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# Fallowfields Residential Home

## Inspection report

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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|---|---|
| Is the service safe? | Requires Improvement |
| Is the service effective? | Inadequate |
| Is the service caring? | Requires Improvement |
| Is the service responsive? | Requires Improvement |
| Is the service well-led? | Inadequate |

# Summary of findings

## Overall summary

This inspection took place on 8 and 10 March 2016 and was unannounced. The home provides accommodation for up to 22 people including people with dementia care needs. There were 20 people living at the home when we visited. The home is based on two floors, connected by a passenger lift, in addition to a basement where the kitchen and laundry are located. There was a choice of communal rooms where people were able to socialise and some bedrooms had en-suite facilities.

A registered manager was not in place at the time of the inspection, although the manager had applied to be registered with CQC and their application was being processed. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

At our last inspection, in June 2015, we identified the providers were not meeting all fundamental standards of quality and safety. We issued warning notices requiring the providers to become complaint with regulations relating to the safe care and treatment of people; staffing arrangements; and quality assurance systems. We also issued requirement notices relating to person-centred care; the need for consent; and the suitability of the premises.

At this inspection we found some improvements had been made, but the providers were still not meeting all fundamental standards and people's safety was compromised in some areas.

Although people told us they felt safe at Fallowfields, we found staff had not received up to date training in how to protect people from abuse and they did not always report incidents of abuse to the local safeguarding authority.

Individual risks to people were not always managed appropriately. Additional measures needed to keep people safe were not always documented and staff did not know how to adjust special mattresses to meet people's individual needs.

Staff had not received essential training to equip them for their roles and demonstrated a lack of knowledge in the way they supported people. Some staff were using equipment, such as stand-aids they had not been trained to use. Staff had not been trained to calculate the body mass of people who could not stand on scales, so could not identify whether people had lost weight. New staff did not follow a structured induction training programme.

Suitable arrangements were in place for managing medicines. However, staff had not received refresher training, they did not always record when they applied topical creams to people and action was not taken when storage temperatures dropped below safe levels.

Safe recruitment procedures were not always followed, as essential pre-employment checks were not always completed to make sure staff were suitable to work with people at Fallowfields.

Environmental risks were managed effectively and arrangements were in place to deal with emergencies, although not all staff understood the systems for opening fire doors. Some improvements had been made to the environment, although further work was needed to support people living with dementia.

Staff did not always follow legislation designed to protect people's rights. They were not aware of conditions that should have been applied to one person, to safeguard their freedom.

People were satisfied with the food. They were encouraged to drink often and supported them to eat and drink when necessary. However, records of what people had consumed were not always accurate.

People told us they were cared for with kindness and compassion and we observed positive interactions between people and staff. However, staff were not always discreet and sometimes lacked insight into people's communication needs.

New arrangements were being introduced which would give people more choice about when they had baths and showers. Activity provision had improved, although it was not always meaningful.

People received care and support in a personalised way and staff responded promptly to their changing needs. However, care plans were not always up to date and did not always reflect the care and support that people had received.

Quality assurance arrangements were still not adequate. They had not identified any of the above concerns and this had led to continuing breaches of regulations. The providers did not tell us about three significant incidents as required. Management arrangements were not robust as the training and knowledge of the providers and the manager were not up to date.

In other ways, the home had an open culture. People and staff said the manager and the providers were approachable; they notified relatives when significant incidents occurred; the previous inspection report was available and had been discussed with people; and visitors were always welcomed.

There were enough staff to meet people's needs. They understood their roles and worked well as a team. People's privacy was protected; confidential information was held securely and people could choose whether they received personal care from a male or a female care worker.

All areas of the home were clean and staff followed appropriate infection control procedures. People were supported to access healthcare services and they were seen regularly by doctors and other healthcare specialists.

People were involved in planning their care and relatives were kept up to date with any changes in people's health. The providers sought and acted on feedback from people and there was an appropriate complaints procedure in place.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within

this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We identified breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

## 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.

Individual risks to people were not always managed effectively.

Safe recruitment procedures were not always followed and pre-employment checks were not always completed.

Staff did not always report incidents of abuse to the local safeguarding authority.

Suitable arrangements were in place to manage medicines safely, although staff had not completed refresher training and the use of topical creams was not always recorded.

Appropriate emergency arrangements were in place, although not all staff were clear about the systems used to open fire doors.

They were enough staff to meet people's essential needs and staff followed appropriate infection control procedures.

### Is the service effective?

**Inadequate**

The service was not effective.

Staff did not always follow legislation designed to protect people's rights or follow conditions designed to maximise a person's freedom.

Staff lacked knowledge and had not received essential refresher training to maintain their competency. However, staff felt supported in their work.

Improvements had been made to the environment, although further work was required to support the needs of people living with dementia.

People ate and drank enough, although records of what they had consumed were not always accurate.

People had access to healthcare services.

## Is the service caring?

Requires Improvement

The service was not always caring.

Not all staff were able to communicate with people effectively and understand their needs. Staff could be overheard when discussing people's care.

People were usually treated in a kind and compassionate way, with dignity and respect. Their privacy was protected.

People (or their families where appropriate) were involved in discussing and planning their care.

## Is the service responsive?

Requires Improvement

The service was not always responsive.

More personalised arrangements for people to receive baths and showers were being introduced but needed time to become embedded in practice.

Activity provision had been improved, although this was limited and not always recorded.

People received personalised care and staff were responsive when people's needs changed. However, care plans did not always support staff to deliver this.

The providers sought and acted on feedback from people. An appropriate complaints policy was in place and people knew how to raise a complaint.

## Is the service well-led?

Inadequate

The service was not well-led.

Action to address failures identified at the previous inspection had not been completed fully.

There was a lack of effective systems in place to ensure the providers complied with all fundamental standards of safety and quality.

The provider did not notify CQC of all significant events, as required. The manager had not been supported to attend additional management training and the providers had not updated their knowledge of best practice guidance in the care of older people.

The management were supportive of staff; the providers were open with people and staff about the findings of our previous report; the manager followed the duty of candour policy; and visitors were made welcome.

Staff understood their roles, were motivated, and worked well as a team.

# Fallowfields Residential Home

**Detailed findings**

## Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the providers were meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 8 and 10 March 2016 and was unannounced. It was conducted by two inspectors. Before the inspection we reviewed previous inspection reports and an action plan we had been sent by the providers. We also reviewed notifications we had been sent by the providers. A notification is information about important events which the service is required to send us by law.

We spoke with nine people living at the home, two relatives and two visiting friends. We also spoke with one of the providers, the manager, five care staff, three ancillary staff, two volunteers and three visiting healthcare professionals.

We looked at care plans and associated records for 10 people and records relating to the management of the service. These included staff duty records, staff training and recruitment files, records of complaints, accidents and incidents, and quality assurance records.

We observed care and support being delivered in communal areas. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

# Is the service safe?

## Our findings

At our previous inspection we identified there were not enough staff to meet people's needs; medicines were not always managed safely; infection control guidance was not followed; and risks to people were not always managed appropriately. At this inspection, we found improvements had been made to the management of medicines and infection control risks, but people's safety was still compromised in some areas.

Individual risks to people were not always managed effectively. A nationally recognised tool was used to assess people's risk of developing pressure injuries. One person had been assessed as at high risk of pressure injuries caused by sitting in one position for too long. They had been supplied with a special cushion to reduce this risk and we saw them using it in the lounge. However, when staff support the person to move to other chairs, they did not take the cushion with them. At lunchtime, we saw the person had been sat on a hard dining chair, without the cushion, for 20 minutes. We brought this to the attention of staff who put the cushion in place. When the person was later supported to transfer back to the lounge chair, the cushion remained in the dining room until we brought this to the attention of staff again.

Some people had been given special pressure-relieving mattresses for their beds. These should be set according to the person's weight. We checked five mattresses and found none was at the right setting for the person's weight; staff did not know how to set them correctly and there was no process in place to make sure they remained at the right setting. This put people at increased risk of pressure injuries.

Risk assessments were completed to identify the support people needed to mobilise safely. When people fell, staff told us they reviewed the incident and considered additional measures that could be taken to prevent further falls. For example, we saw alarm mats had been put in place to monitor when people moved to unsafe positions. However, reviews of people's risk assessments were not always documented and the further measures needed to protect the person were not always recorded to help make sure they were applied consistently by all staff.

The manager told us staff should conduct half-hourly observations for 24 hours when people sustained head injuries during falls; however, there were no records to confirm this had been done for two people who had sustained recent head injuries. One person's falls management plan required them to be given an alert cord when they were in the dining room, so staff would be alerted if the person moved and they could act to support them. We saw this person in the dining room without this piece of equipment, which put them at increased risk of falling.

The providers had placed an alarm at the bottom of the stairs to alert staff if people tried to use the stairs without staff support. Staff told us there were a number of people who would be at risk if they tried to use the stairs independently. During the inspection, we activated this alarm repeatedly when going up and down the stairs, without staff knowledge. On no occasion did any staff member attend to check who had activated the alarm and whether a person was putting themselves at risk.

The failure to ensure individual risks to people were managed effectively was a breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Environmental risks to people were managed safely. A trip hazard had been removed from the lounge area. Assessments had been conducted of the risks posed to people in their rooms. Windows in upper floor rooms had restrictors in place to prevent people falling out of them. Appropriate fire safety arrangements were in place. Hot water outlets delivered water at a safe temperature, although staff were not clear about the maximum safe temperature and there was no process in place to check this. A specialist contractor had been appointed to assess and manage health and safety risks at the home. They had completed a survey and were developing a plan to help make sure all risks continued to be managed effectively.

The providers did not always follow safe recruitment procedures. Legislation requires providers to check potential staff are entitled to work in the UK and that their conduct in previous care roles had been satisfactory. The staff file for one staff member showed they had a foreign passport and birth certificate; the provider was unable to demonstrate that checks had been conducted to confirm that the staff member was entitled to work in the UK. A reference for another staff member, from the last care home they had worked at for a year, was not positive. The manager was unable to explain why it was felt that the staff member was suitable to work with people at Fallowfields. They had not sought a further reference from another care provider the staff member had worked for.

A further staff member had recently worked at another care home, but a written reference had not been provided from their previous employer to confirm their conduct had been satisfactory, or from a person listed as their second referee to confirm they were of good character. The manager told us they had spoken to the previous employer by telephone, but had not made a record of the conversation so were unable to demonstrate that the person was suitable to work with people at Fallowfields. However, the providers did conduct criminal record checks of potential staff with the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions.

The failure to ensure essential recruitment checks were conducted was a breach of Regulation 19 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe at Fallowfields. One person said, "I can't say there's anything that worries me." Another told us, "Nothing worries me; I get on with everyone." A further person said they felt "comfortable and safe".

Incidents of abuse are required to be reported to the local safeguarding authority, so they can investigate and take action to ensure appropriate safeguards are put in place to protect people from further abuse. When we spoke with the manager and staff, they said they knew how to prevent, identify and report allegations of abuse. However, we identified two incidents which had not been reported to the safeguarding authority. A person living at the home had hit one person, which caused them to become "quite distressed" and had "grabbed another resident around the neck and tried to kiss them", which the person described as "frightening". Staff were taking action to reduce the likelihood of further conflict between people and the manager undertook to report the incidents to the safeguarding authority.

There were suitable arrangements in place for the ordering, storage and disposal of medicines. Administration procedures were safe and people received their medicines when required. One person said, "I get all my medicines and when I get migraines they give me special tablets." Another told us, "[Staff gave me] a sickness tablet last night as I felt poorly". Staff had received training and been assessed as competent to administer medicines, although none had received refresher training for over a year, so the providers

were not able to confirm that all staff were working to best practice guidance. Staff recorded when they gave oral medicines to people, although the use of topical creams was not always recorded.

Medicines were stored securely in locked cabinets. Those that needed to be kept at lower temperatures were stored in a fridge. Although the temperature of the fridge was monitored, this was not checked daily and records showed no action had been taken when the temperature had been found to be too low on several days. We brought this to the attention of the manager who told of plans to make the recording procedures simpler for staff but more robust.

A new system had been put in place to monitor and account for all medicines received into the home through clear auditing processes. This included procedures to help ensure that topical creams were not used beyond their safe 'use-by' date. A staff member was positive about the changes and said they helped ensure medicines "were always in stock".

There were arrangements in place to keep people safe in an emergency. Fire safety equipment was checked regularly and improvements to the fire alarm system had been completed to make it easier for staff to identify the source of a fire. Staff had been trained in the use of evacuation equipment and most understood what action to take in the event of a fire. However, one staff member was not clear about one of the two systems used to open fire doors in an emergency and another thought the fire escape doors opened automatically when the fire alarm was activated, which was not correct. Personal emergency evacuation plans (PEEPS) were available for all people; they included details of the support each person would need if they had to be evacuated.

People told us there were enough staff to meet their needs. One person said, "There's always someone to help get you up; you don't wait long. I have a buzzer and [staff] come quite quickly." A visiting nurse told us they were always attended to promptly when they visited to treat people.
The providers had reviewed staffing arrangements since the last inspection, and had made changes based on people's needs. An extra care staff member worked a split shift to provide people with additional support in the mornings and in the evenings. A staff member told us staffing levels had improved, "especially in the evenings".

All areas of the home were clean and hygienic and staff followed appropriate infection control procedures. One person said, "They clean my room every day and keep it nice." We checked five people's bedrooms and found they were clean and had fresh bedding in place. One person had their cat living in the room with them and there were clear arrangements in place to keep the food and cat litter in a safe place, to clean the room regularly and ensure other people were not put at risk.

Staff were clear about how to handle soiled linen safely. They used soluble red bags which could be placed directly into the washing machine without having to be opened first. Guidance in the laundry room informed staff of the relevant washing machine programmes to use for each item of laundry. The laundry rooms were clean and there was a process in place to help make sure clean linen was not contaminated by soiled items entering the laundry.

The providers had assessed infection control risks and taken action to reduce the risks; they had also completed an annual statement of infection control detailing events that had occurred over the past year. Regular audits were conducted to check that best practice guidance was being followed and these had led to additional hand sanitising gel dispensers being installed. Personal protective equipment (PPE) was readily available at key points throughout the home and we saw staff using this appropriately. Cleaning schedules were in place for each area of the home, together with a colour coded system to help reduce the

likelihood of cross contamination between areas being cleaned. Staff completed check sheets to show they had undertaken the cleaning in accordance with the schedules, which we saw were up to date.

Inadequate

# Is the service effective?

## Our findings

At our last inspection we identified that staff were not following legislation designed to protect people's rights. At this inspection we found improvements had not been made and people's rights continued to be compromised.

Some people living at the home were able to make informed decisions about the care and support they received. These people had given verbal consent, or had signed consent forms, indicating their agreement to the care and support they received. For example, one person said, "[Staff] always check and ask if I'm ready before helping me." However, when people lacked the capacity to make certain decisions, staff did not always follow the Mental Capacity Act, 2005 (MCA). The 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 Act 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Staff told us they had not received training in the MCA and we found they were not familiar with its principles or how to record best interests decisions.

Some people living at the home had a cognitive impairment and care records showed they were not able to give valid consent to certain decisions, including the delivery of personal care, the administration of medicines, the use of bedrails and the use of alert mats to monitor their movements. Staff had therefore made some of these decisions on behalf of people. For example, they had made a decision to administer one person's medicines and to use an alert mat to monitor another person's movements. However, they had not documented their assessments of people's capacity to make these decisions and in one case they had not consulted with relevant people to seek their views. Best interests decisions about other aspects of people's care, such as the delivery of personal care, had not been made. Staff had asked a family member of one person to agree to the care and support being provided to their relative, but had not checked that the family member had the legal right to do this. No assessments or best interests decisions had been made for a further person who lacked the capacity to consent to the care and support they received. Therefore, staff were not able to demonstrate that the decisions they had taken for people were in their best interests.

The failure to follow the Mental Capacity Act, 2005 was a continuing breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The providers had appropriate policies and procedures in place in relation to DoLS. An authorisation had been obtained for one person and applications had been made for other people. However, the manager and staff were not aware of the conditions that had been attached to the DoLS authorisation, which had been in place since November 2015. They included the need for the person to be given access to the garden, which staff told us had not been followed due to the weather. We discussed this with the manager who undertook to discuss the conditions with the local authority DoLS assessor and explore ways to allow the person to have regular access to the garden.

People were not always supported by staff who were suitably trained. A staff member had been given responsibility for monitoring people's weights. At the last inspection we identified that they had not been trained to calculate the body mass index (BMI) of people who could not be weighed. At this inspection, they told us this was still the case. They said, "If people can't weight bear (stand), we can't weigh them. We're not trained to do BMIs." The only scales available to weigh people were domestic, stand-on scales. These were not suitable for people who were unable to weight bear. The staff member told us they took action is people visibly lost significant weight, such as fortifying their food or contacting their GP. The inability of staff to monitor people's weight or body mass accurately put people at risk of undiagnosed weight loss.

Some staff displayed a lack of knowledge in the way they supported people to move. For example, when a person stood up from a lounge chair, the staff member instructed them to pull themselves up using their walking frame. This was not safe practice and put the person at risk of falling. The conventional procedure is to instruct the person to push up on the arms of the chair and then transfer their hands to the walking frame. On another occasion, a staff member helped a person onto a dining chair and then twisted the chair around before pushing the chair into the table. The person had had recent hip surgery and the twisting motion could have caused them pain or injury.

Staff told us they had received safeguarding training. However, two staff members said they had received this training while working at other homes, and it had not formed part of their induction at Fallowfields. Other staff could not remember when this training had last been refreshed. Staff did not have a clear understanding of when incidents should be reported to the local safeguarding authority.

Two staff members who had worked at the home for over a year told us they had not received any training in moving and re-positioning people since moving to Fallowfields. They were using equipment to support people to move that they had not been trained to use; this put people at risk of harm. The manager told us they had shown staff how to use the equipment, but said they were "not a moving and handling trainer or assessor".

The providers did not have an induction programme that prepared new staff for their role. New staff said they worked alongside more experienced staff until the manager felt they were competent to work unsupervised. They were also shown how to use fire safety equipment. However, the induction process was not structured and there were no records to show which subjects staff had covered. Arrangements had not been put in place for staff new to care to follow the Care Certificate standards. The Care Certificate is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. The manager told us they were not sure whether a new member of staff had completed a Care Certificate or not, and the providers did not have a process in place to make sure this was done.

Records of staff training were disorganised and the manager was unable to provide evidence that staff had received all necessary training. They told us, "Training records were a mess; you can't work out who's done what." They said they were trying to prioritise training, having concluded that all staff needed refresher training in most subjects. No training had been scheduled or planned, but on the second day of the inspection the manager told us they had identified a possible training provider and the providers had agreed to fund staff training.

The failure to ensure staff received appropriate training was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff felt supported in their work by the manager and the providers. All staff received one-to-one sessions of

supervision. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, and offer support. Some staff had also received an annual appraisal from the previous registered manager and the new manager was planning to complete those that were outstanding. Staff told us these sessions were helpful and spoke positively about the support they received from the manager on a day to day basis.

At our last inspection we identified that some areas of the building did not support the needs of people living with dementia or those with visual perception difficulties. At this inspection we found improvements had been made although further work was needed. A threshold strip between the lounge had been lowered to remove a trip hazard; corridors were better lit; an air conditioning unit had been bought to keep the conservatory at an appropriate temperature in the summer; an additional table and area of seating had been created in the lounge to provide more options for people; noise levels had been reduced by the removal of some alarms; and toilet doors had large signs on them. The manager told us they were planning to put new pictures in people's rooms at a height they could easily view them. However, this had not been completed and an audit of the suitability of the environment for people living with dementia had not been conducted to help staff identify appropriate changes. Doors to people's rooms had still not been personalised and did not make it easy for people to find their own rooms. All doors and door frames were painted in a similar pale colour to that of adjacent walls, so did not help people to navigate their way around the home.

People said they were satisfied with the care and support they received from staff. One person said, "[The staff] are very good here. I get all the help I need, like with washing and dressing." A close friend of another person told us "[The person] is really well looked after. She eats better now than she ever has." A visiting nurse told us, "I have no concerns. [Staff] follow our advice and do everything we ask of them."

People received a suitably nutritious diet and told us they liked the food. One person said, "The food is very good; there's always a choice. They advertise it on the [notice] board. It's always warm and plenty of it." Another person said, "The meals are good. They come and ask what I'd like; and you get a lot of drinks."

People received appropriate support to eat and drink enough. For example, staff prompted people to eat when needed, helped cut up their food and ate with them in the dining room. Drinks were available and in reach in people's rooms and all communal areas, together with a variety of cups and beakers to suit people's needs. Staff encouraged people to drink often. Records were kept of the amount people ate and drank. However, these were not accurate and had not been fully completed; no guidance was available to staff about the recommended amount that each person should aim to drink each day.

People were supported to access healthcare services and they were seen regularly by doctors and other healthcare specialists. One person confirmed this and said, "I always get to see a doctor when needed, like for check-ups." Another person had a hospital appointment on the first day of our inspection and one of the providers had arranged to meet them at the hospital to provide support. A healthcare professional said staff always "contact us when needed".

Requires Improvement

# Is the service caring?

## Our findings

People told us they were cared for with kindness and compassion. One person said of the staff, "They're very nice and kind and considerate." Another person said, "I took to them and they took to me. They're ever so good to me; they're very supportive." A visitor who attended the home often told us, "[Staff] treat people with the utmost care and kindness. They're very patient with people; it's a very friendly place." Other people described staff as "lovely" and "helpful".

However, when staff discussed people's care they were not always discreet and conversations could be overheard. For example, when two staff supported a person to walk into the dining room, one told the manager, in a loud voice, "She didn't wash [the person's] legs."

The ability of staff to communicate with people varied from person to person. Where people were able to communicate verbally, staff interacted with them well. However, where this ability was reduced due to a person's cognitive impairment, interactions were more task-orientated and were not always effective. For example, we heard a person tell a staff member their coffee tasted "strange". The staff member denied this and told them it was "OK". The person repeated this, so the staff member checked with another person, who said their coffee tasted "alright". The staff member walked away and the person's drink was not changed. When the staff member returned, the person repeated their concern and the staff member then gave the person a cup of tea instead, which they drank. The staff member had not initially considered that the person was trying to ask for an alternative drink, which demonstrated a lack of insight about the person's condition.

We observed a person repeatedly trying to stand up. They appeared anxious and were touching their lower abdomen. On two occasions staff responded by encouraging the person to sit back in their chair. On the third occasion, the staff member recognised that the person may have needed to use the toilet, but was unable to verbalise this. They then supported the person to the bathroom. However, while the person was walking, using their walking frame, the staff member held on to the waistband of their trousers, which served no purpose and was not dignified for the person.

However, at other times, staff were understanding and considerate. For example, when we asked to see a person in their room, the staff member said, "I'll just check that's ok with him." They recognised that the person should choose who visited them and sought their views first. Another person, whose first language was not English, had a series of pictures in their care plan to help staff interpret their body language. We also saw staff spent time kneeling on the floor in front of people, so they could engage with them at eye level. When a person became upset, they took time to reassure them and gently encouraged them to accept help and support.

Staff did not rush people when providing care. When people wished to self-mobilise around the home, staff encouraged them to travel slowly and at the own pace. When using equipment to support people to move, staff checked people were ready to move and made sure they were comfortable throughout the process.

People's privacy was protected by staff knocking and waiting for a response before entering people's rooms.

When personal care was provided they ensured doors were closed and curtains pulled. A representative of a faith group told us they were given a private room when they visited to conduct a religious service with a person. People who were able to express a preference for a male or female staff member to support them with personal care had done so. One person said, "I prefer a girl to help me and they always do." Another person told us they also preferred female staff when receiving personal care and confirmed that their preference was always met. However, people's preferences were not recorded in their care plans, so there was a risk this would not be followed consistently by all staff. Confidential information, such as care records, was kept securely and only accessed by staff authorised to view it.

When people moved to the home, they (and their families where appropriate) were involved in assessing and planning the care and support they received. One person told us, "We've talked about the care plan and discussed my needs." Another person said of the staff, "They talk about how I'm looked after and listen to what I say." People and their families were not usually involved in routine reviews of their care, although the manager told us they were exploring ways to do this in the future. Family members told us they were kept up to date with any changes to the health of their relatives. One had been involved in discussing arrangements for end of life care for their relative, to help make sure their wishes were met when the time arrived.

Requires Improvement

# Is the service responsive?

## Our findings

At our last inspection we identified that people were not always able to bathe or shower as often as they wished. At this inspection we found action had recently been taken and staff were in the process of introducing more flexible bathing arrangements for people.

A staff member told us they had spoken with each person to identify how often they wished to be supported to bathe or shower and staff duties had been changed to make more staff available to support this. The manager told us the intention was for people to be able to bathe as often as they wished and for people to be able to have a bath or a shower on any day. They said, "The policy [from this week] is that they can have them if they want them, whereas before it was refused."

One person told us, "I have two showers a week now. It's good; it brightens you up." Another person said, "I have baths when I want, but I feel safer just having a wash." However, not all staff were aware of these changes. A staff member told us, "All I know is that [a person] has a bath on a Tuesday as I do her; and [another person] is on a Monday. I don't know about anyone else." Some staff said the previous bath rota was still in place, although they were unable to find it. Other staff knew they were changing to a new bath rota, based on people's wishes, although none was clear about the new practice of supporting people to bathe when they wished. It was clear that more time was needed for the changes to become embedded in practice.

Activity provision had improved since our last inspection. An activity planner was used to advertise activities; it was displayed prominently in the dining room and was supported by pictures of each activity to help people understand them. People's interests and activity preferences had been recorded in their care plans and records were kept of activities people had engaged in. An activity area had also been created at one end of the lounge.

However, people had mixed views about activity provision. Comments from people included: "You get bored at times, but that goes with the territory. We had a trip out last week, and there's another next week. We have exercises in the afternoon and games like Ludo which is good"; "You're just left to yourself to do what you want to do"; "They have occasional [activities], but we just organise our own entertainment"; and "The social life is good; we all get on. I do a bit of knitting."

The manager told us that activities were planned on a Sunday for the week ahead. People were involved in the planning and staff used picture cards to help people choose the activities they preferred. Staff told us one of them was always deployed to run activities in the evenings and these included "board games, quizzes and music." Another staff member told us the new staffing arrangements meant they had more time to spend with people in the evenings when they "often play board games". They said, the games "helped bring people together into groups".

We found the activities were not always meaningful and the frequency was variable. The report of a recent visit by Healthwatch described activity provision as "sporadic". Records of activities people had engaged in

showed "watching television" and "hairdresser" were the most common activities; other activities included: "sat in lounge"; "in room"; and "reading"

On the first inspection day we observed an "animal" activity in the morning consisted of a few people looking at pictures of animals and talking about them. In the afternoon, an exercise activity was run by a staff member, which consisted of a ball being thrown to people. The activity only lasted a few minutes, but people appeared to enjoy it. We saw one person had been given a board containing locks and catches that they could interact with. Staff did not check that they wanted to interact with it, and after the person had ignored it for some time it was eventually taken away. On the second inspection day a volunteer played a keyboard in the lounge, which some people appeared to enjoy.

People said they received personalised care from staff who understood and met their needs. One person told us "I get all the help I need, like washing and dressing." A visiting friend said, "They encourage [my friend] to keep moving so she doesn't seize up." When we spoke with staff, they demonstrated a good awareness of people's individual support needs and how they preferred to receive care and support. For example, they knew what support people needed to dress; what medicines people were taking, why they were taking them and how they liked to receive them; they understood people's individual dietary needs and where people liked to eat their meals; they recognised when people's behaviour changed, for example if they became abnormally confused.

Staff responded promptly and appropriately to people's changing needs. For example, one person's anxiety levels had increased and the person had become very restless. Staff liaised with mental health specialists and the person's GP. The GP advised contacting the Memory Service for advice, which the manager did. We saw staff followed guidance in the person's care plan when they became agitated, which helped keep the person to become calm. When another person developed a viral infection that caused acute pain, staff contacted the person's GP for additional pain relief, which was prescribed, and later called the out-of-hours doctor service for advice when the person's pain became worse. When a person appeared unusually confused, staff contacted the person's GP and arranged for them to be tested for signs of infection. Staff had recognised that they were not able to meet the needs of a person with particularly complex needs and were working with health and social care professionals to find a more suitable home for the person.

However, care plans did not always support the delivery of individualised care. The manager told us they had spent time updating all the care plans to reflect people's current needs. Care plans were clear about the help people needed with personal care and how staff should support them, although other aspects of people's care were not always up to date. For example, one person's care plan said they needed the support of staff to mobilise, although the manager said this was no longer the case and the person used a stick. The mobility assessment for another person showed they needed the support of two staff members to walk, but they were able to mobilise with a walking frame and the support of one staff member. One person was being cared for in bed and needed full support from staff to eat, but this was not reflected in their nutritional assessment.

Staff recorded the routine care and support they provided to people using a 'tick-box' system for each day. Where any additional support was provided, this was recorded on separate pages. Records we viewed showed these were not always fully completed, including for some whole days where no care and support had been recorded as given to some people. For example, the records showed two people had not had a shower for over 10 days, although the manager said she was "100 per cent sure" they had both had showers that week.

Two people had diet-controlled diabetes. Staff had been advised by the specialist nurse that they did not

need to conduct regular blood sugar tests for these people. However, staff had decided to continue to complete the tests on a weekly basis. The results were kept in a diary in order to monitor the person's readings; however, when the readings strayed outside the normal range, staff did not take any action. The tests, which involved a finger prick with a sharp needle, caused minor discomfort and people were being subjected to these unnecessarily.

The providers sought and acted on feedback from people, including through the use of 'relatives and residents meetings'. One person told us, "We have meetings sometimes and everyone goes. We talk about food and menus." The manager and the cook gave examples of how the menu had been changed in response to people's feedback. During a meeting in September 2015, the providers had sought people's views about improvements that could be made to the environment and some of their ideas were being taken forward; for example, the provision of more pictures hung at appropriate heights in people's rooms. The providers also sought people's views through the use of questionnaire surveys. The latest survey had recently been completed and the manager described how the results would be analysed to identify improvements that could be made.

People knew how to complain and there was a suitable complaints procedure in place, which was included in the 'residents' handbook' which was given to people and their families when they moved to the home. Records showed no complaints had been received in the past year.

Inadequate

# Is the service well-led?

## Our findings

At the last inspection we identified that health and safety risks had not always been managed effectively; actions required from the previous inspection had not been completed; and quality assurance systems were not always effective. At this inspection we found some of the required actions had been completed, but others remained outstanding and the provider had not acted on all the feedback included within the CQC inspection report.

After the last inspection, the previous registered manager sent us an action plan, in November 2015, detailing how they would become compliant with the regulations by 13 November 2015. We found the action plan had not been implemented fully and continuing breaches of the regulations were identified. For example, the action plan said the registered manager had developed best interests forms in consultation with family members, doctors and other professionals, but we found these had not been completed for all the people who needed them. They said they would look into improving the signage in corridors and on people's doors, but this had not been completed.

Following the last inspection, we issued warning notices requiring the providers to make improvements to medicines management; infection control arrangements; and staffing arrangements. These warning notices had been met. However, another warning notice, requiring the providers to make improvements to safety systems and quality assurance arrangements, had not been met fully and quality assurance systems were still not effective.

The providers' quality assurance system was limited to audits of medicines and infection control, and regular reviews of care plans. The system was not adequate to ensure all fundamental standards of safety and quality were met effectively. For example, the medicines audit had not identified that action was not taken when fridge temperatures fell below a safe limit or that the providers' policy was not up to date. Care plan reviews had not identified that measures needed to reduce the risk of people falling had not been documented.

There was no system in place to check that all incidents of abuse were reported to the safeguarding authority; we identified that they were not. There was no system in place to check that pressure relieving mattresses were kept at the right setting; we identified that none were at the right setting. There was no system in place to check that appropriate recruitment procedures were being followed; we identified that essential checks were not being completed. There was no system in place to check staff understood and were following the MCA; we identified that they were not. There was no system in place to check that staff were complying with conditions applied to DoLS; we identified that they were not. There was no system in place to monitor staff training or check staff were suitably trained; we identified staff were not suitably trained and their training had lapsed.

The failure to operate effective systems to assess, monitor and improve the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Providers are required by law to notify CQC of significant events that occur in care homes. This allows CQC to monitor occurrences and prioritise our regulatory work. Whilst most significant events had been notified to CQC, we identified three incidents which had not been notified as required. These related to incidents where one person had physically abused three other people living at the home. We raised this with the manager who acknowledged that these notifications should have been made, but could not explain why they had not been.

The failure to notify CQC of incidents of abuse was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

Management arrangements were not robust. The manager was new to the role and was going through the process of registering with CQC. They had achieved a level four qualification in health and social care in 2011, but had not had any additional management training. They told us all of their essential training was "out of date". The manager said, "[The providers] are good. I tell them what I want and they do it." However, they said their management work had been hindered as they had had to cover care duties as well as management duties since their appointment three weeks previously, which they said was "not good". They told us the need for this would reduce in future as they had just recruited two additional care staff members. The providers visited the home on a daily basis, but had not updated their training or knowledge of current best practice guidance in the care of older people, including those living with dementia. Therefore, they were not in a position to support the manager effectively.

The manager had identified some improvements that were needed and were creating a development plan to implement them. This included improvements in organisation of staff training; care planning; the environment; and the introduction of key workers. A key worker is a member of staff who is responsible for working with that individual and taking responsibility for making sure their needs are met.

People said they liked living at the home and felt it was well-led. One person said the home was "well run and organised". A visiting friend of a person told us "Everything is always tidy and well organised; there's never anything out of place. I wouldn't mind living here myself."

With the exception of notifications to CQC, we found the service was open and transparent. The previous inspection report was available in the entrance hall and the providers had discussed it with residents and relatives. A report by Healthwatch had been made available for people and their relatives to read. There was a duty of candour policy in place and the manager gave examples of how they had followed this appropriately. Communication between management and staff was relaxed; the manager had an open door policy and encouraged people and staff to discuss concerns. Relatives could visit at any time and were made welcome. Links had been developed with the community through families, friends and volunteers.

Staff described the manager and the providers as "supportive" and "approachable". One staff member said, "We see [the providers] and get very good support from them. If [the manager] notices a problem, she gets on and fixes it. If I needed to I could phone her at three in the morning; she's a very, very supportive manager." Another staff member said they had approached one of the providers with concerns and they had been "resolved" quickly.

Staff were clear about the providers' vision to create a "home from home" environment for people. One staff member said, "I like it here because the environment is homely; it's not an institution. We've got good relationships with the clients."

People benefitted from staff who were motivated, understood their roles and worked well as a team. One

person said of the staff, "They don't argue with each other; they get on well." Staff meetings were held to promote team working and seek views as to how improvements could be made. Staff were positive about the meetings and said they "help keep you up to date [with changes]".