Firstsmile Limited

Framland

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

Overall summary

This inspection took place 9 October 2014 and was unannounced.

Framland is located in the town of Melton Mowbray Leicestershire. The service provides accommodation for up to 31 older people. On the day of our visit there were 31 people using the service.

There was not a registered manager in post. 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 and associated Regulations about how the service is run.

People who used the service made positive comments about the care and treatment provided. They praised the staff and spoke positively about the relationships they had formed with staff and with other people who used the service.

Summary of findings

People were supported by staff who had received training on how to protect people from abuse. Safeguarding procedures were in place and staff knew what action to take and who to report concerns to.

Risk was assessed but management plans were not always detailed enough or followed. This meant that people were not always properly protected from harm.

The way that the premises were used and how they had been maintained meant that there were areas that were important in relation to infection control which were difficult to clean effectively. These areas were not clean. We have made a recommendation about the prevention and control of infections.

There was an ongoing programme of staff training and development. Staff had a basic awareness of caring for people with dementia. We found that best practice developments were not always implemented.

Staff were aware of the Mental Capacity Act and Deprivation of Liberty Safeguards but had not consistently followed the requirements of this legislation.

People's nutritional and dietary needs were assessed and people were supported to eat and drink sufficient amounts to maintain their health. People had access to healthcare professionals as soon as this was required.

Staff were kind and compassionate. However some staff did not always anticipate or meet people's individual needs. There was not always a member of staff in attendance in the communal areas to keep people safe. Improvements were needed to ensure the staff had the time to meet people's individual care preferences and attend properly to their safety and wellbeing.

Staff were clear about their roles in ensuring that people were given choice and had their independence promoted. Activities such as bingo, quizzes and other games were provided. Some people had very limited opportunities to take part in activities that were meaningful to them.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

People felt safe and could approach staff with any concern they may have had. Staff had a good awareness of the action they should take to protect people from abuse.

People were not always properly protected from harm. Risk was assessed but management plans were not always sufficiently detailed or followed.

Staffing levels were determined according to the dependency needs of people who used the service. Some concerns were identified with the availability or deployment of staff to keep people safe.

The service was not as clean as it should have been.

Requires Improvement

Is the service effective?
The service was not consistently effective.

People were supported to eat and drink.

Staff knowledge of dementia care and the Mental Capacity Act did not sufficiently meet the needs of people who used the service or fully protect their human rights.

Staff monitored people's health and wellbeing and worked with other professionals to ensure people received the right care.

Requires Improvement

Is the service caring?
The service was not consistently caring.

Relationships between staff and people who used the service were positive and people praised the staff and their attitudes.

Staff did not always anticipate or respond appropriately to people's needs.

Requires Improvement

Is the service responsive?
The service was responsive.

People were given choice and their preferences were respected. Some people had very limited opportunities to follow their interests and hobbies. People were not routinely involved in planning their care and support.

Verbal complaints were not being recorded or used as an opportunity for learning and improvement.

Good

Is the service well-led?
The service was not consistently well led.

Requires Improvement

Summary of findings

Systems were in place to regularly assess and monitor the quality of the service. The views of people who used the service and those of staff had not been effectively sought or used to drive improvements.

Framland

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 9 October 2014 and was unannounced. The inspection was completed by three inspectors.

We looked at and reviewed the provider's information return. This is information we asked the provider to send us to give us key information about their service and the improvements they plan to make. We reviewed historical data that we had received from the provider. We also contacted the local authority and GP to ask them about their views of the service.

We used the short observational framework for inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with 10 people who used the service, the acting manager, area manager, four care staff and the cook. We looked at the care records of six people who used the service and other documentation about how the service was managed. We looked at medication administration records and staff training records.

Requires Improvement

Is the service safe?

Our findings

People said that they felt safe living at Framland. One person said "I'm as safe houses." Another person said, "If I didn't feel safe I would say, I have no complaints, they (staff) are always asking if you're okay." While people we spoke with told us they felt safe we found that some working practices did not properly protect them from harm.

The provider assessed and reviewed risks such as of falling, developing pressure sores and malnutrition on a regular monthly basis. Plans were then developed or amended as appropriate. One person had been identified as at risk of developing pressure sores and their plan of care stated that a special cushion should be used to reduce this risk. We saw that this person was not sitting on a special cushion during our inspection and was not therefore properly protected from harm. We raised this with the acting manager who immediately asked staff to ensure the pressure cushion was used.

Some people had additional needs associated with their health condition that put them at greater risk. We saw risk assessments had been completed that instructed staff of how to manage and minimise the risk.

Some people had behaviours that put themselves and others at risk. Whilst plans of care instructed staff of the overall approach they should take at these times they lacked the detail that staff needed to address the risks effectively. This meant there was a risk that people were not protected from harm. For example, in the month preceding our inspection a person was found by staff attempting to walk with three walking frames at the same time. They had been at high risk of falling. Another person had been physically aggressive to a person who used the service.

Some people had complex needs and were at significant risk of falling and of injury because of this. Although assessments and plans were in place they did not always prevent accidents. For example one person had fallen out of their chair in the lounge and sustained a head injury. In the month preceding our inspection, four people had been found by staff on the floor having fallen when staff were absent from the room.

One person required a hoist and two care workers to support them safely when moving in their room. We received concerns that this plan was not being carried out and that as a result they were placed at risk of injury. We shared this information with the senior care worker and acting manager who said they would take immediate action. These concerns were also subject to an investigation by the local authority safeguarding team and after our visit we were informed that they had been partially substantiated. The provider had taken action to reduce the risk of this happening again.

We looked at the provider's records of accidents and incidents. We saw that there were nine accidents/incidents recorded in September 2014. We asked if there were any examples of action taken as a result of accidents, incidents or safeguarding concerns. Staff gave example where new procedures, guidance and checks on equipment had been introduced.

These matters constituted a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities)Regulations 2014.

We had received concerns about standards of cleanliness and infection control.

No-one expressed concerns to us about the standards of cleanliness in their own rooms or the main communal areas. However we saw that some parts of the premises which were important in relation to the control of infection were not clean. For example all the extractor fans in the bathrooms, shower rooms and toilets we looked at were heavily coated in dust. The walls and floor in the laundry room were dirty and there was heavy dust on the exposed plumbing and pipe work. Open bins of washing waiting to go into the machine were left by the machine opening making the separation of dirty and clean washing difficult. There were boxes of aprons and gloves stored on the floor. This was not a suitable place to store equipment used to prevent or control infection and made cleaning the area difficult. The lack of space for storage throughout the service was making it difficult for staff to maintain good standards of hygiene.

The ground floor shower room was visibly clean but walls were damaged in places and décor was in need of improvement. This meant there were crevices which would make cleaning difficult and allow micro-organisms to accumulate.

Requires Improvement

Is the service safe?

We discussed these matters with the acting manager. They were aware of the lack of storage at the service. An infection control audit was carried out monthly but this had not identified the infection control issues that we found during our visit.

We recommend that the provider consider the current guidance on the prevention and control of infections.

We checked fire safety records and saw there were weekly checks on the fire alarm system. Fire drills were also practiced. We identified that not all staff had participated in a fire drill. The acting manager said they were aware of this and told us fire marshal training had been arranged for October 2014. We were informed by the acting manager that a recent visit from the fire and rescue service had identified action required to ensure the premises complied with their regulations. The provider was in the process of taking action and this included replacing some fire doors.

We looked at the provider's business continuity plan. This instructed staff of the action to take in the event of an emergency affecting the service. We found the hard copy was dated 2010 and the information was out of date. Whilst the acting manager said there was an updated plan on the computer this was not easily accessible to staff. Staff required this document to be easily accessible so they could respond appropriately to an emergency with the least disruption for people who lived at Framland.

People who used the service said that they thought there were enough staff to meet their needs. One person said "They (staff) manage all right. If I was in any trouble they would be there. There is a bell in my room I can use, I only have to press it and they are there." Another person said "They (staff) respond to the buzzer, usually within 10 minutes. If you use the emergency button they're there in seconds."

The majority of staff we spoke with told us there were enough staff on each shift to meet people's needs. Some staff raised concerns about the levels of staff on duty. However, they said that people's assessed needs were met and people were safe. One person said, "Sometimes we are rushed and don't give quality time to people, especially new people." We asked about the skill mix of staff. Staff raised some concerns and said that there had been times when new, inexperienced staff employed for a short time, had been given the responsibility for supporting new staff.

We looked at staff files for two members of staff. We saw that appropriate pre-employment checks had been carried out. These checks are important and ensure as far as possible that only people with the appropriate skills, experience and character are employed. We also saw that the provider was following appropriate disciplinary procedures where potentially unsafe practice was identified

The provider had appropriate policies and procedures in place for the safe management of people's medicines. We saw that medicines were stored securely. We looked at medicine administration records and saw that these were accurate and up to date. There was a separate register to record 'controlled medicines'. We saw that this was also accurate and up to date.

Staff had received training about medicines but had not had their competency in managing them safely assessed. Some medicines were prescribed on an 'as required' basis. We saw that some of these medicines had a protocol in place which informed staff about when they should be given but others did not. There was no other information about this to guide staff and therefore there was a risk that people might not receive the medicine they needed as prescribed by their doctor. We also saw that some 'as required medicines' has not been required for a long time. The need for these medicines had not been reviewed and so there was a risk that people might be given medicine that they did not need.

Requires Improvement

Is the service effective?

Our findings

People spoke positively about the care and support they received. They said that they found staff to be knowledgeable and competent.

One person said "I can't say enough about this place. Dedication of staff. It's amazing how they look after the residents. I've got to know them all (the staff). I can't praise it enough." Another person said, "It's all good, you have your favourites (staff) that's natural."

Staff told us the training opportunities were good. One said, "Training helps us to meet people's needs.

Some people who used the service had complex and high dependency needs associated with dementia and mental health needs. Staff showed a basic understanding of dementia care but were not aware of best practice or developments in dementia care. For example an understanding of the importance of the environment. .

Staff told us about the induction process and that this included new staff shadowing more experienced staff for a period of time. Some staff shared concerns about the induction and gave an example where a new member of staff had to provide direct care on their first day due to a shortage of staff. We looked at records of induction training provided. We saw that one person had not completed their induction training despite having worked at the service for many years. Induction training is important so that staff know how to support people effectively when they started work and on an on-going basis.

People told us that they felt involved in discussions and decisions about their care and support. Comments included, "I've signed documents to show I consented to the care when I moved in, I haven't signed anything for a long time." Other people could not recall if they had signed any documentation about consent but said they felt involved and that staff gave them choices and respected their decisions.

We saw staff gave people choices and sought people's consent before care and support was provided with day to day needs.

We saw a person become anxious and attempt to leave the building. This person had dementia and staff prevented them from leaving for their safety. DoLS is a law that requires assessment and authorisation if a person who lacks mental capacity and needs to have their freedom restricted to keep them safe The acting manager told us this person did not have a Deprivation of Liberty Safeguard (DoLS) authorisation in place. This means they did not have written authorisation from a supervisory body to allow them to restrict this person of their freedom or liberty. We requested the acting manager made an appropriate referral requesting an assessment to the supervisory body as a matter of urgency.

Some people had needs associated with their health condition such as dementia and were unable to consent to specific decisions relating to their care and support. We saw examples where people were given their medication covertly. This meant their medicines were put into food without their knowledge. Whilst we saw the person's doctor and relative had agreed to this, an assessment and best interest decision had not been formally completed or recorded. This is a requirement of the Mental Capacity Act (MCA). The MCA is a law providing a system of assessment and decision making to protect to protect people who do not have capacity to give consent themselves.

Staff showed an understanding of the principles of MCA and we saw they had a best interest approach to care and support. However, staff lacked awareness and understanding of the requirements of the MCA legislation where people lacked capacity to specific decisions. Staff said they had received training on MCA and DoLS, but staff could not name who had a DoLS in place.

Pre-assessments and plans of care did not clearly record that a person's capacity to care and treatment had been formally assessed. We discussed this with the area manager and acting manager, they showed us a document that they said they were going to implement that showed people's capacity to consent would be assessed where appropriate.

People expressed general satisfaction with meals. One person said; "Food not bad at all. Not haute cuisine but adequate. There is a good variety of food from day to day." Another person said, "Plenty to eat and in between we get cups of tea and biscuits. I went out the other day and when I came back they offered me a cup of tea straight away." Another person said "Food is very good. We really enjoy it" Happy with the quantity. I can have second or third helpings if I want."

Requires Improvement

Is the service effective?

We observed the lunch time meal. Food was plated for each specific person by the chef and vegetables were added according to people's preferences by the care staff. This involved kitchen staff repeatedly walking across the room to give individual plates to the carer to add the vegetables. One person said "It's usually hot but sometimes it takes a long time to get it out. Another person said "We seem to wait at the table a long time before it is served." "Sometimes it takes a long time to serve everyone and then it is not so warm. People also told us they liked the food and had been asked for their suggestions and additions for the menu.

Kitchen staff had a good understanding of people's choices and preferences and said they would always offer an alternative if a person did not want what was on the menu. The kitchen staff knew people's special dietary requirements and told us that pureed food was prepared for people requiring this from the main menu and each food was pureed individually to improve the presentation of the food. We observed one person being provided with thickened fluids and others with a pureed diet according to their needs. Another person was provided with adapted cutlery to enable them to eat independently. Staff provided additional support with eating and drinking where this was required. We saw that staff did this in a sensitive and appropriate way.

Menus were available in the dining room. There was a four week menu rotation and a record was kept of the meals served. This showed that there was variety and a choice for each meal.

People told us that they felt their health care needs were met. They said staff arranged for the doctor and other health professionals to visit if requested or required. Comments included, "If I'm poorly they (staff) would get the doctor, they ask if you are alright, they're all good."

"The chiropodist visits weekly, I see them about every four weeks. The optician also visits. If you need the doctor or nurse they (staff) will call them in." "I feel well looked after, I see the doctor and chiropodist, I have no complaints."

In addition to staff handover, a communication book was used to communicate people's needs and health appointments arranged or required. During our visit we saw a visiting health professional who had been requested to visit different people due to a change in people's health needs. We saw daily records that demonstrated health professionals had been contacted in a timely manner when required. We also saw examples where recommendations made by health professionals had been included in people's plan of care. For example, we saw that a person had difficulties swallowing. A speech and language therapist had assessed the person and recommended a specific diet to support safe eating and drinking.

We asked four doctors to provide feedback about the service. They told us that staff appropriately carried out the plan of care and support prescribed by the doctor.

Requires Improvement

Is the service caring?

Our findings

People spoke positively about the staff attitude and care they provided. Comments included, "You can easily say if you're not happy. I refused to go to bed last week, it was an agency worker who I didn't know. It wasn't a problem, I waited until the regular worker was available." "Another person told us "I'm only here for a short break but I would come back again, it's a nice atmosphere, the staff are all kind, caring and respectful, I have nothing but good to say about it."

We saw that clocks in the lounges were not set at the correct time. This was potentially disorientating for people who used the service. We saw that one person who used the service was walking about for most of the time during our inspection. This person was at risk of falling and a member of staff had been assigned to stay with them to keep them safe. We saw that this staff member did not engage with the person they were supervising unless the person was in imminent danger of falling or injuring themselves. This showed that staff were not always effective in meeting people's emotional and or psychological needs. We also saw that some people who used the service were unoccupied and had very little interaction with anyone for a long time.

People told us they received opportunities to express their views and be actively involved in decisions about their care and support. On person said, "My keyworker makes sure I have everything I need, they chat and make sure everything's okay." Another person said, "The staff tell me what I need to know. I did have some concerns about my bed, it was changed but I still have some concerns and want bed sides. I've raised this with staff but nothing's happened about it." We raised this with the manager who assured us that they would look into it.

Staff showed compassion and kindness during our visit. For example, a care worker was seen to tell a person the chiropodist was visiting and asked if they wanted to see them. They waited patiently for a response and then gave them a choice of ways of getting to see them. The care worker then respected their choice and supported them with it.. Another person would request support to go to the toilet by calling out. We saw a care worker respond quickly to this.

However, we also found that there were instances where the approach of staff was less caring. For example we observed two staff supporting a person to transfer using a hoist. Neither member of staff engaged with the person they were helping and they did not explain to them what they were doing or why. We also saw a care worker ask a person sitting in a chair to get up whilst another care worker placed a cushion for them to sit on. They gave no explanation for their request. This clearly confused and puzzled the person they were helping but they walked away without giving any explanation or reassurance.

We also saw one person wait for more than 30 minutes for staff to come and help them move from their wheelchair into a comfortable chair after breakfast. During this time there were no staff present in the lounge and the person had fallen asleep in the wheelchair. Staff then woke the person up when they returned to help them out of the wheelchair. This approach was not caring or person focused.

We saw that a visiting chiropodist carried out treatment in the lounge in full view of other people. We did not see that people were offered their treatment in private. We found that this was not dignified nor did this protect people's privacy.

We saw that a person was offered a drink of their choice but this was then left out of their reach so they could not have their drink until we intervened. Later in the day this person was calling out repeatedly and was clearly distressed and sad. This also had a negative effect on other people who used the service. Staff did not offer any reassurance and this person was ignored for some time.

Some staff showed a good understanding of people's individual needs. They told us about their 'keyworker' role. They said that having a keyworker system helped people feel important and was a good way of getting to know a person in more detail. Plans of care were written showing a caring approach. Information was detailed and included what was important to the person. People's history, interests, hobbies and pastimes were recorded.

Staff gave good examples of how people's independence was promoted. One said, "It's important not to do everything for a person but encourage where possible for people to do things for themselves as much as possible."

Staff told us about the confidentiality policy and what it meant to them and people who used the service.

Requires Improvement

Is the service caring?

Comments included, “Its important confidentiality is respected, we have to be careful that we don’t share or discuss information about a person in front of others or to each other.”

Good

Is the service responsive?

Our findings

Some people we spoke with told us their routines were respected. One person said "I go to bed late and get up very early, that's my routine and it's important to me. Staff know that." People's preferred routines were recorded. We looked at records about what time people got up and went to bed. We saw that a lot of people got up very early and went to bed early. Staff we spoke with were clear about providing people with choice and people told us that staff respected their wishes.

We spoke with people about following their hobbies and interests. They told us about activities on offer. One person said "There are activities like bingo, quizzes you can suggest anything and they (staff) will do it. You only have to only ask and they'll take you out. You're also asked if you want to go to church."

We saw records of activities provided and saw that people had been out for coffee, decorated cakes and been entertained with music. We spoke with one person who had taken on the caring responsibility for one of the cats that lived at the service. There were two cats living at the service and we saw that this was very beneficial and positive for some people who used the service.

We also saw that some people had very limited opportunities for taking part in their chosen hobbies and interests. Staff had recorded in one person's records that they had not been able to engage them in any activities at all. Staff had made reference to people's preferred hobbies and interests in care records but there was not a detailed plan of care for staff to follow with regards to meaningful activity. Plans of care about social needs were generic and did not instruct staff what to do to meet people's individual needs. During our observations we found that some people did not engage in any activity or with any other person for a long time.

People who used the service knew that they had a plan of care but were not routinely involved in reviewing this.

We asked about people's spiritual, religious and cultural needs. Staff said that people would be supported if they had any preferences or wishes. We asked if the home had visitors from different religious communities to provide worship. Staff told us that a person from the local church had made contact and was due to visit the home again to discuss how they could support people. We were informed that there was no one using the service at the time of our visit from a minority community or who had diverse cultural or religious needs.

People told us they would feel confident making a complaint and felt that staff would listen and take appropriate action. One person said they had raised a complaint. They told us that the manager had been to see them about it and had dealt with it and resolved the issue. We looked at records of complaints and saw that none had been recorded since October 2013. The provider's complaints policy stated that all concerns should be documented. We spoke with the acting manager about this, they told us that not all verbal complaints had been recorded and that they would address this issue immediately.

We spoke with people about providing their feedback about the service. We were told there had not been a 'residents' meeting for some time. The responsibility for arranging and chairing residents meeting had recently been given to a senior carer. We were informed that there would be at least one meeting a month. We saw that the acting manager carried out daily 'walk rounds' these included speaking to people who used the service.

Requires Improvement

Is the service well-led?

Our findings

People told us that they felt staff worked well as a team and that the atmosphere in the home was calm, relaxed and organised. One person said "Can't say enough about this place. Dedication of staff. It's amazing how they look after the residents. I've got to know them all (the staff). I can't praise it too much. I have made many friends here."

Some staff said that they felt able to raise issues and concerns but that they were not always confident they would be responded to appropriately. They also said that staff did not always feel comfortable about raising concerns in front of colleagues. We looked at the minutes for the last two staff meetings. We saw that staff had not spoken or provided their feedback during one of the meetings. This did not demonstrate an open and inclusive culture. We saw that meetings for senior staff had recently been introduced and were scheduled to be held monthly.

One member of staff expressed their dissatisfaction with the leadership. They told us that communication was not effective. Other staff described the acting manager as supportive and approachable. One member of staff told us that the service had improved and that 'caring' had improved.

We asked three members of staff if they would be happy for a relative to move into the service. Two staff members said they would but one said they would not because of the lack of stimulation.

The provider had been without a registered manager for over a year.. At the time of our inspection the acting manager was in the process of applying to become the registered manager. There was also an area manager in post to support the acting manager and other staff.

We spoke with the acting manager about the notifications they were required to send to us. We were concerned because the number of notifications we had received was much lower than we would have expected from a service like Framland. We found out that there was an error in the address the acting manager had been sending notifications to. We reminded the acting manager about the events and incidents they must notify us of.

The acting manager told us they carried out daily 'walk rounds' to check and monitor the environment and staff working practices. A sample of people who used the service were also asked for their feedback. We looked at records of these 'walk rounds' and saw that they had been completed regularly but the section for feedback from people who used the service was not always filled in. We saw that monthly quality monitoring checks were carried out about other aspects of care provision and that health and safety audits were carried out every three months. Action plans were developed as a result of these checks. For example, new furniture had been purchased. Food and fluid charts had been changed to improve recording. We saw examples of these and found they were completed.

We were informed that satisfaction questionnaires were due to be sent out to people who used the service and their relatives. We were also informed that new ideas were being trialled to increase attendance at resident and relatives meetings. For example, a meeting where coffee and cake were provided.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People who use services were not protected against the risks associated with receiving care. Care and support was not always planned or delivered in such a way as to ensure welfare and safety, or meet individual needs. Regulation 9 (1) (b) (i)(ii) and (iii)