# Quantum Care Limited

# Fourfields

## Inspection report

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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

The inspection took place on 25 January 2016 and was unannounced. When we last inspected on 28 May 2013 we found the service was meeting the required standards at that time.

Fourfields provides accommodation for up to 52 people with residential and dementia needs. It does not provide nursing care. Fourfields is separated across six separate bungalows with various communal areas spread across the home. At the time of this inspection there were 45 people living at Fourfields.

There was a manager in post who was in the process of submitting an application to register with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People and their relatives told us they felt safe living at Fourfields. Staff demonstrated an awareness of matters relating to safeguarding vulnerable adults from abuse. Risks identified in relation to people's mobility or risk of falls were identified and managed. People told us there were sufficient numbers of staff to support them; however our observations at lunchtime demonstrated staff were not effectively deployed to support people who required assistance with their meal. People were not always supported by staff who had been safely recruited. There were sufficient measures in place to ensure people received their medicines safely.

People were supported to eat a nutritious and healthy diet; however they were not always supported to eat independently in a calm and settled manner. People told us that staff knew how to support them and staff said they felt supported by the management and received adequate training and development. When making decisions about people's health needs who lacked capacity, staff did not always follow the appropriate guidance. People were supported by a range of healthcare professionals when needed.

People told us that the staff were caring, supportive and treated them with dignity whilst respecting their privacy. Staff knew people's individual's needs and preferences and people were involved in the day to day decisions about their care. Throughout the inspection we saw that staff assisted people in a dignified and unhurried manner. They approached people in a friendly and amiable manner that put people at ease.

There were arrangements for people to pursue interests and activities, however due to refurbishment works these were not always provided. People were not consistently provided with an opportunity to provide feedback about the quality of the service. People were confident to raise concerns or complaints with the manager and when they did these were responded to.

People and staff found the manager to be approachable and supportive. Systems were in place to monitor the quality of service that people received, however these were not operated effectively. Audits were carried

out by the provider, however auditing carried out by senior care staff did not identify gaps in people's care records.

## 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 consistently safe.

People were not always supported by staff who had been safely recruited.

People were not always supported at busy times by sufficient numbers of staff.

People were supported by staff who were able to identify, respond to and report any incidents of abuse.

Risks to peoples wellbeing were pro-actively assessed, responded to and reviewed.

People's medicines were managed safely.

### Is the service effective?

**Requires Improvement**

The service was not consistently responsive.

Staff had not ensured that decisions were always been made in peoples best interests when they lacked capacity.

People said they were happy with food provided, however the monitoring of people's nutritional needs was not effective.

People were supported to access a range of healthcare professionals when needed.

Staff told us they felt supported by the manager and had received appropriate training.

### Is the service caring?

**Good**

The service was caring.

People were treated in a friendly, sensitive and caring manner.

Staff were aware of people's individual needs and choices and responded accordingly.

People's dignity and privacy was maintained and people appeared well cared for.

## Is the service responsive?

**Requires Improvement**

The service was not consistently responsive.

People were not always to pursue individual hobbies, interests or be involved in communal activity.

Opportunities to provide feedback for people and relatives through meetings and discussion were not consistent across the home.

People or, where appropriate, those acting on their behalf, were able to contribute to the assessment and planning of their care.

People were encouraged to raise complaints and these were responded to.

## Is the service well-led?

**Requires Improvement**

The service was not consistently well led.

Systems were in place to monitor the quality of service that people received, however these were not operated effectively.

Audits were carried out by the provider, however auditing carried out by senior care staff did not identify gaps in people's care records.

People's views and opinions about Fourfields had been sought and provided an overwhelmingly positive view of the care they experienced.

People and staff found the manager to be approachable and supportive.

# Fourfields

**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 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.

This inspection took place on 25 January 2016 and was unannounced. The inspection was carried out by one inspector and a specialist advisor who was someone who had professional experience of caring for someone who uses this type of care service.

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 information we held about the service including statutory notifications that had been submitted. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we observed how staff support, we spoke with seven people who used the service, two relatives, eight care staff members, the cook, the home manager and a representative of the provider. We received feedback from a healthcare professional involved with the support of people who used the service and from a representative of the local authority social working team. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We reviewed care records relating to seven people who used the service and other documents central to people's health and well-being. These included staff training records, medication records and quality audits.

Requires Improvement

# Is the service safe?

## Our findings

People told us that they felt safe living at Fourfields, one person said, "It's lovely here, I have never had any cause to worry about me or anybody else." People's relatives equally told us they felt their relative was safely cared for. One person said, "I don't have to worry when I leave [person] I can enjoy visiting them and know they are safe when I go."

Staff we spoke with were aware of how to report any incidents or concerns. They told us they documented and recorded incidents or injuries in both the persons care records and also completed an incident report. They felt confident they could report incidents to management and they would be thoroughly investigated. Staff had received training to identify different types of abuse and information for external organisations to report any safeguarding concerns was prominently displayed for staff, people, and visitors to refer to. The provider routinely monitored all incidents and injuries reported by the manager to ensure they were managed robustly, and as part of the provider`s monthly visits, they checked to ensure all incidents, accidents, injuries and safeguarding's were recorded and followed up.

Staff proactively assessed the risks associated with all activities people were doing and ensured measures were taken to mitigate these risks where possible. For example people who were at risk of falls when mobilising independently were assessed for the use of bedrails and specialists beds that could be lowered close to the floor where staff placed crash mats to ensure if people rolled out of bed they were not injured. Where people were in bed, staff ensured their call bell was in reach, and for people who were unable to use a call bell, they had placed a sensor mat by their bed to alert staff if they got up and needed help.

People we spoke with and their relatives told us that staffing levels in Fourfields were sufficient to the needs of people. People said they rarely had to wait for assistance and that when they pressed their call bell staff responded promptly. We saw from the call bell monitoring that people were not left waiting for assistance when they summoned help. One person told us, "Oh sure there are enough staff we are never kept waiting for more than a minute or two when we need them." The manager had been in post for three months at the time of our inspection. Upon arrival at Fourfields they had reviewed people's dependency needs, and increased the staffing levels to reflect this need. We saw that they continually reviewed the staffing levels, based upon both the assessments of dependency, but also by speaking with the staff team and their own observations in the home.

However, we observed at lunchtime that staffing levels across the bungalows were not consistent to assist people with their meal. In one bungalow we observed staff were attentive, caring and took the required amount of time to support people, and if it was required support was offered on a one to one basis. However on a second bungalow we saw that staff were under more pressure to assist people and that one staff member was supporting two people at the same time with their meal. We spoke with the manager about this, who told us they were aware and were in the process of reviewing meal times to ensure all staff, including domestic staff supported people where needed.

We reviewed recruitment records for three staff members saw that staff did not start work until satisfactory

employment checks had been completed. Criminal records checks had been carried out prior to staff commencing employment and the manager had obtained and verified their references. However, in two of the three records we looked at the manager had not sought to investigate gaps in people's employment. For example, one person had unexplained gaps between 2005 and 2008 which had not been explored to ensure they had fully reviewed the persons work history.

There were suitable arrangements for the safe storage and disposal of people's medicines. Medication administration records (MAR) were complete with no gaps or errors and the manager had implemented protocols to guide staff on how and when to give medicines prescribed 'as required'. Guidance about each prescribed medicine was available to staff to review for their uses and side effects. We checked the stocks of medicines held and found these tallied with the stock record, and saw that medicines were received by two staff members to reduce the risk of errors when booking them into stock. However, we spoke with the manager in relation to one person's medicines that had been hand written onto the MAR and not countersigned by a second staff member. They told us that they would review and speak with the staff concerned to ensure they managed people's medicines safely in the future.

Requires Improvement

# Is the service effective?

## Our findings

People and their relatives all told us that staff were sufficiently trained to provide them with care that met their needs effectively. One person told us, "The training and guidance the carers receive must be top notch because I have never had need to complain."

Staff told us they completed an induction programme prior to caring for people they were assessed as competent by a senior staff member before they supported people on their own. They told us that induction comprised of a three day classroom based training event that covered key areas such as safeguarding, moving and handling, food safety, fire safety and mental capacity. Training records demonstrated that all new employees, including the manager, had undergone the required induction.

Staff told us that they felt supported by both their line manager, and the recently appointed home manager. They told us that they were provided with the opportunity to discuss their performance regularly and felt confident in raising any concerns or issues with any of the management team. We observed occasions throughout the inspection where care staff approached both the deputy and home manager for support. On each occasion, they stopped what they were doing and gave their attention to the staff members and took action to provide them with support and guidance.

Staff were provided with regular on-going training in key areas that enabled them to support people safely. The home manager told us they were in the process of identifying staff who would be champions in areas such as dementia care, medicines and infection control. They told us the role of the champion would be to provide a lead in their specific area and provide, 'On the floor' guidance and assistance to care staff to enable them to develop their knowledge through practise. When we looked at the training records for all staff we noted some of the required training had elapsed. The manager told us they had identified this and had arranged for training to be provided in these areas.

The Mental Capacity Act (2005) provides a legal framework for making particular decisions on behalf of people who may lack 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. Where they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working in line with the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

Staff sought people's consent prior to delivering any aspect of care or support. Staff were seen to be patient and sensitive when asking to support people, and gave further explanation when the person seemed uneasy or didn't understand what was happening.

However documentation in people's care records demonstrated that decisions had not always been made

in their best interests when they lacked capacity. For example, one person was due to attend a hospital appointment for an appointment to discuss treatment options for an on-going health condition. The appointment had been arranged through the GP, and the home manager had organised additional staff to escort the person and also arranged transport to take them to the hospital. However, subsequently prior to this appointment, this person's relative said they wished for the appointment to be cancelled. Staff obliged and telephoned the GP and informed them the appointment was cancelled. However, no assessment or consideration had been given about what were the views of this person, or whether this decision was in their best interest. The person's relative did not have any powers granted to them to make this decision on their behalf. Staff and the home manager confirmed the person lacked capacity, and the manager told us they were unaware the decision to cancel the appointment had been made.

The manager was aware of when and how to apply to the local authority to deprive somebody of their liberty in order to keep them safe. We saw from assessments completed that prior to applying for a deprivation of liberty the manager had considered the least restrictive option to limit people`s freedom. We saw that where DoLS applications were granted, the requirements in these were followed. The manager had made all the required applications, some were awaiting an outcome.

People were happy with the food they were provided with at Fourfields. One person told us, "The food is far beyond what I ever thought you would get." A second person said, "It's freshly made, hot, tasty and they [staff] are always on hand to help [people] that are not able to eat independently."

We observed lunch on three units to understand how staff supported people with their meal, and to better understand the dining experience people experienced. People were seen to be in small groups or were able to eat in their rooms or in the lounge areas. The atmosphere was sociable, and staff, relatives and residents in some units were seen to be freely talking and supporting people where they required assistance. People were generally offered a choice of meal by showing them the two options on the dinner plate when lunch was served. We saw one staff member ask a person what meal they wished to have. Their relative was seen to say, "He will have the fish, he can't talk anyway." However the staff member politely told the relative it was the person`s choice and proceeded to offer them the visual option. They may have chosen the same option, but were seen to happily eat their meal, as was their own choice. This enabled people to not only make a selection visually, but also by aroma, and in some observations by taste. People were generally supported to eat their meals independently and were provided with either the necessary support from staff, or equipment to enable them to eat unaided. Those people we saw eating their meals enjoyed what they were eating, and in many cases were offered further helpings.

However, on one bungalow we saw staff were not able to provide support to those people who required this. Food when dished up was not shown or offered to people, staff or the person`s relative made the choice for them. We saw on one table six people were sat for lunch. Two people required assistance with their meal, and a third person showed no interest in their meal. Elsewhere on the bungalow, one person required assistance in the lounge, with a second needing help eating in their room. There were two staff and one relative in the bungalow. One carer was sat supporting two people in the same time, regularly getting up from one person to support another. Plate guards were not used which may have supported this person to eat independently. A third person was seen to sit throughout the lunch time meal for a period of twenty five minutes and ate only very little. The remainder of the time they sat with little encouragement or assistance from staff. Their meal was removed and staff did not offer to either refresh the meal or provide an alternative.

We saw that the relative who was visiting a person assisted four people with their meals. They were seen to provide them with drinks, cut up their meals, and support them with eating. However, this relative had not

had training to provide this level of support to people unknown to them. For example they had no knowledge if any of the people had a variety of needs in relation to their nutritional needs such as soft or pureed diets, or thickeners within drinks, this placed them at risk of harm.

People s weights were regularly monitored to identify any weight loss that if noted was reported to the GP and dietician for advice. However, found that significant weight loss had not always triggered a review of people's nutritional needs. For example, one person was seen to lose weight on consecutive months. This moved them from a low risk of weight loss to a medium risk. The assessment tool asked staff to then monitor the person's food and fluid for three days, and refer to the GP if this had not improved. Staff we spoke with told us that this had not happened. A second person had experienced weight loss of 7.2 kilograms in one month. This had taken them from a low risk to a high risk. Staff had not identified this and they had not taken appropriate actions.

We spoke with the manager about these concerns. They checked the scales with a two kilogram bag of sugar and found the scales to be accurate. They said that people may have not sat in the chair correctly which may provide an inaccurate reading. However, we explained that the weights entered into the care records demonstrated significant weight loss, and staff had not identified this and responded appropriately. They agreed, and told us they would ensure those people identified were reweighed and where necessary referred immediately to the GP. However there was a risk that people may not receive the necessary care in relation to their nutritional needs because staff had not effectively reviewed, monitored and responded to their care needs.

People told us that they were able to see a doctor, nurse or health care professional when they needed to. During our inspection we observed a number of health professionals visiting, including district nurses and phlebotomists. We saw numerous examples in people`s care records that demonstrated that health professionals visited, reviewed and referred people to other health care professionals if it was a need for it. People's relatives told us that they were happy with the health care people received and told us they were kept informed when health professionals visited their relative.

Good

# Is the service caring?

## Our findings

People told us that staff were caring and attentive. One person said, "The care is marvellous, you can't want any more than they do for us now." One person's relative told us, "They are the definition of caring, regularly going above and beyond what is expected of them."

Staff were observed to be friendly and knowledgeable about people`s individual needs and preferences in relation to their care. People we spoke with told us they were involved in decisions that related to their care; in case they were unable people's relatives were consulted. To enable staff to know about people's wishes, aspirations and preferences, they had completed an assessment called, "All about me." This was a history of the person's life that recounted important relationships and times, but also that directed staff clearly how to provide care to the person in an individualised manner. One person's relative told us, "They know [person] they are really special to us both. [Person] can't talk now, but the carer was in there earlier and while carrying out the tasks, they just chatted away to them. I know that [Person] was comfortable and happy because even though they can't speak, they were nodding along and looked content with how they were cared for."

Staff were observed to respect people's privacy when entering their room they knocked prior to entering. When people were in communal areas and required support and assistance with their personal care needs such as support to use the toilet, staff sensitively took the person away with minimal fuss to preserve their dignity. Throughout our inspection people were seen to be well cared for, well-groomed and clean. Where people had spilled a liquid or food on their clothing or wheelchair, staff were very quick to support the person and ensure they were cleaned swiftly. This meant that people were cared for by a staff team who ensured their dignity and privacy was maintained at all times.

People were offered a range of choices, ranging from where they wanted to sit, eat, drink, wear for the day, and whether they wished to socialise or spend time alone. Staff were seen to take time to talk to people, and once they were clear on how the person wanted to be supported they acted upon this in an unhurried and sensitive manner. The relationship between staff, relatives and people was clearly observed to be friendly and respectful and people looked to be at ease and calm in each other's company.

People and their relatives told us that families could visit whenever they chose, and that there were no restrictions on the time they spent with them. We saw that when people's relatives visited they were able to spend time both privately and socially with their loved one and involved themselves in the wider community in the home, interacting and socialising with others and their families which helped to create a warm homely environment.

Displayed around the home were posters and publications for advocacy services and advice with contact details for local services. The manager told us that there had not been a recent occasion where people used an advocate to support them; however they were aware of when one may be required and would not hesitate in recommending this service to people who required this.

Requires Improvement

# Is the service responsive?

## Our findings

People and their relatives told us that they felt involved and able to contribute to and develop their care with staff and other professionals when needed. One person told us, "I feel happy with how things are, the staff talk to me about what I need all the time." One person's relative told us, "I feel like they listen and respond to [Person's] needs, we do it as a team and consult about what's needed."

People's care was personalised and care plans demonstrated that staff had sought the views of people or their next of kin. We reviewed a care plan for a person who was near the end of their life and found this to be clear, concise and informative. It provided a quick and thorough profile of the person, their health, care and social needs in addition to their preferences and provided a person-centred guide to how to care for this person. When we spoke with staff about this person's needs they were able to demonstrate a fundamental and thorough understanding of their needs.

People told us that there were not always enough activities at Fourfields. There was an activity planner on display in each bungalow that recorded which activity was taking place on each day. Activities were organised for people on a communal basis, and where these covered a broad range of interests, there was not any specific activity for people's individual interests. For example, owls were planned to visit on one day, and there were various pamper sessions, coffee mornings, quizzes and musical entertainment sessions arranged. However people told us that for those people in bed throughout the day, there were not the same opportunities provided all the time.

One person said, "It's okay for those of us who can get about, but if you're one of them who stays in bed then there's not much to do but watch the telly." One person said, "It varies day to day, some days are better, but lately there's not been much going on to get involved in, it can be boring." We saw that one of the bungalows was in the process of being redecorated. This meant that during the day, people needed to move across the home and the communal areas usually used for activities were not available for all people to use as this area was occupied for these people to eat and spend their day. This had caused disruption to the usual timetable of activities provided because the usual communal areas were not available for all to use as freely.

We spoke with the manager about the lack of activity, both group and individually based caused by the works and also for those who spent time in their rooms. They told us they were developing their schedule, and had sent staff on external training that supported them to positively engage with people who were resistant to activity or socialising. They also said they were developing further the 'Namaste' program that aimed to provide sensory stimulation to people both in their rooms and in communal areas.

The manager had arrangements in place for people and their relatives to share their views. However meetings were not made available equally across all the bungalows. Minutes of resident meetings demonstrated that these had only been held in three of the bungalows, meaning that people living in the other bungalows, were not provided with an opportunity to provide formally their views and opinions. This was particularly important considering that the home will move location in the near future and all people

should be consulted and given an opportunity to comment on this.

People and their relatives told us they would be confident to raise any complaints or concerns with the management team. The manager told us that they treated grumbles and concerns as seriously as complaints and investigated appropriately.

Requires Improvement

# Is the service well-led?

## Our findings

We found that people's care records were incomplete with gaps in the information about their current needs. We found that assessment tools used to monitor the risks to people's nutritional needs and development of pressure sores were not accurately completed or reviewed. We checked the nutritional assessments for two people and found that the correct plans were not implemented as required by the provider's policy based on reviews of their weight. The manager told us that people were weighed and they were given a copy of these to calculate each person's MUST score.

However, staff had assessed the risks to people without having first received the updated MUST. This meant that the care plans for people who had lost weight and increased their risk of malnutrition were inaccurate. For example the tool indicated that one person who had been low risk of malnutrition before December 2015, due to the weight loss were now medium risk and staff had failed to identify this until we reported our findings. The manager took immediate action to review people again to ensure they were placed on the appropriate care plan.

We found that care plans for identified health needs were not updated or completed when required. We saw daily records documented that one person had experienced two episodes of heavy bleeding which had resulted in emergency services being called. There was no risk assessment or care plan in place to manage this. A second person with pressure ulcers was found to have plan of care in place for how to support them, such as dressing changes and repositioning, however body mapping charts were not always completed and when they were gave little description other than, "Resident has wound." There were no dimensions to review the wound, and one picture had been taken but was not dated. This made it difficult for the wound care to be effectively reviewed because care plans that were required to be maintained had not been. However, when we spoke with staff they were able to comprehensively tell us about the care and support people required. The home manager acknowledged that the care plans required work.

This meant that an accurate record about the health needs of people who used the service had not been maintained.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service did not have a registered manager in post at the time of our inspection. The previous manager had resigned their post and deregistered with the Care Quality Commission on 16 December 2015. At the time of the inspection a replacement manager had been appointed, and was due to register with the Commission. We found that the required notifications of reportable incidents were made in a timely manner to CQC, and the management team had continued to ensure leadership remained visible throughout the home. Staff and people told us that the new manager was visible and led by example; they also said that they felt the 'Open Door' approach they had adopted was positive. One staff member said, "[Manager] is great, they lead by example, and it's nice to have someone who practises the open door policy, instead of just says they do."

The provider carried out regular quality assessments of the care provided at Fourfields. These included areas such as medicines, care records, the environment, staffing levels and development. An action plan was developed from the findings of each assessment and reviewed monthly to monitor their completion. We also found that a recent local authority review of the service had found areas for improvement that the manager was addressing. These included areas such as ensuring training was up to date, and that all audits were kept up to date and actioned in a timely manner. However we found that robust auditing of people's care records remained a consistent area for improvement in both the providers and local authority's assessments and remained incomplete at our inspection. Furthermore we found that since July 2015 staff meetings had not been held consistently for all staff. The manager was clear that this was an issue they were speaking with the senior team in Fourfields about and planned to ensure staff and resident meetings took place frequently.

The provider had organised for an independent organisation to seek the views and experiences of people, relative's, staff and health professionals. They had compiled their findings into a report which had been analysed to identify areas for improvement. We looked at a copy of the report and saw that the feedback from people had been overwhelmingly positive. The general views of people were that the home was managed in a safe manner that provided effective and responsive care in a way that supported people's dignity and care.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The provider did not maintain an accurate record in respect of each person who used the service.<br><br>Regulation 17 (1) (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. |