2)(a)(b)<br><br>How the regulation was not being met: The provider had failed to ensure the proper and safe management of medicines.<br>Regulation 12 (1)(2)(g) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>How the regulation was not being met: The provider had failed to ensure effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of people and others, and to ensure records were accurate and complete.<br>Regulation 17 (1)(2)(b)(c) |