Fewcott Healthcare Limited

Fewcott House Nursing Home

Inspection report

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Date of inspection visit:
31 May 2016

Date of publication:
08 November 2016

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?	**Inadequate**

Summary of findings

Overall summary

We visited Fewcott House Nursing Home on 31 May 2016. It was an unannounced inspection.

The service provides nursing care for up to 40 people over the age of 65. At the time of our inspection 33 people were living at Fewcott House. Some people were living with dementia or had a learning disability.

Prior to this inspection we had received concerns that people were not always being treated with dignity and respect and were not being protected against the risk of abuse.

We had previously carried out an unannounced comprehensive inspection of this service on 1 June 2015 and identified a number of areas where improvements were needed to ensure that people were receiving care that was safe, effective, caring, responsive and well-led. We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people had not always been treated with dignity and respect. Medicines had not been stored safely and staff had not received appropriate training or development. We also found that there were not effective systems in place to maintain records in relation to the management of the service to ensure safety and quality.

We undertook this inspection to follow up the concerns that had been raised prior to our inspection and to check the service had made the required improvements from the inspection on 1 June 2015. Not all of the improvements had been made.

This inspection was the seventh inspection of Fewcott House since February 2013. At each inspection we saw changes had been made to bring the service up to the required standard but also highlighted further areas for improvement. There has not been a stable management team at the home during this time, which meant the improvements had not all been sustained or embedded in practice. A new manager was in post because the registered manager had left in September 2015, however, they had not yet registered with the Care Quality Commission. 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 this inspection we found there was a failure to protect people from the risks of abuse. The provider failed to recognise and report when people had been put at risk or had been subject to harmful situations. There had been unacceptable delays in the provision of information to the local authority safeguarding team and the Care Quality Commission.

The provider had not ensured safe recruitment procedures were followed when recruiting the new manager and other staff.

People had not been protected by the safe management of medicines. Procedures regarding ordering and

stock control of medicines had not been followed by staff.

Appropriate risk assessments were in place to manage any identified risks. People in the service and relatives we spoke with felt the service was safe.

Staff had not completed the necessary training to ensure they had the skills to undertake their roles and responsibilities effectively. Lack of training had been identified at the last inspection but we found not all staff had completed this training at this inspection.

Staff had not received regular one to one meetings with their managers to ensure they were supported and were being monitored to ensure they undertook their roles correctly.

People did not always have appropriate assessments in place when they lacked capacity to make decisions.

People in the service and their relatives described the service as caring. We saw many examples of staff providing a warm and kind approach to those they supported on the day of the inspection. People were treated with dignity and respect and appropriate privacy. People were encouraged to maintain their independence skills.

Care plans were in place but the guidance in them was not always being followed to ensure people were receiving the correct treatment and support.

Staff knew the people they were supporting well and activities were being arranged and future activities considered in line with people's interests.

Complaints were adequately managed by the service.

The service was not well managed. Management had failed to ensure that they followed the correct procedures when concerns had been made known to them. They had failed to notify the relevant organisations, such as the local safeguarding team and the Care Quality Commission (CQC) of serious incidents as required. When recruiting staff, management had not ensured that all the steps required by law had been followed before people started working in the service.

Policies were not always updated to reflect current best practice and terminology. Not all policies and procedures had been adhered to.

Information had not been analysed or evaluated to improve the service. Records had not been kept as required to monitor aspects of people's health.

An action plan after the last inspection had been submitted but had not addressed the issues raised at the inspection. Some actions from this plan were still outstanding in this inspection.

Notifications had not been made for all required events to the Care Quality Commission.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of the Regulation 18 Care Quality Commission (Registration) Regulations 2009. We also made one recommendation in respect of the Mental Capacity Act 2005.

Following this inspection the provider was asked to submit weekly action plans to show what they were

doing to address the findings from the inspection. Since that time, we have received these weekly updates as requested.

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 safe. There had been a failure to protect people from harm and to recognise and report when people had been put at risk or had been subject to harmful situations.

Staff recruitment processes had not been fully completed to ensure they were suitable to work in the service.

Medicines were not safely managed.

People had been assessed for any risks and records were in place for these.

Is the service effective?

Requires Improvement

The service was not effective. Not all staff had received training, supervision and professional development to enable them to deliver safe care and treatment to people in the service and to an appropriate standard.

Care plans did not always contain mental capacity assessments in relation to specific decisions.

Some people who used the service were subject to restrictive practice which was not being regularly monitored in line with the Mental Capacity Act (MCA) 2005 and The Deprivation of Liberty Safeguards (DoLS).

Areas of the environment needed attention to ensure it met the needs of people in the service.

People enjoyed the meals but their nutritional needs were not always monitored effectively.

Is the service caring?

Good

The service was caring. We saw people were treated with kindness and warmth.

People and their relatives said the staff were caring.

People were treated with dignity and respect and their privacy was ensured by staff delivering their care.

People were encouraged to maintain their independence where possible.

Is the service responsive?

Requires Improvement

The service was not always responsive. Care plans were not always being followed or kept up to date by staff delivering care.

Staff were knowledgeable about how people preferred to be supported.

Activity opportunities had been improved so that people could participate in more activities.

Complaints had been managed effectively.

Is the service well-led?

Inadequate

The service was not well-led. Management of the service had not ensured people were kept safe by following procedures where concerns were identified.

Policies had not been updated to reflect latest legislation, current best practice and terminology.

Information was not analysed and evaluated to improve the service.

The service had not submitted an adequate action plan after the last inspection.

Not all notifications had taken place as required by law.

Fewcott House Nursing 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 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 31 May 2016 and was unannounced. The inspection was carried out by three adult social care inspectors, a specialist advisor and an Expert by Experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before this inspection we reviewed all the information we held about the service. We looked at the notifications we had received for this service. Notifications are information about important events the service is required to send us by law. We spoke with the local authority safeguarding team, and contracts and commissioning team about their views of the service

During the inspection we spoke with the provider, manager, team leader, a nurse, four care assistants, an activity co-ordinator, chef and a housekeeper. We spoke with 10 people and five people's relatives. We looked at 12 people's care records and medicine records for 11 people.

We observed how staff interacted with people who used the service and monitored how staff supported people during the day by using 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 to us.

We looked at how the service implemented the Mental Capacity Act 2005 and Deprivation of Liberty code of practice to ensure that when people were deprived of their liberty or assessed as lacking capacity to make their own decisions, actions were taken in line with the legislation.

We also looked at documentation relating to the management and running of the service including policies, records of accidents and incidents. We also looked at staff rotas, five staff files, supervision records, recruitment procedures, training records and team meeting minutes.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection on 1 June 2015 we found medicines were not always stored in a safe way. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) regulations 2014.

At this inspection we found one person's records which had been updated on 2 May 2016, stating pain relieving topical medicine was to be applied three times a day to the person's hands for pain. We reviewed their medicine records and found the relevant medicines administration record (MAR) detailing the pain relieving topical medicine (gel). The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicines were required to initial the MAR chart to confirm the person had received their medicine. However there were no signatures to indicate this medicine had been applied. We asked to see previous MAR charts and a member of staff found one dated between 29 February 2016 and 27 March 2016 where there was a handwritten entry confirming the application of the gel. We saw no signed records after the 27 March 2016 to indicate it had been administered. We asked to see the pain relieving gel but when the member of staff looked, there was none in the medicine trolley or in the person's room. We spoke to a nurse who told us, "I have no explanation. The GP didn't send a repeat prescription and we didn't notice". During our inspection we heard the person calling out stating they were in pain.

A 'when required' medicines protocol (PRN) was in place but did not provide enough detail to describe when the medication should be administered. For example, records had written 'Use paracetamol for pain or fever. However there were no details of what signs the person may show if they were in pain. National guidance states that 'when required' medicines are in place, these should be noted in a person's care records with instructions on when and how to take or use the medicine. Records should also state how they are monitored and what effect they expect the medicine to have. (Managing medicines in care homes, National Institute for Health and Care Excellence (NICE) 2014). For people living with dementia, it can be difficult for the person to verbally tell someone they are in pain. Assessing pain can therefore be helped by using additional information to indicate that certain behaviours may indicate a person is in pain. The service had no system in place to use any assessments or pain scales to assist staff to know when pain medication may be necessary. This meant that people may not have medicines prescribed or administered to meet their needs.

We saw a medicine administration error report form in the quality assurance records. National guidance states that services should have a medicines policy stating when others should be notified of errors. (Managing medicines in care homes, National Institute for Health and Care Excellence (NICE) 2014). The provider had a policy stating that the manager and the person's GP or any other health professional should be notified immediately. We saw that one person's medicine had not been given to them on the morning of 10 April 2016. The report showed the manager had not been notified until 12 April 2016. There was no record of the person's GP or any other health professional being notified. Therefore, the person was at potential risk due to not receiving the intended medication as prescribed.

Staff were not always aware of arrangements for covert medication. Covert medication is the administration

of any medicine in a disguised form, for example, hidden in food or drink. The person does not know they are receiving the treatment. This needs to be agreed in consultation with medical professionals. We saw that this had been agreed and a best interests decision document had been completed. We spoke with the team leader who told us a person had been receiving all their medicines covertly but no longer required this as they now took their medicines willingly. When we spoke with the nurse we were advised that only one of the medicines had been given covertly not all the medicines. This meant staff were not always clear about which medicines were been given covertly and that only one medicine had been agreed to be administered this way, not all.

The nurses were not managing dressings stocks effectively and safely. A number of absorbent dressings on a trolley had manufacturer's expiry dates on them. We saw that some of the dressings had expired in December 2014 and July 2015. There were 43 of these dressings available, some of which were going out of date in June 2016. Two sizes of these dressings were in one box with different expiry dates. Effective stock control and management of medical supplies had not taken place to ensure that people had access to products which were safe and fit for purpose.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Concerns had been reported to the manager on 2 March 2016 about the behaviour of certain members of staff. We reviewed the action taken by the manager in respect of these allegations and found that they had not followed a robust system to respond to these concerns, notified the appropriate authority or put in place interim measures to ensure that people using the service were protected while ongoing investigations were being carried out.

The recruitment process did not always ensure that all necessary pre-employment checks were completed to ensure potential staff were suitable to work with vulnerable people. Three of the five files we looked at contained incomplete information, such as, a full employment history, employment references or proof of identity.

The failure to respond effectively to concerns about a person's fitness to support people and complete all necessary pre-employment checks meant that the provider was not able to assure themselves that people were safe and the staff they employed were of good character and suitable to work with the people they supported.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they felt safe living at Fewcott House. Comments included, "'Very safe really, nice people, no problems" and "Feel safe and can do what I want to do." Relatives we spoke to on the day of the inspection were confident that the people were safe. A relative commented "[Name] is safe and that is good for me as well".

People were supported by staff that were knowledgeable about how to keep them safe in relation to the care they received. For example, one staff member said, "Safeguarding is about making sure people are looked after, the equipment is working, people are eating, cared for and spoken to with respect". Another staff member said, "It's making sure the environment and equipment is safe and making [peoples] lives comfortable".

People's care plans contained risk assessments. Where risks were identified most care plans contained information in relation to how risks would be managed. Staff told us they used the care plans and risk assessments to inform them how to assist people in a safe way. For example, where people had been identified as at risk of developing pressure ulcers they had specialised equipment in place to prevent skin damage such as pressure relieving cushions and mattresses. Staff knew which people were at risk and ensured people sat on their cushions and their pressure relieving mattress was set correctly.

We also saw that people who had been identified as at risk of falling were referred to the care home support service for assessment and advice on how to manage the risks. Staff encouraged people to be as independent as possible whilst managing risks. For example, one person wanted to get out of a chair. Staff encouraged the person to stand by them self and move independently. Staff kept their distance in the background ready to offer immediate support if necessary.

There were assessments in place to address the risks associated with some people's choices or preferences. For example, one person chose to smoke and did not always wish to be accompanied by staff when they went outside to smoke. Staff had involved the community mental health team in the person's risk assessment to ensure this person was as safe as possible.

There was enough staff to meet people's needs. The provider calculated staffing levels according to people's dependency. We observed call bells were answered promptly and people were assisted in a timely way. A staff member told us that "Staffing levels are good and we have time to meet people's needs". A person told us, "There are enough staff about to help at night. This bell is available and the other night it only took 48 seconds to get help".

Checks on water quality and temperatures had been undertaken. We saw a recent legionella test certificate and electrical equipment had been tested. Fire safety inspections had been carried out by the fire service and issues noted in the last inspection had been addressed. Fire extinguishers were in date and were in the correct locations. Weekly alarm tests had been documented. Equipment such as lifts, hoists and bath lifts had been serviced. An emergency evacuation plan was in place.

People were protected by safe infection control processes. We saw colour coded cleaning equipment to prevent cross contamination. Gloves and protective aprons were available to staff providing personal care. We saw hand gels located throughout the building. Infection control posters were displayed in toilet areas and hand wash areas.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection on 1 June 2015 we found people were not always cared for by suitably skilled staff that had been kept up to date with current best practice. This was because there were gaps in staff training. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection we found the provider maintained training records for each member of staff. We were informed the record was accurate up to 31 May 2016. Training was delivered in both an online and face to face. However, whilst some staff had completed the provider's mandatory training there were still gaps where some staff had not completed initial or refresher training. For example, 15 out of 40 staff had not attended training in Safeguarding vulnerable adults. Twenty nine staff had not received training in the control of substances hazardous to health (COSHH).

We saw that 16 staff had not received training in the use of Malnutrition Universal Screening Tool (MUST). This is a screening tool to identify adults, who are malnourished or at risk of malnutrition and includes management guidelines which can be used to develop a care plan. The provider's training matrix identified this as required training and during the inspection we noted that fluid intake was not always being monitored and that people had experienced weight loss with no investigation.

Not all staff had received training in caring for people living with dementia and one staff member had been employed at the service for over a year. When we spoke with them it was evident that they did not always understand the needs of the people they cared for living with dementia. For example, they described the way one person communicated as, "Talks a lot of rubbish but that's her dementia" and described another person communicating as, "Talked a lot of rubbish too, gobbledygook". We spoke with a professional who regularly visited the service. They told us that gaps in training meant staff did not always understand people's needs, particularly those who were living with dementia. They said "Staff need prompting, for example, have you weighed them? They need more training especially in dementia and how to manage behaviour".

Newly appointed staff told us they went through an induction period which involved shadowing an experienced member of staff. The provider's training policy stated that during staff induction all staff would receive job specific training. We looked at the training records for staff that had been employed at the service in the previous six months and had been in post for longer than 12 weeks. Apart from manual handling, these staff had not completed any other training that would be considered necessary to carry out their role and responsibilities. For example, they had not received safeguarding or infection control training which would be required in all roles. The provider had not followed recommended 'good practice'. For example, the Care Certificate which is a recognised national induction programme for new staff.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Some staff had been supported to attend external training. For example, one member of staff told us the service was sponsoring them to do a national qualification in health and social care. This is a qualification aimed to further increase skills and knowledge in how to support people with their care needs.

Staff felt supported by the manager. One staff member said, "[Name] is a good manager, open door, can talk about anything". Another staff member said, "[Name] is very nice, door is always open for us if we have concerns. Feel supported".

Not all staff had received training in relation to the Mental Capacity Act (2005). The Mental Capacity Act 2005 (MCA) providers 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 made on their behalf must be in their best interests and as least restrictive as possible'.

Care plans did not always contain mental capacity assessments in relation to specific decisions. For example, one person's cognition care plan stated, 'Due to dementia [Person] is unable to make decisions'. There was no mental capacity assessment to support the care plan or to determine which specific decisions the person lacked capacity to make.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interest and is 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 within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. The manager told us several DoLS applications had been submitted to the supervisory body before they commenced work at the service. The manager had made three applications since starting at the service. However, there was no system in place to regularly review the restrictions placed on people while they were awaiting assessment by the supervisory body. We could not be sure that people were being supported in the least restrictive way.

We recommend the provider follows best practice guidance in respect of the requirements of the Mental Capacity Act 2005 and associated code of practice.

Some staff had an understanding of their responsibilities in relation to the MCA. They understood the principles of the Act and how to apply them in their work. One member of staff had been involved in best interest decisions and understood the importance of involving appropriate people in the best interest process. We saw and heard people being asked by staff if it was alright to move them, to support them and whether or not they would like personal care. Care was only carried out with the person's consent and where a person declined their decision was respected. For example, we saw that a person was asked if they would like to get dressed. They declined and their wishes were respected.

Where people had appointed lasting power of attorneys (LPA) this was documented in their care plans and copies of the LPAs were available. Where attorneys were appointed there was evidence in care files that they had been involved in people's care planning and decision making. For example, one person had a risk assessment in relation to the use of bed rails. The LPA person had signed the form to agree to the bed rails being in place.

People's nutritional needs were not always being met. For example, one person's care plan stated they had experienced weight loss and required a fortified diet. The person was also diagnosed with diabetes which required this condition to be managed by medication and diet. When we asked the chef about this person,

they told us the person had 'normal' food and that they were not diabetic. However, the provider later informed us that the chef was aware and it could have been that he did not understand the question. A white board in the kitchen had coloured coded symbols which were individual to each person's dietary needs.

Mealtimes were not always flexible to suit people. For example, at 8.55am one person was sitting in the lounge. They were shouting at another person and looked upset. One staff member asked the person what was wrong. The person stated this was because they had been in the dining room but had not been given any breakfast. The staff member told the person "It was because we were in handover. I can get you something now and bring it down". The staff member returned at 9.20 with the person's breakfast.

The food was served at the correct temperature from the kitchen. However the food was taken upstairs on an unheated trolley. It arrived at 12.20 and the plates were covered with plastic lids. The meals for two residents were taken in at 12.35 so were left on trolley for 15 minutes. Therefore, it was not clear whether the food was at an acceptable temperature when people ate their food. We did not see any staff member check the food temperature before it was served.

We saw people being supported to eat and drink. During our observations in the lounge during the morning we observed people being encouraged and supported to drink. People who needed assistance to eat were given the support they needed. People we spoke with were mostly positive about the food. Comments included, "'Meals are very good. I couldn't run the food down". One person said "Food is good but could be better. They come round and ask us what we want". A relative said, "I haven't eaten here but I take [name] down for supper. Food couldn't be better.'

The adaptation, design and decoration of the service was not always suitable for people who were living with dementia. Although we saw pictures and photographs to help people orientate, there were minimal adaptations to meet people's dementia needs. The lighting was of a very low level and in parts of the home the lights were flickering. A person told us "The lights in my room are not bright enough". The manager confirmed that they had applied for an audit pack to assess the service's dementia suitability and to ensure they followed 'best practice' for people living with dementia.

We saw a hole in the ceiling exposing the roof space and a hole in a carpet where a sink had been moved. The flooring in places was not secure and had been covered in tape but was loose in some places causing a potential trip hazard. The manager told us the flooring was due to be replaced.

People were supported to stay healthy and care records described the support they required to manage their health needs. Records in people's personal files indicated that they had access to a range health care services which included GP's, chiropodists, opticians, Care Home Support Service (CHSS) and members of the community mental health team. We saw evidence that nurses and care workers recognised when a person's condition changed or their health had deteriorated and sought the help and advice of other professionals. For example, we looked at the care records for a person who had become unwell. Nurses had become concerned that this person may have an infection in their leg. An immediate referral to a GP had been made. The GP had prescribed antibiotics. Staff had ensured the person had taken their antibiotics and their leg had improved. We spoke with a professional who regularly visited the service. They told us staff communicated well with them, were proactive in identifying peoples changing needs to them and followed any advice or instruction. A person told us "I have had a number of meetings with people connected with the chain of caring. I am due to have a knee replacement so to get me ready they encourage me to move about, on my walker as much as my knee will allow. I am due to come back here for recovery".

Good

Is the service caring?

Our findings

At the previous inspection on 1 June 2015 we found people did not always experience care in a respectful way. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Prior to this inspection we had received concerns that people were not always being treated with dignity and respect. We had discussed these concerns with the provider and the local authority safeguarding team. Following this, the provider took action whilst they completed an investigation.

People told us they felt cared for. A person told us "I like the people here, very friendly. Lovely place. The owner took me to the cemetery to visit my parent's grave because he knew I wanted to go there." A relative told us that the staff had been caring and supportive to a person who had a recent bereavement. They said, "They have been so kind and caring towards [name] since the death."

On the day of the inspection, we saw many kind and caring interactions. Staff were warm in their approach and put people's choice at the centre of the support they offered. For example, one person was sat with their walking stick on their lap while they were waiting for their lunch. One care worker approached the person and knelt down to speak with them, suggesting they may find it easier to eat their lunch without their walking stick in their hand. The person did not want the walking stick moved. The care worker respected the person's choice and touched them reassuringly on the arm before leaving. When the care worker bought the person's lunch they checked again if the person would like them to put the walking stick to the side while they ate. The person agreed. The care worker showed the person where they were putting the walking stick and reassured them they could have it whenever they wished.

The mealtime was a social time and we saw good interaction between people in the service and staff. During lunchtime we saw people being supported to sit where they chose. People were offered a choice of drinks and food. Where people didn't like the choice on the menu they were offered alternatives. People who required help to eat their meals were supported in a dignified way by staff that ensured that residents had finished before asking if they would like to have more. One person became anxious and raised their voice. A care worker immediately knelt down by the person, made eye contact and reassured the person.

During the inspection people were very complimentary about the support they received from the service and told us the staff were kind and caring. One person told us, "It's lovely in here. Staff are lovely. They couldn't be nicer". Staff told us about a person who arrived and was reluctant to talk. They found out they followed a particular football team. The activity co-ordinator wrote to the club and they sent lots of 'freebies' and they were put in the person's room. The co-ordinator wrote back, enclosing a photograph which the football club published in a match day programme. The person was thrilled and as a result communicated more and were joining in more. A person in the service loved cats and we heard they often had one to one sessions for a chat and looked at cat pictures.

We observed staff spoke to and treated people in a kind and respectful way. For example, we heard one staff member discreetly ask a person, "May I wipe your face?" Staff spoke with us about ensuring people were treated in a respectful way. One staff member said, "It's what I would like. Treat people as you want to be

treated".

There was a warm friendly atmosphere at the service. When staff entered the lounge they took the opportunity to acknowledge and talk with people. Conversations were pitched appropriately for the individual and ranged from the more serious through to light hearted banter.

We observed people being involved in decisions about their day to day lives. For example, decisions about what they wanted to wear, eat and drink. One staff member told us how they would help people make a choice, for example, holding up two items of clothing. One staff member said, "I show them, hold up trousers or a skirt". Those people who were able, had free movement around the service and could choose where to sit and spend their recreational time. We heard staff offering one person a shower. When the person declined they told the person they could have one the following morning or later in the day if they had changed their mind.

Staff were mindful of peoples' privacy. We saw that when staff went into a person's room to provide care they knocked, waited to be invited in and closed the door behind them. We asked staff about how they maintained privacy and dignity for people during personal care. One staff member told us; "It's important to respect people's privacy, keep them covered and make it personal and private". Another staff member said, "Tell people what you are going to do, ask them, draw the curtains, wash the top half first then dry and put their top on, then do the bottom half". We observed staff asking permission to carry out care tasks. Staff demonstrated a caring approach during care tasks. For example, one person was being supported to move using a hoist. Staff brought a hoist to the person and with another colleague asked if it was alright to use the hoist to move them to their wheelchair. During the process staff explained what they were doing and reassured the person, who remained calm throughout the procedure.

People were encouraged to be as independent as possible. One staff member told us promoting peoples independence was important to, "Make people feel individual and in control". Some people used equipment to maintain their independence. Staff ensured people had the equipment when they needed it and encouraged people to use it. For example, one person used a walking stick to aid their mobility. We observed the person getting up from their chair and walking without their stick. A staff member noted this promptly and reminded the person about their stick and fetched it for them.

People with diverse communication needs were supported to make their wishes known. For example, one person found it difficult to communicate verbally. Staff understood how this person communicated by using body language and noises to express their wishes and remain involved in decisions about their care. Peoples preferred ways of communicating was documented in their care records. For example, one person who could become anxious, communication care plan stated 'please maintain eye contact and a friendly posture during conversations'. We observed staff speaking with this person. They sat beside the person or crouched down beside them, and looked the person in the eye as they spoke with them maintaining a calm and friendly tone.

Requires Improvement

Is the service responsive?

Our findings

People were assessed prior to moving into the home and these assessments were used to develop care plans that identified how people's needs were met. Care plans provided guidance for staff on how to respond to them. The care plans were supported by risk assessments. Some care plans included information relating to people's likes, dislikes, hobbies and history. For example one person's care plan identified they had been a teacher. However, this was not consistently completed in all files we looked at.

People's care plans also included recommendations from health professionals. However we found that recommendations were not always followed. For example, one person had been seen by the care home support service (CHSS) as they had a high risk of falls and had experienced several falls. CHSS recommended the person be supported to sit in a recliner chair for two to four hours each day. Records showed the person had been supported to sit in the chair for 30 minutes on 30 May 2016. There was no other entry for May 2016. The person had only been supported to sit in the chair on three occasions in April and two occasions in March 2016. We spoke to the nurse who told us the person did not always want to sit in the chair. There was no record that the person had been offered the opportunity to sit in the chair and no record that the CHSS had been notified the person was not wanting to follow the recommendations.

This person's care record also included recommendations from the CHSS that the person should wear hip protectors to minimise the risk of injury if they experienced a fall. There was no record in the care plan that the person had hip protectors or was being encouraged to wear them. We spoke to the nurse who told us the person did have hip protectors but did not wear them. The nurse agreed that the person should be encouraged to wear them and it should be recorded in their care plan.

We also saw that some people required their food and fluid intake monitored. These people had food and fluid charts in their rooms, however there was no target amount of fluid recorded, records were not always completed and fluid records were not totalled. Therefore, it was not known if the person had drunk the required amount to keep them hydrated. For example, one person had no fluid record on 27 May 2016 and there were no totals for 11 dates in May 2016. Fluids were entered on the fluid chart and the separate food chart but there was no system to ensure all fluids were totalled as entries on both charts were not always consistent. We saw that another person only had a fluid chart available day of inspection. We saw that it was recorded that at 11am the person had taken 200mls juice. We observed this still on the side table at 13.30, half full. We also saw that the speech and language therapist had recommended a beaker with no lid. However, we saw drinks were still been given a beaker with lid.

There was no evidence the information documented was being evaluated over a period of time to establish whether people were getting the required nutrition and fluids. We spoke with the nurse who told us night staff were responsible for totalling fluid charts. The nurse told us, "I would know because staff tell us". Staff could not accurately monitor that people were receiving enough fluids to meet their needs.

People's records did not always document information to monitor risks as stated in their care plan. For example, one person had lost weight during a recent hospital stay. Following their return to Fewcott House,

the care plan stated the person should be weighed weekly to ensure weight was monitored. At our inspection on 31 May 2016, the person had not been weighed since the 13 May 2016. We asked a member of staff and they could not find a record of weight being taken and could not confirm that it had been done. Another person's weight was being recorded and we saw records of these over a six month period. The person had lost weight for a two month period and there was no explanation for why the weight loss had occurred or what action had been taken.

Care plans and risk assessments were reviewed on a monthly basis. However changes in people's health needs were not always updated in the care records. For example, one person had an infection in their legs. This had been noted promptly and the GP had been called and prescribed antibiotics. However, the person's tissue viability, falls or medicines care records had not been updated with this information and therefore staff did not always have access to the latest information necessary to support people safely. Each of these care records had been reviewed since the GP had visited the person. Staff told us changes to peoples care were discussed in staff handover. However one staff member told us, "The handover was good but I wasn't given as much information as I would like. You get given an update on the last 24 hours but if you have been off could have missed the last three days".

This meant the provider was failing to maintain accurate, complete and contemporaneous records of the provision of care and treatment to people at Fewcott House.

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

Staff were knowledgeable about how people preferred to be supported. One member of staff told us, "It's very important to know people and their choices". Another staff member said, "I try to see the world from their point of view". People's preferences about how they wanted to be addressed, bathing arrangements, and other choices about how they wanted their care delivered were documented in their care records.

Staff understood their role in providing people with person centred care and support. For example, one person's care record stated they liked knitting. Staff who supported this person understood why this was important for this person and ensured they brought the persons knitting bag to them when they sat in the lounge.

People told us they were involved in their care planning. One person said "'I am involved in planning my care. They sit down with me every few months and ask me how things are going and is there anything else that I would like doing." Another said, "'I have had a number of meetings about my care". A relative we spoke with said they were involved in "Regular meetings to talk about [name] care". Another relative said they had "Meetings about the care plans. They explain everything. We tell them what we think and they listen".

At the previous inspection on 1 June 2015 we found there was a lack of stimulation for people especially those living with dementia or who had a learning disability.

At this inspection we found staff spent more time speaking with people and activity provision had improved for people who were able to engage with staff. We observed an exercise activity in the lounge. Four of the eight people sat in the lounge participated in the activity. However three of the people who did not take part in the activity and were not invited or supported to join in.

A temporary activity coordinator was in charge. Activities from the local area included musicians, singers, guitar music therapy and a therapy dog that visited people in the service. Plans were being considered

about taking a group of male residents to a local pub to watch the football tournament in the near future. A programme of daily events was displayed on boards around the home. We spoke to the activities co-ordinator who said "A person had a series of physio exercises to do prior to an operation but was very self-conscious and reluctant to do them so we did them as a group so they wouldn't feel left out. [Name] joined in willingly."

During the day we observed a music session, an indoor skittles session and a music exercise session and musical quiz run by an external specialist. The activities were fully inclusive and enjoyed. Photographs displayed around the home showed people taking part in a variety of activities.

Peoples' spiritual needs were met. Services were held at Fewcott House on a regular basis by visiting priests. A person told us, "Religion is important to me. Every three or four weeks the vicar will come in and hold a Holy Communion service for a group of us".

The coordinator used an activity assessment tool to assess people's ability to participate. This tool helps to guide what activities to consider and any one to one activities needed. People were asked for suggestions. One person in the service produced and edited the 'Fewcott Files', an annual magazine for residents, staff, and friends. People in the service, staff and management were encouraged to write articles. Posters advertising 'Make it Happen' are displayed throughout the home. People are being encouraged to tell staff about something they have always wanted to do, see or somebody they would like to meet. For example the service had put in place plans for one person to visit a zoo.

People knew how to raise a complaint if necessary. One person said, "No complaints at all, but I know that they would sort out things if there was a real problem". Another said, "I know management would sort things out and things do get sorted". Copies of the home's complaints procedures were clearly displayed around the home. We saw a complaints policy and that complaints had been recorded and actioned. However, a relative we spoke with said "Issues raised were dealt with. However, they do tend to put all clothes in one bag and wash everything at a high temperature which ruins things like jumpers."

Inadequate

Is the service well-led?

Our findings

At the previous inspection on 1 June 2015 we found the service did not have current policies and procedures in place to promote safe and effective care. All of the homes policies were dated 2007 and had not been reviewed or updated since this date. We also found audits had not always been effective. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found the policies had not been updated to reflect latest legislation, current best practice and terminology. For example, there was a safeguarding policy and procedure in place. However, the safeguarding policy was dated March 2016 and included reference to Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA). These organisations merged on 1 December 2012 to become the Disclosure and Barring service (DBS) and no reference of this was in the policy. Therefore, staff who used the policy for guidance and support could not be assured that the other information in the policy was up to date, relevant and accurate.

During this inspection, we found the service did not have systems and processes being operated effectively to assess and monitor and mitigate risks in the service. The service did not have a system to analyse, reduce or remove certain risks. For example, some people needed their weight monitoring. An external company had carried out an audit in March and April 2016 and stated there were not enough weighing scales available to be used when repairs were being carried out. It noted that there were several entries in people's notes saying 'not weighed' as scales were being repaired. We also found that not all people were having their food and fluid intake monitored.

An audit had been completed in March and April 2016 by an external company. The audit highlighted areas of concern in line with the five key questions covered by a CQC inspection, however the provider had not taken action to implement all the improvements needed. Staff files were 'difficult to navigate as documents were not properly filed'. There was not plan in place which identified when supervisions and appraisals needed to take place. This would ensure that these meetings with staff were not missed and the next one was scheduled in.

An audit had been carried out on medicines management by the provider. However, this had not identified the issues we found in this inspection concerning ordering and recording of medicines. This meant there was no effective system in place to protect people from the unsafe use and management of medicines.

Accidents and incidents were reported and recorded. However, there was no system in place to fully identify and analyse trends or themes for individuals or for the service as a whole in order to minimise risks and improve outcomes for people. For example, all falls were recorded. One person had experienced six falls in an 11 week period. All falls had taken place between 9:10pm and 10:40pm. We spoke to the manager who had not identified this pattern and so was not able to consider what specific conditions could be contributing to the fall. When asked about falls the manager told us everyone was referred to CHSS. This meant there was no effective system in place to assess, monitor and improve the quality and safety of the service in relation to accidents and incidents.

People's care records were not always complete and accurate. For example, people's MAR charts had not always been signed to indicate medication had been administered. This meant it was not clear whether the person had received their medication.

We found staff lacked leadership and oversight from the provider and manager. This meant that risk was not managed effectively and important care issues were not followed up; this had impacted on the safety, health and welfare of people who used the service. Staff we spoke to were not always confident about questioning practice and reporting concerns. They did not always feel that concerns they raised were investigated thoroughly. A person said "Care staff are brilliant but management is weak". Staff were not always clear of their roles and responsibilities. One member of staff said they felt they lacked direction.

Although we found the staff to be caring on the day of the inspection, compassion, dignity, respect, and safety were not always evidenced. For example, the concerns and lack of appropriate action from the management regarding reported incidents were not in line with their policy and procedures. This showed the lack of suitable management to keep people safe. During the inspection two members of staff told us of a bullying and intimidating culture. One person reported they continued to be bullied even though this had been reported to the manager. We did not see evidence of appropriate action taken by the manager or the provider.

Team meetings had taken place. There were references in the notes about poor practice. For example, it stated that a person had been given a drink without thickener. It stated 'Next time this will be safeguarded as a risk of choking'. No action was recorded as having taken place to manage future risks.

Close circuit television (CCTV) was being used in the lounge area of the home. Providers should record the purpose(s), and initial assessment of why surveillance was necessary. It should be recorded what alternatives to using surveillance have been considered and why they are not suitable, as evidence to support any decision to use surveillance. The CCTV code of practice issued by the Information Commissioners Office provides guidance and advice for CCTV users on how to comply with the Data Protection Act. We discussed whether guidelines had been followed before using the CCTV and the provider did not have any knowledge of these requirements to comply with the law.

Following the inspection on 1 June 2015, an action plan was required by the Commission to be sent by 26 July 2015 in response to the areas of the service that were in need of improvement. Over a six month period, repeated submissions of the action plan were sent by the provider. However, the Commission had not received an appropriate action plan by the time of this inspection. We found that requirements from the last inspection were still outstanding, for example, outstanding training and improvement of governance of the service.

This inspection was the seventh inspection of Fewcott House since February 2013. At each inspection we saw changes had been made to bring the service up to the required standard but also highlighted further areas for improvement. However, these improvements had not been sustained

The last registered manager left in July 2015, and the manager who had been in post since August 2015 left the service following this inspection. The provider has not ensured strong leadership to improve and maintain the service and support staff effectively. There has not been a stable management team at the home during this time, which meant all of the improvements had not been sustained or embedded in practice. This is evidenced by the failure to meet regulations as outlined in this report. Staff had not been supported and felt compromised about raising concerns. Safeguarding matters had not been dealt with in an open, transparent and objective way. The lack of good quality assurance meant that risks and

improvements were not effectively managed.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had failed to notify the Care Quality Commission about all incidents they were legally required to.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had not notified the Care Quality Commission of all incidents that affect the health, safety and welfare of people who use services.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured the safe and proper management of medicines. Regulation 12(2) (f) (g).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured systems and processes were in place to meet requirements in other regulations under the HSCA RA Regulations 2014 Regulation 17(1) (2) (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not operated a robust recruitment process ensuring all relevant checks.

	Regulation 19(1) (2) (3) (5).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received appropriate support, training, supervision and appraisal as is necessary to enable them to carry out their duties. Regulation 18(2) (a).