Aspire Care (UK) Limited

Fawnhope Rest Home

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?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 8 and 9 August 2016 and was unannounced.

Fawnhope Rest Home is registered to provide accommodation and personal care for up to 19 older people including people who may be living with dementia or other mental health conditions. Fawnhope Rest Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

At the time of our inspection there were 16 people living at the home, 14 of whom were accommodated in a converted and extended residential building with a shared lounge and dining area. Two people were accommodated in a separate annexe. At the time of our inspection they chose to have their meals and daytime activities in the main house. There was an enclosed garden.

There was a registered manager in place. 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.

We previously inspected Fawnhope Rest Home on 24 and 25 May 2016 and rated the home as Good. We found a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) 2014, Premises and Equipment. This was because the provider had failed to adequately assess risks associated with fire safety as not all actions required by Hampshire Fire Service had been completed. At this inspection we saw that the fire risk assessment was complete and any issues identified had been actioned. The provider was no longer in breach of this regulation. However, we found that the provider did not have robust arrangements in place to ensure all staff could act appropriately in the event of an emergency. We have made a recommendation about best practice fire safety guidelines.

We also found other breaches of regulations at this inspection.

The administration and storage of medicines was not managed safely. This had not been identified by the service because effective checks had not been undertaken.

There was not a robust quality assurance process in place. Audits to assess the quality of service provision were ineffective in identifying some of the improvements needed. Action plans were not developed to ensure improvements were made.

Not all complaints received had been recorded to show how the complaint had been managed and that the complaints procedure had been followed. We have made a recommendation about the management of complaints.

Care plans did not contain information that was always reflective of people's current needs. There was conflicting information in some people's care plans.

Staff sought verbal consent from people, before providing support, but did not always follow legislation designed to protect people's rights when making decisions on their behalf. Care plans did not have mental capacity assessments in place.

Some activities were provided for people; however, the provision of activities did not always meet people's emotional, social and psychological needs. Feedback about staffing levels was mixed and we observed that people spent long periods of time without engagement from staff. We have made a recommendation about the determination of staffing levels.

Feedback about the food on offer was positive and people were given a choice. Where people needed support to eat, this was given in a dignified way. However, people did not have their fluid intake adequately monitored.
Some risk assessments were not reflective of people's current needs and this documentation needed improvement to ensure clear guidelines were in place for staff to follow. However, we saw that measures had been put in place to address and reduce risks for people.

Most care plans in place were person-centered and included details about people's life histories and what was important to them. People were supported by staff that knew them well.
The home was visibly clean and staff used protective equipment when needed. Staff were seen to follow infection control procedures except for one time during our inspection.

People were complimentary about the staff. All interactions we observed between staff and people were positive. Staff promoted people's privacy and dignity and encouraged people to remain as independent as possible.

Staff displayed good knowledge on how to report any concerns and could describe what action they would take to protect people from harm. Accidents and incidents were recorded and monitored to determine if any trends were occurring.

Safe recruitment processes, including pre-employment checks had been followed.

During our inspection we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the registered provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not administered or stored safely. People did not always get their medicines as prescribed which presented a risk to their health and wellbeing.

Measures were in place to manage risks to people but risk assessments were not always reflective of people's current needs.

The provider did not use a systematic approach to ensure there was enough staff on duty to meet people's needs.

Environment risks had been assessed and improvements had been made to the management of fire risks. However, the provider did not have systems in place to ensure staff could act appropriately in the event of an emergency.

People told us they felt safe and staff were aware of the procedures to follow regarding safeguarding adults.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not always follow legislation designed to protect people's rights.

People were positive about the food on offer; however, fluid intake was not adequately monitored which could present a risk of dehydration.

Staff were appropriately supported in their role and arrangements were in place for them to receive training, supervisions and annual appraisals.

Staff worked well as a team and people had access to appropriate healthcare services.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider had not always ensured that people received a caring service because of their lack of oversight.

People, relatives and health and social care professionals told us staff were kind and caring.

Observations reflected people were comfortable and relaxed in staff's company. People were cared for with kindness and compassion.

People's privacy and dignity was respected and they were encouraged to be independent.

Information about people was stored confidentially.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not always contain current and up to date information about people.

The provision of activities were poor and people were not consistently supported to ensure their social and emotional needs were met.

There was a complaints procedure in place, however, records did not always demonstrate that complaints were investigated or satisfactorily resolved.

People were cared for at the end of their life appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

An effective quality assurance system was not in place. Audits conducted had not been robust and action plans were not in place to drive continuous improvement to the service people received.

Feedback about the service was sought but there was no system in place to ensure feedback had been acted on.

Staff told us they enjoyed working at the home and the

registered manager was supportive.

Fawnhope Rest 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 comprehensive inspection was triggered due to a number of concerns raised about risks associated with the moving and handling of people; risks about people leaving the building which could cause them harm and a lack of oversight of the home when the registered manager was absent. We informed the local authority of these concerns and they were in the process of carrying out an investigation when we inspected the home.

This inspection was unannounced and took place on 8 and 9 August 2018. The inspection team consisted of one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience in older people and dementia.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is information about important events which the service is required to tell us about by law. Prior to our inspection we asked the registered provider to complete a Provider Information Return (PIR) as part of the Provider Information Collection. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We spoke with the local authority to gain their views about this service. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with ten people, three relatives, the registered manager, the provider, five members of staff and two healthcare professionals. We observed how people were cared for whilst they were in the communal areas of the service. We looked at the care records for five people and the medicine records for all people.

We reviewed staff recruitment, supervision and appraisal records for two staff. We looked at records relating to the management of the service, policies and procedures, maintenance, quality assurance documentation and complaints information.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us they were safe living at Fawnhope Rest Home. One relative told us, "Yes, it is definitely safe here". We saw feedback from surveys that people, relatives, staff and health care professionals thought the service was safe. One relative had stated 'Mum is safe here' and another had stated 'Much safer here than at home'. Despite people's positive feedback, we found areas of care which were not consistently safe.

People were not adequately protected against the risks associated with unsafe management of medicines. We looked at people's Medication Administration Records (MARs) to see if people received their medicines as prescribed. We saw that some medicines that were prescribed for people were not consistently in stock and therefore not available for people to take. For example, one person who was at risk of constipation did not have a medicine to manage this condition available for one week. We discussed this with a member of staff and they told us the medicine had been ordered but had not arrived from the pharmacy. We could not see evidence that this medicine had been 'chased up' to ensure the person had the medicine as prescribed.

We reviewed the MAR gaps for one person and found six unexplained gaps where staff had not recorded whether a medicine had been administered. Therefore, it was unclear whether the person had received this medicine or not. This meant that the person could have become unwell because they hadn't received their medicines as prescribed. We also noted that the wrong dose of a different medicine had been administered to this person. This meant there was a risk that the person had received too much of the medicine and could cause them harm. These errors had not been identified or acted on to protect people and ensure the safe management of their medicines. We brought these concerns to the attention of the registered manager who took action during the inspection process. They sought advice from a healthcare professional to ensure the safety and wellbeing of the person.

We noted that some medicines had been handwritten onto the printed MARs from the pharmacy by staff administering medicines at the home. Most had not been signed by the member of staff adding the medicine or countersigned by another member of staff to confirm the instructions were correct, as is best practice considered by The National Institute for Health and Care Excellence (NICE). Some tablets were prescribed to be taken as either one or two. Staff had signed the MAR but had not recorded whether they had given one tablet or two. This meant that it could not be determined how many tablets people had taken.

MAR charts had a variety of recording codes noted at the bottom of the chart. These codes were recorded to demonstrate why a person may not have been administered their medicine. We identified that staff were frequently using wrong codes. For example, one person was prescribed a tablet to be taken on alternate days, staff were using the code for 'offered PRN – not required' on the days that the tablets were not to be given. If medicines are not recorded in line with current guidance people are at risk of receiving too much of the medicine or not enough of the medicine which has been prescribed for them.

We looked at how people's medicines were ordered and booked into the home. There was no record of how

many tablets were received into the home for the month of August 2018. When we counted the tablets in boxes we were not easily able to determine whether it was the correct amount because there was no record of how many tablets had been delivered and no record of how many tablets had been carried forward from the previous month. Medicines were not audited on a regular basis to ensure there were correct amounts in the home. It is important that medicines are regularly audited to ensure people have received their medicines as prescribed and any anomalies are identified and acted on promptly. When we discussed this with the registered manager and a member of staff, they were unable to tell us why the number of tablets received in the home had not been recorded in August 2018; however, they advised it was not usual practice and demonstrated two previous months' worth of Medication Administration Records (MARs) audits. We saw that on these occasions the number of tablets received into the home had been recorded. The registered manager also told us they would begin to audit the medicine count and stock medicines regularly.

We saw that people who were prescribed medicines that would thin their blood, and as such pose a risk to them, did not have risk assessments and clear guidance for staff to follow. However, when we spoke with a staff member they were able to tell us about the risks associated with these medicines. Whilst regular staff members were aware of the associated risks, for new staff or agency staff, the lack of robust guidance posed a risk.

Some medicines are prescribed to be taken when required. These are used to treat short term medical conditions or long-term conditions when people may experience 'flare ups' such as medicines to manage agitation, anxiety and pain. Records showed that when people were prescribed these medicines, information was mostly available to guide staff as to what the medicine was for, when and how much to administer. However, these protocols were not consistently in place. This meant there was not guidance in place for staff to know when and how much of a medicine to administer for a person. When staff had administered these medicines, they had not recorded the outcome for the person after receiving the medicine. This meant the efficacy of the medicine could not be reviewed.

Safe practice was not followed to ensure people's medicines were safely stored. On the first day of inspection the fridge located in the kitchen which was used to store medicines was unlocked. There were records for the temperature of the medicine cupboard and the medicine fridge. However, records showed that readings for the medicine cupboard were frequently over the safe storage temperature (25 degrees). Medicines may not be effective if they are not stored at the correct temperature. This had also been identified by a pharmacist during their visit in June but this had not been acted on by the provider.

The failure to protect people from the risks associated with the unsafe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

We brought the above concerns to the attention of the registered manager who was responsive to our concerns. During the inspection process they began putting measures in place to manage medicines in a safer way and support was also sought from the local authority

At the last inspection in May 2016 we found the provider had not assessed the premises for risks from fire effectively as not all actions required by Hampshire Fire Service had been completed by the provider. This was a breach of Regulation 15 of the Health and Social Care Act 2008 (regulated activities). At this inspection we saw that the fire risk assessment was complete and any issues identified had been actioned.

Records demonstrated that fire drills had taken place in February 2017 and April 2018. However, not all staff had taken part in these. Although the staff we spoke with could tell us what the fire procedure was, failure to

participate in the fire drills posed a risk as not all staff would be clear about the actions required if a fire occurred or able to evacuate people safely and confidently.

We recommend that the provider considers current guidance on fire safety and takes action to update their practice accordingly so staff are clear about their responsibilities in an emergency.

Each person had a personal emergency evacuation plan (PEEP) in place and these had been regularly reviewed. PEEPs describe the support and assistance that people required to reach a place of safety when they are unable to do so. The provider had a business continuity plan in place to ensure people were kept safe in the event of an emergency. Other health and safety checks were also conducted such as regular testing of electrical equipment. A risk assessment regarding the environment was in place.

People had risk assessments in place. Risk assessments assist staff to be aware of any potential concerns or risks relating to the person, and how the service is working to minimise those risks. There were risk assessments about pressure ulcer prevention, the prevention of malnutrition, incontinence and falls. Most risk assessments were reflective of people's needs and measures had been put in place to mitigate these. For example, one person had been assessed as having a high risk of falling. The plan detailed steps staff should take to reduce this risk and we saw these were being practiced during the inspection.

Other risk assessments were not reflective of people's current needs. For example, on one person's risk assessment it was recorded they were at medium risk of falls but they had fallen nine times in the last month. Risk assessments should be reviewed when a person's needs change to ensure the risk assessment remains robust. Additionally, risk assessments for the prevention of malnutrition had not been updated since January 2018. One person who had a Deprivation of Liberty Safeguard in place was at risk of leaving the building unsupervised and had done so prior to our inspection. This person did not have a detailed risk assessment in place to guide staff on how to manage this risk. Despite some risk assessments being out of date or not being detailed, we saw that measures had been put in place to address and reduce risks for people. All staff we spoke with were aware of these risks and were able to tell us what measures were in place to reduce these. However, risk assessments that are not detailed or current could pose a risk for staff who were not familiar with the people living at the service.

Before the inspection we had received concerns about poor moving and handling practices for some people. These concerns were raised with the local authority who were supporting the service. Since their visit, the registered manager had ensured the moving and handling plans were clearer with specific details of the equipment used. We spoke to staff in the home and they could tell us how people were moved safely. Staff told us they thought the practices were safe. We also saw that external health and social care professionals had been consulted about the best way to move people. However, on one person's moving and handling plan it stated they could stand well with equipment but the daily notes frequently stated this was not the case. We discussed this with the registered manager and they told us they felt the issue was due to the person's behaviour rather than physical needs. They told us they would review this. The registered manager has since put a mobility matrix in place where all people's mobility needs are reviewed weekly with the input of care staff. Mobility assessments are now kept in people's rooms so staff have the necessary guidance easily available.

Some people displayed behaviours which challenged others. Information was available in some people's care plans which helped staff to recognise signs which highlighted when a person may be becoming agitated; how to support the person during this time and how to assist them afterwards. We viewed one person's care plan and this was comprehensive and detailed. All staff we spoke with could tell us about the person and what techniques they used to successfully manage their behaviours. However, we saw from

another person's daily notes that they were frequently non-compliant with personal care and moving and handling procedures, they were often verbally abusive to staff and had struck a member of staff on one occasion. This person did not have information available in their care plan for staff to manage this risk. We brought these concerns to the attention of the registered manager who agreed to review their care plan.

Staff told us and rota's confirmed that there were three care staff on duty at all times of the day and night. They were supported by a chef and housekeeper who worked in the morning. There were mixed reviews about staffing levels in the home. One member of staff told us, "There's enough staff but it all depends on the day, three is plenty on the calmer days", another staff member told us, "There is enough staff apart from when someone goes sick, then we have to cover to make sure the rota is covered" and a third staff member told us, "We definitely need more staff, I was told to undertake two tasks at once but this wasn't possible". A health and social care professional told us, "Three members of staff feels low".

Our observations demonstrated that staff responded to people's needs promptly, however this left other people with long periods of having no interaction from staff. Whilst people's personal care needs were acted on promptly, we have reported the failure to meet people's emotional and social needs in the responsive domain. For example, one person's falls technology alarm sounded frequently, on the first day of inspection we saw that it sounded eight times in ten minutes, this meant one staff member was attending to them while another staff member had been tasked with monitoring another person who walked around the building and was at risk of leaving the building unsupervised and the third member of staff was preparing for lunch time. This meant there were no staff available to attend to the remaining 13 people in the home.

When we discussed this with the provider and registered manager they told us they felt there were enough members of staff on duty. However, the provider did not have a systematic approach to determine the numbers or deployment of staff and range of skills required in order to meet the needs of people using the service and to keep them safe at all times. This meant staffing levels were not calculated according to people's needs and we could not be assured that sufficient staff were therefore available to meet people's needs.

We recommend the provider seek advice and guidance from a reputable source about using a systematic approach to ensure sufficient staff are deployed to meet people's needs.

There was an infection control policy in place and most staff had received training in infection control. We saw care staff followed best practice guidance by wearing personal protective equipment (PPE) and washing their hands appropriately. Two staff members still had their PPE on when leaving a person's room and walked through the home with it on, this could pose a risk of cross infection. When we discussed this with the provider and registered manager they told us this was not common practice and they would monitor this to ensure it didn't happen again.

The communal areas were clean, in a good state of repair and were warm and welcoming. However, some areas in the corridors and people's rooms were in need of attention such as worn carpets, marks on walls and damaged paintwork. One corridor and one person's room was malodourous. The provider confirmed these issues were included in future redecoration plans. A cleaning schedule was in place which included deep cleans and this was signed appropriately and completed.

The provider had a policy in place to ensure staff and the registered manager had guidance about safeguarding people. Staff had received training and were able to demonstrate an understanding of the signs of abuse and the action they would take if they suspected abuse. Records were held of safeguarding concerns that had been raised. These had been referred to the local authority.

There was an accident and incident book in place and the registered manager had investigated the accidents and incidents that were recorded in it. An analysis of these took place and trends and patterns were identified. For example, we saw that one person had fallen numerous times and the registered manager had put measures in place to reduce the risk of them falling in the future. They had sought the assistance of external healthcare professionals and communicated the changes for the person's care to the staff team.

The provider had safe recruitment processes in place. Staff files contained evidence of application forms, the names of two employment referees and any relevant training. There was also a statement that confirmed the person did not have any criminal convictions that might make them unsuitable for the post. A Disclosure and Barring Service (DBS) check had been obtained by the provider before people commenced work at the home. The Disclosure and Barring Service carry out checks on individuals who intend to work with children and adults, to help employers make safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

People received care and support from staff who knew them well. A relative told us, "Mums needs are catered for as requested" and another relative said, "The staff are helpful and seem good". A health professional told us, "The staff are knowledgeable about people; the care homes team have worked with them and have skilled them up". However, despite people's positive comments, we identified areas of care which were not effective.

The Mental Capacity Act (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible.

Most people had signed consent forms in their care plans for areas such as information sharing and consent to care while at Fawnhope Rest Home. However, staff told us that the majority of people had some level of confusion due to dementia or a brain injury and capacity assessments had not taken place to determine if people could understand what they were signing for. For example, one person had signed these consent forms but records showed that their relative had Lasting Power of Attorney (LPoA) for health and welfare. This caused confusion about who the decision maker was because there was no capacity assessment in place. We saw that three people regularly refused their medication but despite the staff informing the GP there were no capacity assessments in place to determine if these people understood the implications of this. There was also no evidence that best interest meetings had taken place to determine the best course of action in these circumstances. Another person who was at risk of falls had a mat by their feet which sounded an alarm whenever they moved, staff attended to the person when this happened. These mats can be seen as a restraint because they have the potential to restrict a person's freedom of movement. It is therefore necessary to ensure either the person consents to using these or that a mental capacity assessment and best interest decision process is followed if they are not able to consent.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). 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.

We had received information prior to the inspection from an external social care professional who said they were concerned that DoLS were not always applied for when they should have been. When we carried out the inspection, we saw that a DoLS application had been made on behalf of four of the 16 people living in the home. We asked staff whether some people who did not have an application for a DoLS would be able to leave the home of their own free will. One staff member said "No" another said, "Of course not". When we asked them why, they replied "They would be at risk", "They would get lost" and "It's not safe". This meant that people may not be lawfully deprived of their liberty. These findings demonstrate that the registered

manager and provider lacked the understanding of when to identify a potential deprivation of liberty safeguard. When we spoke to a healthcare professional they told us the registered managers knowledge was "improving" in this area.

The failure to work within the principles of The Mental Capacity Act was a breach of Regulation 11 of the Health and social Care Act 2008 (Regulated Activities) Regulations 2014.

We brought the above concerns to the attention of the registered manager who confirmed this was an area of practice that needed improving. Subsequent to the inspection, the local authority advised that mental capacity assessments were being undertaken and as a result, DoLS applications had been made for 11 more people.

Staff told us they had received training in the MCA and were clear about how they sought verbal consent from people before providing care and we saw examples of this taking place during the inspection.

People spoke positively about the meals, describing them as, "Good" and "Lovely". People also said they could choose where they took their meals. Details of the food people liked, disliked and their preferences were recorded in their care records. These were used to help ensure people received meals they enjoyed. Staff told us people could have a choice of meals and we saw that people were offered snacks throughout the day. One person requested a sandwich mid-morning and this was promptly provided and another person had requested chocolate gateaux for breakfast which was given. The chef also gave an example of changing the menu according to people's preferences.

We observed lunch in the dining area on the first day of inspection. Some people were assisted to sit at the table for lunch but got up and left because the meal took 20 minutes to arrive after they were first seated. The atmosphere at the beginning of lunch time was chaotic but then settled into a pleasant experience for people. Staff were on hand to support people to eat. Most people just needed occasional prompting to eat and we saw this was done in a supportive way.

Each person had a nutritional care plan and staff monitored people's weight regularly. If people experienced unplanned weight loss, staff took appropriate action, including referring people to GPs and dieticians.

People had access to drinks at all times and were encouraged to drink often. The daily target for how much a person should drink each day was recorded in people's care plans. Staff recorded people's fluid intake on a chart to monitor how much fluid a person had taken if they felt there was a need. However, we saw there was no accountability for checking and acting on the fluid information that was recorded. For example, we saw on one person's fluid intake chart that they had not reached their daily fluid intake target numerous times but no actions had been identified or recorded to address this. The lack of evaluation of fluid charts could put people at risk of dehydration. We discussed this with the registered manager and they told us they would put measures in place to ensure this information was monitored, evaluated and acted on in the future.

People were cared for in an environment where some adaptations had been made to meet their needs but additional work was needed to develop this further. A health professional had commented on a feedback survey that 'Considerable investment is needed in the refurbishment of this home'. The provider told us they were updating the environment and we could see during the inspection that this was taking place. A health professional told us, "It is nice to see updates to the environment have been carried out, I hope the bedrooms will also be done". The communal areas were bright, well-lit and welcoming but the corridor and some bedrooms appeared dark. While not entirely maintained in a dementia friendly style (e.g. using

differing colours to distinguish areas, items and clear signage) efforts had been made to add interest for the people living there. For example, pictures of film stars and singers were put on the walls in the corridor. There was a large activities board and date/time/weather board in the reception area, however these were not reflective of the current situation. Although some people's bedrooms appeared dated, they could personalise their rooms as they wished. The provider told us they were using guidance from a reputable source to improve the environment for people.

Arrangements were in place for staff who were new to care to complete training that met the standards of the Care Certificate. The Care Certificate is an identified set of standards that health and social care staff adhere to in their daily working life. Staff confirmed they had received a good induction into the home. One member of staff told us, "The induction was good, it covered a lot such as fire, safeguarding and capacity".

The registered manager had a training plan in place. Training included safeguarding, moving and handling, medication, equality and nutrition. Each staff member had a training matrix in place and this showed what training they had undertaken. Most staff had completed training the provider considered essential for their role. Most staff told us they had enough training. One member of staff told us, "The training is great" and another told us, "The training seems good". However, another staff member told us, "I have done the training but would like to refresh it more regularly, when the training falls on my shift, I can't go, we have to take turns". Records demonstrated that on occasion some staff had to wait until the next training session to refresh their knowledge.

Staff received regular one-to-one sessions of supervision and an annual appraisal with their line manager. This was a formal process which provided opportunities to check performance and ensure staff were being supported appropriately. Staff told us that they found the supervisions to be effective and had helped to resolve any issues that they had previously had. They also told us they could speak to the registered manager at any time between supervisions and were confident they would be supported.

Staff told us they worked well together and information about people and their changing needs were communicated through a handover. People were supported to access other healthcare services. Records demonstrated that people regularly saw doctors, specialist nurses and mental health professionals. One person had been referred to an occupational therapist following a reduction in their mobility and another person had been referred to an optician. An external health professional told us, "The home works well with us, everything that I ask staff to do, they do".

Requires Improvement

Is the service caring?

Our findings

People, relatives, staff and health professionals told us people were supported by kind and caring staff. One person told us, "The girls look after me and are lovely", a relative told us, "The staff are very nice and definitely caring" and a health professional told us, "All the staff I have come across are caring". However, despite people's positive comments about the staff team, we identified areas of practice which were not consistently caring.

The provider and registered manager had not ensured people were adequately supported in terms of protecting their rights, ensuring that medicines were managed safely, providing stimulating activities and ensuring people could provide feedback about their care and the service which was acted on. We have discussed the associated risks of this within the 'Safe', 'Effective', 'Responsive' and 'Well-led' section of this report.

We spent time in communal areas observing interactions between staff and people who lived at the service. Although staff were busy and task orientated in their approach, staff were seen to support people in a caring manner, staff engaged with people, made eye contact, bent down to their level and used touch appropriately to reassure and we saw that where people requested support it was provided promptly and discreetly.

People using the service responded well to staff; they appeared relaxed and there was lots of chatting and laughing. We overheard staff speak to people kindly. For example, we heard one member of staff say, "Your hair looks lovely" which made the person smile.

Staff made every effort to include people, one person introduced a staff member to us as their colleague and the staff member responded by saying "We do this together". Another person was encouraged to pour drinks for others and a staff member asked a person to go baby clothes shopping with them, the person was delighted by this.

The registered manager told us that people were involved in making decisions about their care when they reviewed the care plans. We saw that people had signed a form which demonstrated that they had been involved. However, there were no comments recorded from people about how they would like to be supported. People were not able to tell us how this process worked, it was therefore difficult to assess how people had been able to express their views and whether they had been acted on.

Many of the staff had worked in the home for a considerable length of time and knew people well. One staff member described how they understood one person's needs who was unable to communicate. They said, "(Name) loves her routine, I know what she wants from her body language and posture". Another member of staff was heard talking with a person about where they grew up and their previous job. Staff spoke about people fondly and with respect. One member of staff told us, "I love them, they are like my family" while another member of staff said, "The best thing about my job are the residents, I admire them".

Staff respected people's privacy and dignity. Staff were seen to knock on people's doors before entering their bedrooms. They also asked or waited for people's permission before entering. Staff told us how they protected people's privacy and dignity and gave examples such as "Shutting doors and curtains when giving personal care" and "Covering people while helping with personal care". We observed one person talking to a member of staff. They were upset that another person had gone into their room uninvited and taken some belongings. The staff member asked the person if they would like their own key and after they had said yes, arranged with the registered manager for this to happen.

People were encouraged to be independent. One staff member told us, "I always encourage the residents to do things for themselves". We observed an occasion where a relative tried to help a person up from a chair, a staff member intervened and said, "Let's let (Name) get up on her own, she can do it". The person could do this independently.

The home ran a 'Ladybird' Scheme. This was where allocated staff members assisted certain people with tasks such as tidying wardrobes and ensuring people had enough toiletries. The registered manager told us that a person had chosen the name of the scheme because it reminded them of ladies in waiting. The registered manager went on to say that this worked well and meant people had the "little things looked after".

People received care and support which reflected their diverse needs in relation to the seven protected characteristics of the Equalities Act 2010. The characteristics of the Act include age, disability, gender, marital status, race, religion and sexual orientation. Peoples' preferences and choices regarding these characteristics were appropriately documented in their care plans. We saw no evidence to suggest that anyone who used the service was discriminated against and no one told us anything to contradict this. The provider had organised a church service in the home once a month. Staff had received training in equality and diversity and were able to tell us how they put this knowledge into practice.

The Accessible Information Standard is a framework which was put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The service had produced the complaints procedure in a pictorial way and the statement of purpose and charter of rights were provided to people in a large print version.

Relatives and friends were welcome to visit any time. People were also supported by staff to maintain relationships with friends and family outside of the home. For example, a staff member told us that they had assisted a person to 'Skype' their family member who lived abroad.

There was a confidentiality policy in place for staff to follow. People's personal information was stored securely and computers were password protected in line with the Data Protection Act.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives felt staff had a good knowledge of the needs of those they supported. One person told us "The girls know me well, they are very good". A healthcare professional told us the staff and the registered manager had an "excellent" knowledge of the people who lived at Fawnhope Rest Home and sought extra support for people when their needs changed.

People had care plans in place which considered their care needs such as mobility, health and nutrition and personal care. However, the information provided was not always up to date or reflective of people's current needs. Care plans were not in a sequential order and out of date information was not always extracted. This made it difficult to find current and relevant information about people. For example, people had their 'First Care Plan' near the front of the file which contained details of how to meet their needs when they were admitted to the home which was not the most recent information. There was also a form called 'My Care Plan Outcome', this contained a short summary of how to meet people's needs. These were not dated and we saw that on one person's document information was not reflective of their current needs. Another form was in place which was titled 'Care Plan Information Gathering' which detailed the information needed to compile the care plan.

There were old forms in care plans. For example, we saw chiropody and bath records from 2016 and body maps from 2017. We noted that one person had two weight records in their file and for the last two months different weights were recorded. We asked the registered manager about a document that should have been in a care plan, it could not be found in the care plan but was located on their computer. Staff who were unfamiliar with people would need to rely on the information in people's care plans and the lack of organised care plans posed a risk that they would not easily locate current and relevant information about people. When we discussed this with the registered manager they told us they liked to keep information but would review the care plans to ensure relevant and current information about people was easy to find.

The registered manager told us they reviewed people's care plans on a monthly basis and included people in this process. We saw signed records of this. However, we saw that one person's care plan was not reflective of their current needs. The person had become recently unwell but the care plan had not been updated to reflect this. One person did not have a full care plan in place. The registered manager told us it was because they were new and they had been absent from work. However, this person had been in the home for two months. The registered manager told us they would put measures in place to ensure people had a completed care plan in a timely manner.

A failure to ensure accurate, up to date and contemporaneous records placed people at risk of not receiving the appropriate care and support. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the above concerns, we found evidence of people's changing needs being identified and met. For example, staff were able to tell us about one person's needs who had recently become unwell, they were also able to explain how one person's whereabouts needed monitoring as they were at risk of leaving the

building alone. Staff told us they knew how to respond to people's needs because they knew them well.

Some areas of people's care plans were comprehensive and detailed. They contained information for staff about how to meet people's needs in a variety of areas, including washing and dressing, eating and drinking, communication and mobility. There was information about the person's life history, preferences and activities they enjoyed.

Information about people's health needs were recorded. For example, one person had diabetes and information of how to support them with this was detailed. Another person had a care plan about the support they needed with their dementia. There was information that was person-centred and demonstrated that staff knew people well. Examples included: 'I dislike getting a draft from the window', 'I am proud to be a Londoner' 'I prefer food that I can eat with my hands' and 'I dislike fish if it does not have batter on it'. This information helped staff support people in the way they preferred. People's preferred routines were recorded including what time they preferred to get up and go to bed and where they liked to eat their meals.

We observed people sitting in the lounge for long periods of time without any social engagement. The television was on all day and people were generally not watching it. Other people were walking around the home and only had interaction from staff when they were passing through from completing their tasks. One member of staff told us, "There is no time to sit and chat to people, we are always on the go". Another member of staff told us, "I would like to see more activities for the residents to do". We viewed feedback from a health professionals survey and a comment included, 'Appears little stimulation for patients'. Another health professional told us "There is a singer and hairdresser that comes in, I've never seen anything else happening, the TV is always on".

In one person's file it stated they enjoyed reading, crosswords and puzzle books but we did not see the person being supported with this. The person was clearly very active and liked to be busy. They spent most of the time walking around the home and sometimes following staff. Staff tried their best to engage with the person and were seen singing with them and including them in their own tasks, however we observed the person spent a lot of time walking around on their own, and frequently asking "What can I do?"

Planned activities in the home consisted of a visiting pets for therapy dog and a singer once a fortnight. Staff on duty took responsibility for arranging and managing the remaining activities. One member of staff said, "We are usually able to spend time with people between two and four pm, we do some activities at this time". There was a cupboard in the lounge which staff could take activities from. On the second day of inspection, we saw one member of staff carry out a game of throwing an object at a target mat. They were encouraging and supportive of people when they took part, they also helped some people to add up their scores and celebrated their success with them. Some people enjoyed this activity but others declined to join in. There was a lack of stimulating and meaningful activity for people to meet their emotional and social needs.

We discussed the lack of activities for people with the provider and registered manager and they told us they had advertised for a designated activity co-ordinator to improve this area in the home.

The failure to assess, plan and provide activities to meet people's emotional and social needs and preferences was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a complaints policy and this was on display in the entrance hall. One relative told us, "I

wouldn't know how to complain but my sister probably would". We looked at the complaints log. We saw that two complaints had been received. The first complaint had been recorded on the log and a satisfactory outcome was recorded. However, the second complaint was not recorded on the log and there was no evidence that this had been investigated or resolved for the person. We discussed this with the provider and registered manager and they told us the complaint had been resolved but had not been recorded.

We recommend that the service seek advice and guidance from a reputable source about the management of and learning from complaints.

The service supported people and their families in relation to end of life care, however no one in the home was receiving end of life care at the time of our inspection. Some people's preferences and choices were detailed in care plans, however other people's advance care plans were blank. A staff member told us this would be completed "nearer the time". Where appropriate there were Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders in place. Staff had training in supporting people at the end of their life. The registered manager told us they were supported by district nurses, doctors and the local hospice when people needed end of life care and this worked well. We saw a thank you card from a relative which stated, 'You all helped mums end of life to be very peaceful and dignified, you were so caring not only to mum but the whole family'.

Requires Improvement

Is the service well-led?

Our findings

Systems and processes were not always effective in monitoring and improving the quality of the service. There were some quality checks in place which included infection control audits, environment checks and medicines audits. When actions were identified as required, these were not always signed off to say they had been resolved. For example, on the infection control audit, areas for improvement included 'cooker needs a thorough clean' and 'deep clean needed under units and shelves'. However, there was no evidence recorded to say this had been reviewed or completed. The medicines audit was not sufficiently robust and did not identify the concerns we found during our inspection.

The registered manager told us care plans were reviewed on a monthly basis, but this did not include oversight of the overall quality of care plans in order to identify areas for improvement. Such as; missing information, duplication and the lack of up to date and accurate information about some people's needs. There were no systems in place to audit some of the areas of the service where we identified concerns. We have reported in other domains the shortfalls we found in determining staffing levels, activities for people, adhering to the Mental Capacity Act (2005) and complaints management.

The provider engaged people, their representatives, staff and health professionals in the running of the service and invited feedback through the use of questionnaire surveys. Feedback was predominantly positive, however there was no evidence that when individual issues raised, these were explored or resolved for people: for example, we saw comments such as; "I wish dad was in a downstairs room" and" More staff needed, especially when there is sickness".

The registered manager told us they held meetings for people but were unable to locate the records of these. The lack of records meant there was no audit trail of how people's comments were analysed or acted on.

No action plan was developed following these meetings or surveys, this meant there was no structured system to ensure people's feedback was acted upon or that the provider had used the feedback to drive improvement in the home.

People and staff told us the provider was in the home frequently and they knew them. However, there were no documented quality checks in relation to the safe and effective running of the home which had been undertaken by them. There was a lack of coordination in the service which made some areas difficult to audit. The provider told us they had enlisted the help of a consultant but their input to the safety and quality of the home was unclear.

A failure to have effective systems and processes in place to monitor the safety and quality of the service and to drive improvement was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before our inspection, we had received information of concern regarding the governance of the service

when the registered manager was absent. One member of staff told us they, "Didn't know who was in charge when the manager was away". The registered manager told us about the staffing structure in the home. They told us they had 12 'care planners' who undertook extra tasks such as covering the rota and running the shift when the registered manager was absent. This was instead of a deputy manager or senior staff. The provider told us they were also available at this time. However, we found the home was not consistently well led when the registered manager was absent as some risk assessments and care plans had not been updated while they were away and a member of staff told us they felt unsupported at this time. The registered manager told us they were planning to delegate some tasks to other staff members in the future. They also told us they were going to make some of the staff members into champions, this meant they would have extra responsibilities in a certain area of the home such as nutrition or continence.

The registered manager held regular staff meetings to support staff to understand their roles. During one meeting we saw that staff undertook a workshop in completing their job role. This covered all aspects of their role to refresh their understanding of what was required of them. During another meeting staff completed a refresher quiz about infection control. Staff we spoke with told us they found the meetings useful.

The registered manager and provider were consistently described in a positive manner by staff, people and relatives. They were described as open, supportive, approachable and caring. One member of staff said, "The manager is amazing, you can contact her 24/7, she's taught us so much, I could go to her with anything" and another told us, "The manager is always there for us, she guides us with things like regulations, she's very supportive".

Staff described the culture in the home as very good. One staff member told us, "It's like a home from home, residents can do what they like", another staff member told us, "It's like a family here, I can't imagine working anywhere else, once you come here, you never leave, that's why some of the staff have worked here for so long". Staff members were also complimentary of each other. One staff member told us "We all work well together, there is a real unity" and another member of staff told us "The team is great".

The provider worked in partnership with other organisations to make sure they were providing appropriate care for people. These included social services and healthcare professionals such as G. Ps, dentists and opticians.

Registered persons are required to notify CQC of significant events that occur in the service. This includes any allegations of abuse, incidents reported to the police and serious injuries. We found that this had been done in line with legal requirements. Providers are required to display their CQC rating at their premises and on their website if they have one and we saw that this was prominently displayed.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person Centred Care. The failure to assess, plan and provide care and treatment to meet people's needs and preferences Regulation 9 (3)(a).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users was not provided with the consent of the relevant person. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA RA Regulations 2014 Safe care and treatment. The failure to protect people from the risks associated with the unsafe management of medicines. Regulation 12 (2)(f)(g)

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care

Regulation 17 HSCA RA Regulations 2014 Good governance

Regulation 17 HSCA RA Regulations 2014 Good governance.

A failure to assess, monitor and improve the quality and safety of the services provided and to seek and act on feedback from relevant persons. Regulation 17 (2)(a)(e)(f)

The failure to maintain an accurate, complete record in respect of each service user. Regulation 17 (2)(c)