

New Forest Quaker Care Home Limited

Quaker House

Inspection report

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20 October 2017

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Ratings

Overall rating for this service	Requires Improvement 
Is the service safe?	Requires Improvement 
Is the service effective?	Requires Improvement 
Is the service caring?	Good 
Is the service responsive?	Requires Improvement 
Is the service well-led?	Requires Improvement 

Summary of findings

Overall summary

Quaker House offers accommodation for up to 40 older people. We carried out an unannounced inspection on 17, 19 & 20 October 2017. Thirty-one people were living in the home at the time of the inspection.

At our inspection in October 2016 we identified the provider was not meeting three regulations. Risk assessments were not always completed and regularly reviewed and actions were not taken to mitigate risks. Staff had not always followed safeguarding guidance to ensure people were protected from abuse or harm. Records in respect of people living at the home were not always accurate and up to date and the provider had not maintained appropriate oversight of the service. At this inspection we found that there was still some work to do to ensure risks to people were safely managed and the effectiveness of record keeping, which was sometimes out of date and did not reflect people's current needs. We also found three new breaches of Regulations relating to people's nutritional needs, the need for consent and person centred care.

The home had been through three management changes since our last inspection. At our inspection in October 2017 we found a new interim manager was in post until a new registered manager could be appointed. An advertisement went out for a registered manager the week after our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the home. 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 home is run.

Initial assessments were carried out before people moved into Quaker House to ensure their needs could be met. Care plans were not always up to date and did not always reflect their current care needs.

Individual risks relating to people's health, safety and welfare had not always been completed or adequately reviewed to identify, assess and reduce those risks.

Although staff received training to administer medicines and were assessed for competency, people had not always received their medicines at the correct time, and in some cases, they had not received their medicines at all. The interim manager had requested to the Board of Trustees to change the medicines management system.

People were not always supported to eat an appropriate diet that met their assessed nutritional needs and people's food preferences were not always supported.

Not all staff understood and followed the principles of the Mental Capacity Act 2005 designed to protect people's rights and ensure decisions were made in their best interests.

Most people told us there was not enough to keep them occupied and they were often bored. Staff confirmed they were often too busy providing care and did not have time to provide regular social or physical activities. There were sufficient staff deployed to meet people's care and support needs.

People and relatives told us they felt the home was safe. Staff understood how to identify abuse and explained the action they would take if they identified any concerns. However, not all staff knew how to report concerns to external agencies such as the Care Quality Commission.

Some recruitment checks required improvement to ensure that only suitable staff were employed.

Staff had not all received appropriate supervision, appraisal and training in line with the provider's policy although actions had been taken to address this.

The manager had a good understanding of their responsibilities in relation to meeting the Health and Social Care Act 2008 regulations. They had notified us appropriately of events required by law.

Systems were in place to monitor and assess the quality and safety within the home although this was a work in progress and recent action plans had not yet been implemented.

Incidents and accidents had been investigated and learning shared with staff.

People were supported to maintain their health and well-being and had access to a range of healthcare services when they needed them.

Staff interacted with people with kindness and care. Staff treated people with dignity and respect and ensured their privacy and independence was promoted.

Friends and family were able to visit their loved ones at any time and felt welcomed by staff.

Residents meetings took place and enabled people to share their views about the service. People and relatives knew how to raise concerns and would do so if they needed to.

Staff felt supported by the interim manager who provided clear leadership and direction. Staff felt able to raise any issues or concerns with them and felt listened to and involved.

We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Whilst the management of some risks associated with people's care had improved, individual risks to people's safety and welfare had not always been assessed appropriately. People did not always receive their medicine on time or at all.

Recruitment practices and safeguarding procedures were in place although these required some improvement to ensure people were fully protected from abuse and harm.

There were sufficient staff deployed to meet people's care and support needs. Fire safety checks were carried out and equipment was regularly serviced and maintained. The home was clean and tidy and staff were aware of infection prevention and control procedures.

Requires Improvement ●

Is the service effective?

The service was not always effective.

People were not always supported to eat in a way that met their specific dietary needs and food preferences.

People's rights were not always protected because staff had not always sought consent when required, or acted in accordance with the MCA 2005 and DoLS.

Not all staff had received regular supervision, appraisal and training to support them in their roles although this was in hand.

People had access to health professionals and other specialists when needed.

Requires Improvement ●

Is the service caring?

The service was caring.

Staff knew people well and there was a good rapport between them and the people they supported. Staff were kind, caring and

Good ●

compassionate and reassured people when they were upset or worried.

Staff treated people with dignity and respected their privacy. Family and friends were made welcome and could visit at any time.

People were encouraged to make choices and maintain their independence.

Is the service responsive?

The service was not always responsive.

Care plans did not always reflect people's current needs and it was not always clear how people and their relatives had been involved in reviews of the care.

There was a lack of meaningful activity and entertainment for people to enjoy and people told us they were bored.

People had opportunities to share their views about the way the home was run. Complaints were appropriately recorded and investigated. People were confident if they had any complaints or concerns these would be listened to and addressed.

Requires Improvement ●

Is the service well-led?

The service was not always well-led.

Care planning systems had not improved and some records remained out of date and not reflective of people's current needs. Monitoring of the quality and safety of the service had improved significantly since our previous inspection although there was still work to do.

Staff felt well supported by the interim manager who was approachable and provided clear leadership and direction.

People, their families and staff had opportunities to feedback their views about the home and quality of the service being provided.

Requires Improvement ●

Quaker House

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 checked whether the provider is 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. We had received some concerns about people's care and wellbeing and needed to check to ensure people were receiving the care they required. We also needed to check the provider had made improvements they told us they would make following our inspection in October 2016.

The inspection was unannounced and was carried out by a lead inspector on 17, 19 and 20 October 2017. The lead inspector was accompanied by a second inspector on 17 and 20 October 2017.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and all of the information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. We also reviewed the action plan the provider sent us following our previous inspection.

We spoke with five people who lived at the service and one visitor. We spoke with four care staff, the maintenance staff, house keeper, team leader and the interim manager. We observed people being cared for and supported at various times in communal areas during our visit. Following the inspection we also received feedback about the service from a community healthcare professional. We also spoke to the Chair of the Board of Trustees and a representative from the external organisation who had been supporting the service with improvements.

We looked at a range of documents including four people's care records, five people's medicine administration records (MARs), and six staff recruitment, supervision and training records. We also looked at

other records related to the running of the home, such as complaints, incidents, accidents and quality assurance records.

The home was last inspected in October 2016 where we found three breaches of Regulations.

Our findings

People and their visitors told us they felt safe living at Quaker House. One person told us "About 7am and at bedtime, about 9pm, they [staff] come in and check all the bells to check they're working. When I fell out of bed they came really quickly. Once I had a false alarm and three of them rushed in! It was pretty good." Another person told us, "I feel safe here. I have a buzzer around my neck. I press it if I need them [staff]. They come quickly."

At our previous inspection we found the provider was in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014; Safe care and treatment. The provider had failed to adequately identify and assess risks to people's safety and wellbeing. At this inspection we found the management of some risks had improved however, action had not been taken to address all of the issues raised at our previous inspection. For example, risk assessments for people who used the stairs had not been completed. One person had a risk assessment for bedrails, although this did not provide guidance on how to manage the risks associated with the use of bedrails. For another person staff had noted they had passed black stools on two occasions. This could have indicated the person had a health condition which required investigation. This had not been reported to the interim manager and no action had been taken to request medical advice or attention.

A healthcare professional told us they had supported the previous registered manager to implement a system to investigate, assess and monitor falls. However, they had not embedded this practice within the home. In April 2017, one person's care records showed they had had a fall and complained of neck pain to staff when they found them on the floor. Staff had assisted the person to get up from the floor without first obtaining medical advice or attendance which could have resulted in further injury to the person. There was no incident or accident form to record this had happened. The interim manager had implemented a new falls procedure and post falls observation in September 2017; however, we noted another person, who had banged their head during a fall, had not been monitored in line with the post falls observation protocol to ensure their welfare. For a third person who had fallen twice in October 2017, their falls risk assessment had not been reviewed following these falls.

Failure to identify and assess risks to people's safety and wellbeing is a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safe care and treatment.

Systems were in place to manage and administer medicines, however, these were not always followed by staff. The provider had implemented an electronic medicines management system which included a

number of safety features to reduce the likelihood of medicines errors. For example, colour codes enabled staff to check if medicines were due, overdue or if it was too soon to give them. However, we noted that some people had still not received their medicines at the correct time and incident reports showed five people had not been given their medicines at all on one morning in October 2017.

Failure to ensure people received their medicines as prescribed is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Safe care and treatment.

Where people wanted to manage and administer their own medicines, risk assessments had been completed and these were regularly reviewed. People received their medicines from staff who were appropriately trained and regularly re-assessed for their competency. Each person had an e-MAR (electronic medicine administration record) which staff completed when their medicine had been given.

There were systems in place for the ordering; storage and disposal of medicines, including Controlled Drugs (CDs). CDs are specific medicines which are managed under the Misuse of Drugs Act 1971. A spot check of CDs showed these were current, in date and the amount of stock corresponded with the CD register which two staff had signed when medicines had been given. Medicine stocks were managed through the electronic system and were ordered in a timely way. Stocks were well controlled to ensure no excess medicines built up. We noted that electronic medicines audits identified numerous issues with missing medicines. This was due to the way the system provided the information and did not give an accurate overview which was unhelpful to staff. We saw that since September 2017 staff had completed manual audits of medicines which showed there were no issues. Medicines, including CDs, were appropriately stored. Daily temperature checks ensured medicines were stored in line with manufacturer's instructions and remained effective and safe to use. Spoilt or unwanted medicines were recorded and stored safely until they could be returned to the pharmacy.

At our previous inspection we found that the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014; Safeguarding service users from abuse and improper treatment. At this inspection, we found that some improvements had been made although there was still work to do to embed this practice in the home. The previous registered manager had sought advice and guidance from the local authority safeguarding lead officer on how to escalate concerns. Safeguarding concerns had been reported to the local authority and the Care Quality Commission as required. The home's safeguarding policy had been reviewed and updated in October 2017. This policy included contact details and guidance for staff on how to report concerns to outside agencies such as CQC. Staff understood how to identify different types of abuse and how to protect people from abuse. Staff we spoke with were aware of how to report concerns to their manager or senior staff however, not all staff were aware of how to report concerns to external agencies if they needed to. Safeguarding training had been completed by most staff during 2015 and 2016 although some refresher training was now overdue.

At our previous inspection we noted that not all staff had provided a full employment history as required by Schedule 3 of the Health and Social Care Act 2008. This recruitment practice still required improvement as at this inspection we noted that not all staff had provided this information and it had not been sought by the provider. The interim manager said they would address this within the application form process in future. All other requirements had been met. For example, proof of identification, satisfactory references and Disclosure and Barring Service (DBS) checks were in place for staff. DBS checks help employers to make safer recruitment decisions. Whilst initial DBS checks were in place, the interim manager told us they wanted to put a schedule in place for staff to re-apply for a new check as some were now very old.

There were sufficient staff deployed to meet people's needs and keep them safe. We observed staff had time

to sit and chat with people and responded to their requests for support in a timely way. For example, when they rang their call bells or needed the toilet. Most staff told us there were usually enough staff on duty and the interim manager helped to cover shifts if needed. Agency staff were employed to help cover shifts when required. One staff member told us, "There are always four or five staff on duty. We work as a team, everything is fine." Three waking night staff were on shift each night. The home also employed a day time chef, a tea time chef, a kitchen assistant, a housekeeping team, a receptionist and a maintenance person. The interim manager told us they had reviewed staffing and were in the process of increasing the care team to include two senior staff members on each shift alongside four care staff and the team leader. They would also include a senior staff member on each night shift. We reviewed the rotas for October and saw that most of the time the staffing was in line with what we had been told.

Regular servicing and maintenance of equipment and fire systems was completed by external contractors. A log book of on-going internal checks was completed, for example; alarm tests, fire-fighting equipment and emergency lighting. However, we noted there had been a period of time during 2017, while maintenance staff were off sick that this had not been allocated to other staff to continue. Other checks, such as flushing water outlets had been completed by housekeeping staff during this time. We spoke with the maintenance staff who had returned to work and confirmed with us that they had resumed all of these checks.

The home was clean and tidy and we saw that staff used personal protective equipment (PPE) when required to minimise the risk of cross infection. The housekeeper showed us their schedule of daily room checks and cleaning and the periodic deep cleaning which helped them to maintain a high standard of cleanliness in the home.



Our findings

We received mixed feedback from people about the quality and choice of food offered to them at Quaker House. One person said the food was lovely and they looked forward to their meals. However, other people we spoke with said they thought meals could be better. One person said, "It's the same vegetables and they are overcooked. I'm beginning to think they've stopped growing other vegetables." Another person said, "It [the food] does get a bit boring."

People were not always supported to have a choice of foods which met their dietary needs. People were asked by staff in the morning for their meal choice from the menu. A staff member had offered a person, who did not eat meat, the choice of vegetable cottage pie or sweet and sour chicken. The person asked if the vegetable cottage pie had meat in it. There was a confused conversation as the staff member did not understand what the person was asking and again gave them both options to choose from. Our inspector had to intervene to clarify with the person that the cottage pie was the vegetarian option which they then chose. Another person had been assessed as being at risk of malnutrition in May 2017 and had been put on a high protein diet by their GP. Staff told us they understood how the person's diet could be fortified, such as adding cream in their mashed potatoes and custard, or topping their jacket potatoes with beans and extra cheese. However, they told us the person had not received such a diet. We noted in the person's food charts throughout May and June 2017 that their food intake did not demonstrate they had received a high protein diet or a sufficient quantity of food for a person who was losing weight. For example, records on 29 May recorded the person had eaten porridge and toast at breakfast with no other recorded food intake for the day. On 3 June they had eaten porridge, bread and butter and marmalade for breakfast, cake and tea but no other recorded intake for the day.

Staff told us that people did not always have their food preferences met. For example, they said where people had requested eggs on toast for breakfast instead of cereal or porridge, or an omelette for lunch instead of the menu choice, a chef had said they could not do this. Several people told us they would like more variety of vegetables and a change in the menus as they had become too routine. We saw a food questionnaire which had been given to people by the previous registered manager for their views about the food. This had been responded to by a chef. However, we found some of their responses were dismissive, unhelpful and not person centred. Whilst the interim manager told us they had spoken with the chef, who had requested additional help in the kitchen, we found the lack of responsiveness to people's requests did not support people's choices and preferences.

Failure to provide appropriate nutrition for people's dietary needs and adequate choice to meet people's

preferences is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Meeting nutritional and hydration needs.

The dining room was pleasant and nicely laid out although a little cramped in places, however staff assisted when there were difficulties. For example, one person who used a wheelchair had tried to get through to their place setting. We observed a member of housekeeping staff say, "I don't think you'll get through there my sweet. I think you'll need to walk with a carer," and went to get a member of staff to help. Tables were laid with linen table cloths and napkins in holders. People told us they had enough to eat and we observed that staff offered second helpings of the lunch meal. People received appropriate support from staff, such as cutting up their food, with consent, or having a plate guard fitted to prevent food from spilling over the edge of their plate.

A health professional had recently supported the previous registered manager to implement the 'Hydrate project' which provided training to staff in how to ensure people remained hydrated. They told us however, that the previous registered manager had not provided the feedback they had requested about people's hydration needs, so they were unable to assess if these needs were being met. We saw during our inspection that staff regularly offered drinks to people and there were jugs of water and squash available in communal rooms and people's bedrooms. One member of staff told us, "There is always water in their rooms and jugs in the lounge and water on the table [at lunchtime]. They [people] can drink when they want. There are drinks at all times, tea and coffee."

People told us staff asked for their consent before providing any care or support. One person said "Oh yes, they always ask first." We observed staff asking people for consent. For example, "Have you finished. Can I take it?" before removing their empty plates at lunchtime.

Although people told us, and we observed, that staff asked for consent for day to day decisions, staff had not always acted in accordance with The Mental Capacity Act 2005 (MCA) when more complex decisions were needed. The Act 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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We had identified at our last inspection that staff had not fully understood their responsibilities around the Act. At this inspection we found where people lacked the mental capacity to make decisions this had not always been appropriately assessed and recorded. One person's records suggested they had capacity to make more complex decisions. However, they had a 'Do not attempt cardio pulmonary resuscitation' (DNACPR) form in their care file which had been completed by their GP. This stated they did not have the capacity to consent to the decision. Staff also told us they thought the person did have capacity but had not sought clarification from the GP. The manager told us the GP had carried out reviews of several people's DNACPR forms and they would seek a review of this person's DNACPR form as well. We spoke with another person who told us they did not want bedrails so we arranged for the manager to speak with them. When the person told the manager they did not want bedrails, the manager showed the person how they could lower the bedrails and the person agreed for them to be left like that. The manager understood the person had capacity to make the decision and said they would review their risk assessment and care plan to reflect this. They had identified the Local Authority's MCA toolkit as the preferred system to follow when assessing people's capacity and this would be implemented in the home. They had also identified that MCA training was required for all staff although this was yet to be booked.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their

best interests and legally authorised under the MCA. The application procedure for this in care homes is called the Deprivation of Liberty Safeguards (DoLS). We had identified concerns in relation to the staff team's understanding of DoLS at our previous inspection and found on-going issues at this inspection. The previous registered manager had submitted a DoLS application to the local authority for one person for authorisation to use bedrails. This had been refused by the local authority as the person had been deemed to have capacity. However, there was still a DoLS care plan in place for the person explaining the necessity to use bedrails. There was no mention that the application had been refused and the person had capacity make the decision for themselves.

Failure to act with consent of the relevant person is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Need for consent.

Staff had completed a range of training including; first aid, fire safety, moving and handling, and infection control which they were required to complete every three years. Some staff had completed training more frequently. A senior staff member told us the interim manager was in the process of reviewing the training provided and was sourcing new suppliers of training and we saw minutes of a staff meeting in September 2017 which confirmed this and informed staff, "You will be notified of training dates as they are arranged." Staff told us they had opportunities for further development and one senior staff member said "I had started level four [of a nationally recognised qualification in health and social care] and now moved up to level five." New staff completed an induction which included working alongside experienced staff as well as completing the Care Certificate, where required. The Care Certificate is a nationally recognised set of induction standards which staff working in health and social must adhere to.

Staff had not received regular supervision and appraisal in line with the provider's policy. The interim manager explained this had not been happening and they had a schedule in place to bring everyone up to date. They told us they would complete each staff members first supervision, then department heads would continue these for their own staff, for example the head housekeeper would supervise their housekeeping staff and the daytime chef would supervise the kitchen staff. The interim manager told us all appraisals would be completed by the end of December.

Staff were proactive in requesting visits or reviews from health professionals, such as GP's or district nurses, when they had concerns. People told us that staff sought advice from health professionals to help them maintain their health and wellbeing. One person told us "I was in pain with my arthritis. They sent for a doctor." They went on to tell us they had followed up treatment for the condition. They also told us they had used a physiotherapist in the past and could do so again in future if needed. Details of contact with health professionals were recorded and we noted, for example, that one person had received an assessment from an occupational therapist and a visit from their GP who had prescribed antibiotics for an infection. Actions and recommendations had been carried through and recorded. People had access to a range of preventative health care, such as opticians, dentists and chiropodists to maintain their health and wellbeing.

Our findings

People and visitors told us the staff at Quaker House looked after them well. One person told us, "They're very kind and caring. Every one of them." Another person said, "The staff are really helpful. I like it here." A visitor told us, "[Staff member] is lovely. She'd do anything for you. They're all an extended family here. You don't have to ask for anything more than once."

The atmosphere in the home was calm and relaxed. People seemed happy and we observed laughter and banter between them and the staff who supported them. Staff had a good knowledge of the people they supported, such as their life histories and interests. Although busy, most staff found time to sit with people throughout the day and chatted with them about things that were important to them and listened to what they had to say with interest. One staff member told us, "They are entitled to my time. I can make them laugh. I have a good relationship with them. Another staff member told us, "I'm happy here. It's relaxed here. It's like a family."

Communal areas were comfortable and homely with pretty décor, co-ordinated furniture and soft furnishings to match. Flowers were placed around the communal areas in vases and pictures decorated the walls. One person had just celebrated their 100th birthday with a party at the home which the Mayor had also attended. Flowers and cards were still evident to remind everyone of the occasion.

Staff were caring, compassionate and thoughtful and provided re-assurance to people if they were upset, unwell or had a worry about something. For example, maintenance staff were helpful and sympathetic when one person said they could no longer reach the hanging rail in their wardrobe due to their arthritis. The person told us they had not mentioned this before as they didn't want to make a fuss. The maintenance staff were prompt to address this and said it was very simple to make the adjustment needed and that it was no trouble.

Staff respected people's privacy when providing care. For example, they knocked on people's doors and waited for a response before entering their rooms. One person told us, "They always knock on my door. They respect my privacy." People's rooms were personalised with their own photographs, pictures and other personal belongings that were familiar to them.

People were supported by staff to maintain their dignity and self-esteem. We observed people were clean and well dressed and if they wished to do so, wore make up, jewellery and other accessories. Staff respected people's dignity in the way they spoke with them and used people's preferred names where appropriate.

One staff member told us they always tried to be, "Polite and friendly. They're like my grandma or my mum, a member of my family."

Staff encouraged people to retain their independence as much as possible. Staff understood that people's ability to care for themselves could fluctuate and told us they would adapt the level of support as necessary. Some people were very independent and could make choices for themselves. One person regularly went out for a walk to buy a newspaper or meet up with their relative. They also sometimes bought a ready meal for their lunch from the local shop and heated it up themselves in the communal kitchenette. They told us, "I had a beef dinner today and ate it in my room in front of the TV." Another person went out in their buggy to get the local paper. They told us, "I thought I'd make the most of the sunshine."

People were encouraged by staff to maintain important relationships with their relatives and friends. There were no restrictions on visiting times and we observed visitors coming and going freely. It was clear that staff knew people's relatives well and greeted them warmly when they came to visit. Relatives were able to join their family member for lunch which was confirmed by one person who told us, "My son visits me and drops in my paper. They [visitors] can even stop and have meals here." We saw one relative had joined their family member for lunch. It was a social event and everyone around the table was chatting with each other.

People had the freedom to entertain their visitors in their rooms if they wished and there were other private, quiet areas, such as the garden room or upstairs lounge, where people could sit and chat with visitors. One person said, "There's a little sitting room with a fridge and microwave. You can close the door, make tea and coffee. There's also the garden room. I often sit in there. If you have friends visiting you can close the door."



Our findings

At our previous inspection people told us that activities provision could have been improved. We found at this inspection that improvements were still needed to ensure people had meaningful activity and interaction. Most people told us they wanted more to do to keep them occupied. One person said, "Activities have gone flat. We help each other. We get bored otherwise." People commented that staff used to organise a movie afternoon on Fridays with popcorn, crisps and sherry but told us it didn't happen now. One person had now taken on the responsibility for arranging a film for everyone to watch and people told us that without this person they wouldn't have their film to look forward to. People told us that when entertainers did come to the home, such as a harpist and a keyboard player, they enjoyed it. One person told us, "Whatever you want, they know it and will rattle it off." They went on to say, "I don't usually sit in the lounge. It's demoralising doing nothing." Another person told us, "It's a long afternoon with nothing doing. There's sometimes things going on but not today."

Staff told us they did not have an activity co-ordinator at present and they did not always have time to organise activities although we noted that some staff had time to sit with people and engage them in board games which they seemed to enjoy. One staff member said, "We need to be more proactive. I hate walking in to the lounge when people are all asleep." Another staff member told us they were a qualified instructor in a specific type of exercise which was suitable for older people who could take part whilst sitting down and they were going to start this at the home in the near future. A recent staff survey confirmed that staff felt they could provide a better service if they had more time to spend interacting socially with the residents.

Failure to provide adequate opportunities for people's social needs to be met is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Person-centred care.

At our previous inspection we found that people's care records were not always detailed and up to date. At this inspection we found that improvement had not been made and have written more about this in the well led section of this report. Initial assessments had been completed before people came to live at Quaker House, either permanently or for a respite period, which enabled staff to determine if the home could meet their needs. Care plans had been developed from these assessments to provide guidance for staff in how to meet, for example, people's mobility and personal care needs. They also included things that were important to people, such as their life histories, hobbies, likes and dislikes, preferences and choices. However, although care plans were reviewed regularly, they did not always include sufficient information about any changes to people's support needs and it was unclear how people and/or their relatives had been involved in this.

Although care plans did not always reflect people's current needs, we observed that most staff had a good understanding of people's support needs and preferences. Staff attended a handover meeting at each shift change and a written record was maintained which included details, for example, of people's level of independence, their risk of falls or choking, their mobility, eyesight, and preference for male or female care staff. We noted that other information had not been included, such as preferred names and when people had an infection such as a urinary tract infection, which would have been useful for staff.

People were given opportunities to share their views about the way the home was run. Resident's meetings took place and minutes of the last meeting in August 2017 demonstrated that people felt able to raise issues that were important to them, such as activities, staffing and maintenance. We noted at a meeting in November 2016 three people were thanked for their involvement in the process of recruiting new staff. This was a valuable opportunity for people to be directly involved in decision making about who was employed to support them.

The home had a complaints procedure which was given to people and relatives when they first moved into the home. We noted that since the interim manager had been at the home any complaints or concerns had been logged and investigated appropriately. One complaint was in the process of being investigated so had not yet been responded to with an outcome. People we spoke with told us they had no complaints but would speak to the interim manager and felt confident they would be listened to and any concerns would be addressed.

Our findings

At our previous inspection in October 2016, we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Good Governance. The provider had failed to ensure they maintained sufficient oversight of the management of the home and had failed to retain accurate and up to date records in relation to the running of the home and people's care.

At this inspection we found ongoing concerns. People's care plans were not always detailed and did not always reflect their current needs. Monthly care plan evaluations often stated 'no changes' but this did not relate to the initial care plan, and people's current needs could not be easily identified without reading through several pages of reviews. We identified in some cases that there had been significant changes to people's needs, although these had not always been identified and recorded by staff. For example, one person had been identified as at risk of malnutrition and their GP had requested a high protein diet. However, their care plan did not say how or what staff should do to ensure this happened. Another person had a 'night care plan' but this made no mention of their bed rails which were in place and provided no guidance for staff in how to use them. A third person had a 'choking' risk assessment which identified a specific swallowing condition. This was not mentioned in their dietary care plan which stated the person "sometimes needs supervision with some foods" but did not provide further details for staff.

Failure to maintain accurate and complete records in respect of each service user is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Good governance.

The interim manager told us the home was not still compliant as care plans lacked detail, were inconsistently completed, and risk assessments and care plans were not compatible. They said they were in the process of reviewing the care planning systems and people's care plans as a priority. They said, "Care records are not as I would want them to be. They need to be person centred and in their rooms. I want all assessments and care plans done from scratch and want it all on the computer so we can update and date any changes. I want them [staff] to write up notes as they [people] are supported and not do it at the end of their shift." They also told us they were going to implement a hospital passport so that all important and relevant information could be passed to clinical staff if someone was admitted to hospital.

At the start of this inspection the interim manager was very open and honest with us and said that not much had changed since our previous inspection, although the external organisation had been brought in to support with identifying the improvements needed. They told us the Board of Trustees had been more involved and now had a better understanding of the extent of what needed to happen to ensure the

Regulations were met.

Since the previous inspection there had been three changes to the management of the home which had caused uncertainty and pressure on senior staff until the interim manager had been appointed in September 2017. A senior staff member had taken on the day to day responsibility of ensuring people received their care with the support of the staff team. One staff member told us, "She was the only person we could go to and talk. She did a very good job. She was thrown in at the deep end but kept calm." Minutes of a resident's meeting in August 2017 showed that people were also very appreciative of the senior staff member's efforts and commitment in providing some continuity during the time of change.

Since May 2017, the provider had employed the services of an external organisation to support with improvements in the home. The external organisation had also provided a mentor to support the senior staff member with the on-going day to day running of the home. They had carried out a series of audits to assess what improvements needed to be made within the home in relation to care delivery and governance systems. These included care plan audits and general health and safety such as fire safety, moving and handling, equipment safety, first aid, legionella and fire safety. This work was now almost complete. We spoke with two staff from the external organisation whose audit findings reflected the issues and concerns we found during this inspection. They told us the action plans from the audits were completed and now the Trustees needed to make some decisions and move the service forward.

We spoke with the Chair of the Board of Trustees who told us they had been "shocked" when they realised how little had been completed following our previous inspection. They had brought in the external organisation to support with the improvements and were confident in the action plans that had been produced. They told us the Board was committed to making the changes and had now recruited new board members with a background in care which they thought would help with their understanding of what was required.

Arrangements were in place which enabled the provider to maintain oversight of the service and this had improved significantly since our previous inspection. The Board of Trustees was supplied with a monthly report which summarised all aspects of care provided and governance. For example, safeguarding, risk, staffing, medicines management, infection control and complaints. We noted the interim manager had raised the medicines system, staff training and recruitment checks in their report. They had also requested an 'employee of the month' reward scheme to be considered "to recognise the hard work staff put in to looking after our residents."

At our previous inspection, we noted that incidents and accidents had not been appropriately recorded, investigated or analysed for any learning in order to reduce the likelihood of re-occurrence. Records showed this trend continued throughout 2017 with very few or no incidents recorded on the monthly log until September 2017 when the interim manager had put more robust systems in place. Since then the number of recorded incidents and accidents had increased significantly. This indicated these had not been recorded appropriately prior to this. The interim manager agreed this was the case. All new incidents and accidents had been investigated and actions taken to address any learning.

Systems were now in place to monitor and assess the quality of the service. A recent survey had taken place to obtain feedback from people and their relatives on the quality of care received and help drive improvement. The results of the 2017 survey were mostly positive although satisfaction with activities was low. A staff survey was undertaken in August 2017 and results showed most staff who had responded thought the service was average or good in key areas of care such as maximising people's independence and supporting them to make genuine choices.

Staff felt supported in their roles by the interim manager who was approachable and supportive and provided clear leadership and direction. One staff member told us "I think she [the interim manager] will be good". Another staff member said, "She wants the best for this care home. She's looking for small details, meticulous. She always says well done. I've never felt so valued and appreciated." Senior staff members told us, "There was [previously] no consistency. You got support one day but not the next. [The interim manager] is very knowledgeable. We can move forward now and do what we should be doing," and, "If [the interim manager] wasn't here we would be doomed. With the other managers, we didn't get the leadership."

Regular staff meetings took place which enabled staff to discuss ideas and issues in detail and agree any actions to take. Minutes of the most recent meeting in September 2017 demonstrated that the interim manager had shared their vision for the future of the home and how staff should be working together to achieve this. They also outlined their expectations of staff and their working practices. Staff told us they felt listened to and involved in developing the service and felt they could raise issues and would be listened to. One staff member told us, "I like [the interim manager]. She tells it like it is. I feel listened to. I can discuss anything. I hope she stays." Staff all had a good understanding of the vision and values of the home and were committed to providing a homely, safe and person centred place for people to live.

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	<p>Regulation 9 HSCA RA Regulations 2014 Person-centred care</p> <p>The provider had failed to ensure people's social needs were being met.</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 11 HSCA RA Regulations 2014 Need for consent</p> <p>The provider had failed to always act with the consent of the relevant person.</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 12 HSCA RA Regulations 2014 Safe care and treatment</p> <p>The provider had failed to ensure risks to people's safety and well being had always been identified and assessed. The provider had failed to ensure people always received their medicines as prescribed.</p>
Accommodation for persons who require nursing or personal care	<p>Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs</p> <p>The provider had failed to always ensure that</p>

people's dietary needs and personal preferences had been met.

Regulated activity

Accommodation for persons who require nursing or personal care

Regulation

Regulation 17 HSCA RA Regulations 2014 Good governance

The provider had failed to ensure that people's care records were always accurate and up to date.