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Fallowfields Residential 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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 1 February 2017 and was unannounced. Fallowfields is a care home that provides accommodation for up to 22 people including people with dementia care needs. There were 16 people living at the home when we visited. The home is based on two floors, connected by a passenger lift, in addition to a basement where the kitchen and laundry are located. There was a choice of communal rooms where people were able to socialise and some bedrooms had en-suite facilities.

A registered manager was not in place at the time of the inspection, although the manager had applied to be registered with CQC and their application was being processed. 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.

This comprehensive inspection was carried out to check on the service's progress in meeting the requirements made as a result of the previous inspection in August 2017. During that inspection we identified that risks to people were not always managed appropriately, a hoist was not fit for purpose and quality assurance processes were not operated effectively.

Following the inspection in August 2016, the providers sent us an action plan detailing how they would become compliant with the regulations. At this inspection, we found action had been taken, but further improvement was still required.

There were appropriate procedures in place to manage medicines safely. However, staff did not always follow these correctly and did not take action when storage temperatures were too low for some medicines.

There were enough staff deployed to meet people's needs, although the deputy manager was covering night shifts, due to staff shortages, and staff were task-orientated during the mornings. However, the manager was in the process of recruiting more staff.

Most people received effective care that met their needs. However, records did not confirm that two people received the specific support they needed. Further improvements had been made to the environment, although noise levels were intrusive and the use of the dining room for staff training was not appropriate.

People were complimentary about the food and their dietary needs were met. People were encouraged to drink well; however, the recording of people's fluid intake was not always accurate and action was not always taken when records indicated they had not drunk enough.

People said they were treated with kindness and compassion. We observed many positive interactions between people, although some staff, at times, did not show consideration for people in the lounge.

Providers are required to conspicuously display their CQC performance ratings on their website and within the home. The rating from the previous CQC inspection was clearly displayed at the entrance to the home, but was not displayed on the providers' website. When we pointed this out, the provider took the website offline until the matter could be rectified.

Quality assurance processes had improved and had led to some improvements. However, they were not always effective and needed further time to become fully embedded in practice; for example, they had not identified that the medicines procedures were not being followed correctly by staff.

Staff acted in an open and transparent way when people came to harm. However, the manager did not always provide written information to the relevant person following an accident.

Individual and environmental risks to people were managed appropriately. People were supported to take risks that helped them retain their independence and avoid unnecessary restrictions.

People felt safe at Fallowfields and staff knew how to identify, prevent and report abuse. Safe recruitment processes were followed to help ensure only suitable staff were employed. Staff were suitably trained and appropriately supported in their role.

People were supported to maintain friendships and important relationships. Their privacy and dignity were protected. People were encouraged to remain as independent as possible and were involved in decisions about the care and support they needed.

People received care in a personalised way according to their individual needs. Care plans were informative and staff encouraged people to make as many choices as possible about how and where they spent their day.

Activity provision had improved and people had access to a wide range of individual and group-based activities; these had been tailored to people's interests and were meaningful to them.

The providers sought and acted on feedback from people and their families. There was an appropriate complaints procedure in place and people knew how to raise concerns.

People and their relatives had confidence in the management of the home. The providers, the manager and staff were responsive to feedback and demonstrated a shared commitment to working hard improving the service. They were receiving support from external social care professionals to develop. Staff enjoyed working at the home and spoke positively about the management.

We identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken 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 always administered safely or recorded correctly. Action was not always taken when storage temperatures were too low.

There were enough staff to meet people's needs.

Individual and environmental risks to people were managed appropriately. There were suitable plans in place to deal with foreseeable emergencies.

People felt safe at the home and staff knew how to identify, prevent and report abuse. There were enough staff to meet people's needs and the process used to recruit staff was safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Records did not always confirm that people had received the required care and support. However, staff were suitably trained and appropriately supported in their role.

Improvements had been made to the environment since the last inspection, but noise levels were intrusive and the use of the dining room for staff training was not appropriate.

People's dietary needs were met and they received appropriate support to eat and drink when needed. However, the recording of people's fluid intake was not always accurate and action was not always taken when records indicated they had not drunk enough.

Staff followed legislation designed to protect people's rights. People were supported to access healthcare services including doctors and specialist nurses.

Is the service caring?

Requires Improvement

The service was not always caring.

Most staff treated people with kindness and compassion. However, we also observed instances when people were not treated with consideration.

Staff supported people to maintain friendships and important relationships. They protected people's privacy at all times and encouraged them to remain as independent as possible.

People, and their families where appropriate, were involved in planning the care and support they received.

Is the service responsive?

Good

The service was responsive.

People received personalised care from staff who understood their individual needs. Care plans contained comprehensive information and were reviewed regularly.

People were supported and encouraged to make choices about every aspect of their lives. They had access to a wide range of meaningful activities.

The provider sought and acted on feedback from people to help improve the service. There was an appropriate complaints policy in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The quality assurance process had been improved but needed time to become fully effective.

A registered manager was not in place, although the manager had applied to register with the CQC. The providers' previous CQC rating was displayed in the home but not on their website.

Staff acted in an open way when incidents occurred, but did not always provide written information to the relevant person.

There was a clear management structure in place. People were happy living at the home and had confidence in the management. Staff were also positive about the management of the service.

Fallowfields Residential Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. This inspection was also carried out to check whether improvements had been made from the previous inspection in August 2016.

This inspection took place on 1 February 2017 and was unannounced. It was conducted by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. We also reviewed written comments sent to us by a GP who visited the service often and three family members.

We spoke with seven people living at the home and six family members. We also spoke with the two providers, the manager, five care staff and the cook. We looked at care plans and associated records for seven people, staff records, recruitment files, accident and incident records, and quality assurance records.

We observed care and support being delivered in communal areas of the home. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

There were appropriate procedures in place for the safe ordering, administering, storing and disposing of medicines. Staff were suitably trained to administer medicines and the manager had assessed their competence to do this. However, staff did not always follow the providers' procedures. These required staff to administer medicines to people individually and to sign the medication administration record (MAR) after each administration. On the day of the inspection, we saw a staff member administer medicines to all of the people on the first floor of the home and then sign all the records together. This posed a risk that the administering and recording would not be accurate and is contrary to guidance issued by the National Institute for Health and Clinical Excellence (NICE).

The NICE guidance also recommends that any hand-written entries on MAR charts are checked by a second member of staff to make sure they are accurate. We saw this had not been done. Some of the entries had been made by the manager, who acknowledged that she should have asked another member of staff to check them with her and undertook to do so in future. Separate MAR charts had been created for staff to sign when they had administered topical creams to people. Staff told us, and the manager confirmed, that the signatures on the MAR charts were not those of the staff member who had applied the creams, but of the person responsible for the medicine round each day. The manager told us they had adopted this approach as care staff had a history of forgetting to sign the MAR charts, but accepted that the records were not accurate as a consequence.

Some medicines need to be stored at low temperatures to maintain their effectiveness. A special fridge was in use for this purpose and staff recorded the temperatures daily to check they remained within safe limits (i.e. between two and eight degrees Celsius). During January 2017 we identified seven occasions when the temperature had fallen to one degree Celsius and no action had been taken. Staff were not clear about the safe temperature range. One staff member said it was "less than eight [degrees]" and the manager thought it was "between four and eight [degree]". Previous record sheets, in a different format, had included clear guidance to staff about the safe range but this had been omitted from the current sheets.

The failure to administer and store medicines safely and record them correctly was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each person who needed 'as required' (PRN) medicines had clear information in place to support staff to understand when these should be given, the expected outcome and the action to take if that outcome was not achieved. People confirmed they were offered and could access pain relief when needed and we saw arrangements were in place to monitor people's pain using a nationally recognised pain assessment tool. Some people received medicines that required additional support, such as regular blood tests to check the correct dose. Staff kept the results of these tests with the relevant MAR charts, so they were able to check they were giving the correct dose.

There was a medicine stock management system in place to ensure medicines were not used beyond the manufacturers' safe 'use by' date, together with a process for the ordering of repeat prescriptions and the

disposal of unwanted medicines. Staff supporting people to take their medicines did so in a safe, gentle and respectful way. People were given time to take their medicines without being rushed. Staff explained the medicines they were giving in a way the person could understand and sought their consent before giving them. One person had difficulty swallowing tablets, so staff had arranged for them to receive one of their medicines in liquid form, which was easier for the person to take.

There were enough staff to meet people's care needs, although people and staff expressed mixed views about the staffing levels. One person said of the staff, "You only have to press the buzzer and they come. It's really reassuring at night." Another person said, "If I need somebody, then I use the call button; they are pretty fast at coming." However, another person told us, "In the day they come quickly, but not so quick at night; there are only two people here at night and it can be busy." A family member said, "There are enough staff; the atmosphere is normally very calm and staff have time for you." Staff told us they were very busy during the mornings but felt this did not have any impact on people. One said, "We manage [people's needs] okay. We've got into a routine now. Everyone is seen to and we do the breakfasts between us." However, another staff member told, "I'm trying to do three jobs here. It's always busy in the mornings"; and a further staff member added, "It's always been the same, it's really busy for us [staff]."

On the day of the inspection there were three care staff on duty, together with the manager, a cook and a housekeeper. At night, two care staff were available to support people. The deputy manager was currently working night shifts due to staff shortages which meant they were not available to support the manager and fulfil their management responsibilities. The manager told us they were recruiting additional staff to address this. During the morning, we observed that staff were rushed and task orientated, although they had more time to spend with people during the afternoon when visitors arrived and staff had the opportunity to interact, relax and talk with people.

The manager told us staffing levels were based on people's needs. Three people currently needed two staff to support them with personal care and to re-position in bed. The manager told us that a person who was currently in hospital might also need two staff to support them if and when they returned; if that was the case, they said they would increase staffing levels accordingly.

At our last inspection, in August 2016, we identified a breach of regulation as risks to people were not always managed appropriately and a hoist was not fit for purpose. The provider wrote to us detailing how they would become compliant with the regulation. At this inspection we found action had been taken to address these concerns. A new electric hoist had been purchased to replace the manually operated hoist and individual risks to people were managed effectively.

People were protected from harm in a way that supported them appropriately and respected their independence. Staff had assessed the risks associated with providing care to each person; these were recorded along with actions identified to reduce those risks. For example, people who were at risk of falling had risk assessments in place in respect of the support staff should offer to help them mobilise safely. During the inspection we observed staff monitored people and offered support in line with their risk assessments. For example, one person had agreed to wear a chair alarm which would alert staff if they fell out of the chair, and we saw this was in place.

Records confirmed that people were involved in risk taking decisions. One person, whose room was on the first floor of the home, had experienced a series of falls. Staff had recommended that the person moved to a ground floor room. The options had been discussed fully with the person and a family member; they had agreed to the move and this had prevented further falls. Another person had experienced a fall in their bedroom and had agreed to the use of an alert mat so staff would be aware when they moved to an unsafe

position and could offer support.

The manager monitored the frequency of accidents, such as falls, on a monthly basis. They had identified that two people had fallen when coming out of a toilet, so had taken steps to help ensure staff monitored people more closely in this area.

The risk of people developing pressure injuries had been assessed using a nationally recognised tool and appropriate action was taken when people were identified as at high risk. For example, they were provided with special, pressure relieving, mattresses and these were set up correctly according to the person's weight. Staff also encouraged people to eat and drink well to further mitigate the risk.

Environmental risks were managed appropriately and records showed repairs to fixtures and fittings were made promptly. Regular checks of gas and electrical equipment were conducted and the water temperature of sinks was regulated and checked on a monthly basis. There was a process in place to check fire safety equipment on a regular basis and staff had received recent fire safety training. Personal emergency evacuation plans had been completed for each person, detailing the specific support each person required to evacuate the building in the event of an emergency. Staff were knowledgeable about people's specific plans and the fire procedures for the home; they had also been trained to administer first aid.

People told us they felt safe at the home. One person said, "I've no reason not to feel safe." Another person told us, "The staff look after me; they help to keep me safe". A family member said of their relative, "She is settled here and happy here and I know she is safe." Another family member said of the staff, "They do a wonderful job here. It makes me feel reassured that they are taking good care of [my relative]". Staff had the knowledge and confidence to identify and report safeguarding concerns, and acted on these to keep people safe. Staff told us they would have no hesitation raising concerns and had confidence that the manager would take appropriate action. One staff member said, "If it looks like there is something wrong, then we are told to tell the manager." Another staff member told us, "There are many different types of abuse, we learnt all about it in training. I think the main thing is to tell the manager what's going on". Staff were aware of external organisations they could contact for support, including the local safeguarding authority. Where safeguarding concerns were identified, the manager conducted appropriate investigations and took action to keep people safe.

Appropriate recruitment processes were followed and staff were checked for their suitability before being employed by the service. Staff records included an application form, written references and checks with the disclosure and barring service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Staff confirmed these processes were followed before they started working at the home. One staff member said, "I had to wait nine weeks for the [DBS] check before I started."

Requires Improvement

Is the service effective?

Our findings

People and their relatives felt staff had the necessary skills to support them to meet their needs. One person said of the staff, "Ever so good they are here." A family member said, "I'm very happy with the care [my relative] gets and the way she is treated." Another family member told us their relative received "excellent personal care and attention". Written feedback from a further family member stated: "I am happy with the care [my relative] receives. She is always clean, has good food and is very happy there."

Whilst most people received effective care, records of the daily care provided did not confirm that two people who needed catheter care received this consistently. Catheters are devices used to drain a person's bladder through a flexible tube linked to an external bag. The two people's care plans specified tasks that needed to be completed on a daily or weekly basis to ensure their catheters continued to work correctly, but the daily records did not confirm that these tasks had been completed. We discussed this with the manager, who was also unable to confirm that the necessary support had been given. They told us they were planning to move to a new format for recording the delivery of people's care which they felt would be more effective.

Staff told us they had completed a wide range of training in the past year, including infection control, moving and handling, safeguarding adults, and the Mental Capacity Act (MCA). They were positive about the skills they had developed and demonstrated a good understanding how to apply the training in practice. For example, one staff member told us they had recently received training to support people living with dementia. They said, "I feel more confident talking to people with dementia now, whereas I avoided it before. They now recognise me and appreciate me popping in for a quick chat." Other staff supported people to move using appropriate equipment and techniques. The manager used staff meetings as an opportunity to reinforce the training. For example, the most recent staff meeting had focused on the MCA and involved discussion and real life examples, followed by a competency based quiz.

New staff completed an appropriate induction programme before they were permitted to work unsupervised. Arrangements were also in place for staff who had not worked in care before to undertake training that met the requirements 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. It provides assurance that care workers have the skills, knowledge and behaviours to provide compassionate, safe, high quality care and support.

People were cared for by staff who were appropriately supported in their role. All staff received one-to-one sessions of supervision, which were recorded. These provided an opportunity for the manager to meet with staff, discuss their training needs, identify any concerns, and offer support. A staff member told us, "I have my regular supervision now; this has got a lot better."

Further improvements to the environment had been made since our last inspection. Lighting levels in corridors and in people's rooms had been improved and the lights were left on throughout the day so people could see where they were going. Handrails had been painted a contrasting colour so people could see and use them more easily. Additional signs had been installed around the home which included words

and pictures to show people the way to rooms such as the dining room and toilet. Visible signage encourages people to be move around the home independently as well as aiding continence. There was also a 'dementia clock' in the lounge. This showed the time, in large numbers, together with the day and the date to support people living with a cognitive impairment. A family member said of the home, "I find it homely. It's old fashioned, but that suits [my relative]. It's like her home." Written feedback from another family member stated, "I have found Fallowfields very homely and the right place for [my relative]."

However, we found noise levels were intrusive and were not conducive to the creation of a calm, peaceful environment. A leaking gutter above the conservatory made a continuous, loud, dripping noise on the conservatory roof. When we asked staff about this, one of them said, "Yes it's from the guttering. It's really annoying but you just switch off from it." Whenever a call bell was activated, it caused a loud, piercingly shrill to emanate from a panel in the hallway that could be heard throughout the home until the bell was cancelled. In addition, an alarm at the bottom of the stairs activated each time someone passed it, causing a further high pitched sound that lasted for several seconds each time. This created noise pollution that could irritate or over-stimulate people, particularly those living with dementia. Guidance by the Social Care Institute for Excellence states: 'Of all the senses, hearing is the one that has the most significant impact on people with dementia in terms of quality of life. Noise that is acceptable to care staff may be distressing and disorientating for a person with dementia'. We discussed this with the manager who undertook to explore ways of reducing noise levels in the home.

In the afternoon, a staff training session was held in the dining room. This was not an appropriate learning environment for staff. Two staff members were called away to support people, so missed parts of the training and there were constant interruptions with people, staff and visitors continually passing through the area. This meant they were not able to discuss any real life examples relating to people living at the home. It also deprived people of the opportunity to use the room, for example to meet visitors. The session had to be brought to a premature end as people needed to use the room for their supper. The manager told us a spare bedroom was available that would be a more suitable training environment and they agreed to consider this.

People were complimentary about the food and their dietary needs were met. One person said, "There's quite a good choice." Another person told us, "There is always plenty to eat." A family member added, "[My relative] loves the food and there are always drinks available."

A picture menu of the main lunchtime meal was posted on the wall of the lounge to help people understand the option and they were asked if they were happy with this. If not, the cook discussed a range of different options with them. One person told us, "We have a good cook. She will always do me something else if I fancy it. Today is sausage and mash but she's doing me a bacon omelette. She comes to see me every day."

Where people had specific dietary needs these were assessed and food profiles developed. These detailed information about people's food and drink preferences, allergies, specialist diets, medical conditions such as diabetes, where they liked to eat and any assistance they required. Staff were attentive to people at lunchtime. They prompted people to eat, cut up their food where necessary and offered additional portions. With the exception of one person, who could not be weighed, all other people had their weight monitored on a monthly basis to identify if they started to lose unplanned weight. Appropriate action was then taken, including closer monitoring of the person's intake and referral to their GP where necessary.

Jugs of squash and water were available throughout the home. We saw people's glasses being topped up regularly and people being encouraged to drink often. One person liked to have a glass of wine with their meal and were supported to do this. Staff routinely recorded the fluid input and output for all people and

compared it with a target amount based on the person's weight. However, records and audits showed staff were not always recording the amounts accurately and action was not always taken when a person did not achieve their target amount. We had identified this as a concern at the last inspection. In addition, the fluid charts for three people showed they had not received any drinks after 5:00pm each day. The manager told us people would have received drinks after 5.00pm, but these had not been recorded. They said they were working with one of the providers to promote awareness of people's hydration needs and encourage more accurate recording by staff. They agreed it remained an area for improvement.

Staff followed the MCA to protect people's rights. The 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. Care records confirmed that where people lacked capacity to make decisions, staff completed assessments using the recommended two-stage test. They consulted with family members and made decisions in the best interests of people. These included decisions relating to the administration of people's medicines and the use of bedrails. Where people had capacity to make decisions, they had signed their care plans to indicate their agreement with the care and support they received. In addition, staff asked people for consent before providing them with care or support.

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 found the provider was following the necessary requirements. DoLS authorisation had been approved where needed and renewal applications had been submitted in good time. Staff understood their responsibilities and knew how to keep people safe in the least restrictive way.

People were supported to access healthcare services when needed. Records showed people were seen regularly by doctors, specialist nurses and chiropodists. They also had access to dental care and eyesight tests when needed. A person told us, "They got the doctor for me the other day as my eyes were sore. I got some eye drops." Another person said, "The physio came yesterday and is coming next week."

Requires Improvement

Is the service caring?

Our findings

All but one person told us they were cared for with kindness and compassion. They described staff as "friendly" and "caring". One person told us, "The staff are wonderful. We have a laugh." Another person said, "It's lovely here. The staff are very helpful." One person told us they had a "clash of personalities" with a staff member. They said, "Sometimes [the staff member] can be abrupt and doesn't realise she is." They told us the manager had "had a word with the staff member" and things had improved. Comments from family members were positive and included: "They [staff] all seem very friendly and have a laugh and a joke"; "I can only sing the praises of staff, they are very caring"; "I think the staff make a real effort to support [my relative] emotionally"; and "The staff are so caring, they really do care".

We observed many positive interactions between people and staff. Staff used people's preferred names and approached them in a friendly and relaxed manner. When medicines were being given, staff checked people were happy to receive them and explained what they were for. When supporting people to move, staff gave clear instructions in a patient and supportive way and praised people for the effort they made. When people, for example those living with dementia, struggled to express themselves, staff observed the person's body language and facial expressions and were able to understand their needs from their knowledge of the person. They also spent time engaging with them at eye level and using supportive communication techniques, including pictures.

Most staff spoke about people warmly and demonstrated a detailed knowledge of them as individuals. For example, a staff member asked how the person was and asked after their son, a subject the person was happy to talk about. A staff member who had experience of working in other care settings said of Fallowfields, "There's a lot of love in this place. It's a cosy, family home. The families are very close; it's quite extraordinary. You get hugs and thanks."

However, we also observed instances where some staff did not treat people with consideration. For example, a staff member in the lounge was heard to say, "I'll just go and sort [named person] out as she's giving me GBH [grievous bodily harm]." This was said in front of other people who would have heard the comment. Later, the same staff member entered the room of a person without seeking their permission to show us the person's creams. The person was in bed and awake but unable to respond as they were very unwell. The staff member had not needed to enter this room in particular and could have chosen another room that was empty or where the person would have been able to give their consent.

Another staff member carelessly placed a file in front of the 'dementia clock' which prevented a person from seeing the time. This caused the person to become anxious and they asked us to move it. People's care plans were stored in a locked cupboard beneath the television in the lounge. Each time a staff member opened the cupboard, they obstructed people's view of the television. This happened 11 times in a half hour period and caused disruption to people's viewing. One person in particular had to crane their neck to see the television, which was at an awkward angle for them. We asked if this was comfortable and they said, "Not really, but you get used to it." We discussed this with the manager who undertook to review the layout of the lounge and the storage arrangements for people's care plans.

People were supported to maintain friendships and important relationships. Two people had formed a close friendship while living at the home. When one of them was admitted to hospital, one of the providers took the other person to hospital to visit them. This helped both people maintain their friendship. Relatives told us they were encouraged to visit whenever they wished. A family member told us, "I've got a good relationship with the staff. If [my relative] is going to hospital, they would use hospital transport and then phone me, so I could follow her up there." Written feedback from another family member stated: "My [relative] is very happy at Fallowfields. She finds the staff friendly and caring and has made friends with other residents."

People's privacy and dignity were protected. Staff took care to make sure toilet and bathroom doors were closed when they were in use and described practical steps they took to protect people's privacy when delivering personal care. These included keeping the person covered as much as possible, explaining what they were about to do and checking people were ready and willing to receive the proposed care and support. One person told us, "I like my door open in the day but when I'm having a wash, or I'm on the commode they [staff] always close the door." When supporting a person to use the bathroom, we heard a staff member tell the person, "I'm going to close the door. Ring the bell if you need me." People told us they could choose the gender of the care staff member, or request a particular staff member, to support them with personal care. This information was included in care plans, known to staff and followed.

Staff encouraged people to remain as independent as possible within their abilities and to do as much as possible for themselves. For example, they described how they let people attend to their own personal care when they could, but supported them by washing areas they were unable to reach. A staff member told us, "I give people the option to wash parts themselves. Some will let you do it but I promote independence and encourage them to do it if they can." People's care plans also encouraged staff to promote people's independence. For example, one person's personal care routine detailed how they were to be encouraged to wash their own face and hands.

When people moved to the home, they (and their families where appropriate) were involved in assessing, planning and agreeing the care and support they received. Comments in care plans showed this process was on-going and family members told us they were kept up to date with any changes in the health of their relatives. One family member said of the staff, "They keep me informed. I come every day and they tell me anything; but they would phone me if they need to." Another family member told us, "I've looked through [my relative's] care plan and we talk about things in passing whenever I'm here. If I've got anything to ask, I just ask it."

Good

Is the service responsive?

Our findings

Most people received personalised care from staff who understood and met their needs well.
A family member told us, "My relative has chosen to stay here; they seem in tune with her needs and can tell when she is having good days or bad days". Another said of the staff, "They offer choice and are quite flexible about when [my relative] gets up and goes to bed."

A doctor who had regular contact with the home provided written feedback expressing their personal opinions. They said staff cared for people "very well" and added: "The staff are caring and responsible and do not hesitate to raise any medical concerns appropriately with me. Over the years I have become particularly impressed with the careful attention given by staff to end of life care for my patients which is handled professionally and compassionately."

Assessments of people's care needs were completed by the manager and one of the providers before people moved to the home. One person told us, "The owner and the manager came to visit me in hospital [to complete the assessment]." Care plans were then developed and reviewed on a monthly basis so staff had access to up to date guidance about how they should meet people's current needs. The care plans were centred on the needs of each person and detailed their normal daily routine, their backgrounds, hobbies, interests and personal preferences. For example, they specified whether people preferred baths or showers and how often they liked to receive them. They also indicated when people preferred to get up and go to bed

Staff demonstrated a good awareness of the individual support needs of people living at the home, including those living with dementia. They knew how each person preferred to receive care and support. For example, which people needed to be encouraged to drink; the support each person needed with their continence; and where people liked to spend their day. They recognised that some people's mobility varied considerably from day to day and were able to assess and accommodate the level of support they needed at a particular time. For example, one person told us, "I walk down [to breakfast] if my knees are good. If not I go down in a wheelchair [with staff support]."

People were supported and encouraged to make choices about every aspect of their lives, including when they got up and went to bed, where they took their meals and how and where they spent their day. One person said, "I just ring my bell when I'm ready and they [staff] help me." Another person told us, "I have my meals in my room which I like." We repeatedly heard staff offering choices to people in a supportive way, such as "Would you like to go through to the sun lounge to the comfy chairs?"; "Would you like me to close the door?"; and "Do you fancy a cup of tea?".

Activity provision had improved since the last inspection. An activity calendar was seen on the wall of the dining room. This informed people of planned activities for each day and was supported by pictures to aid understanding. The providers had secured funding from a local charity for two people to receive one-to-one time with a volunteer to pursue their interests. The providers had also recently recruited a staff member to support people with activities. They had started meeting people individually to discuss their interests and

explore activities they wished to pursue. The manager told us people were responding positively to this support and this was confirmed by a family member who said of the providers, "They have employed somebody to help with the activities a couple of times a week. I think this has been positive". Records showed people had taken part in a wide range of activities, including music, bingo, board games, knitting and reminiscence.

One person felt isolated and had a history of depression, but responded well to one-to-one trips to local attractions with one of the providers. The provider told us, "I take her out once a week to help her feel better." Another person was supported to knit when they were anxious as they found this relaxing and we observed them doing this. A person with a mechanical background enjoyed interacting with a board containing locks and bolts that had been specially made for them and we saw them using this. They had also been given books about subjects they found interesting, which they showed us with enthusiasm. Other people spent time in their rooms pursuing individual interests.

The provider sought feedback from people and their families in a variety of ways. These included the use of a suggestions box, questionnaire surveys and three monthly 'residents meetings' which were well-attended by people and their families. A family member told us, "[The manager] always asks our opinions." Feedback was used to improve the service; for example, minutes of a residents meeting indicated that people wished to see more fish on the menu and this had been provided.

People knew how to complain about the service and the complaints procedure was prominently displayed. People and family members felt senior staff were approachable and that any concerns or complaints would be listened to and addressed effectively. A family member told us, "I'm not a complainer but I would do if something was wrong."

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in August 2016, we identified a breach of regulation as the provider was not operating an effective quality assurance system. The provider wrote to us detailing the action they would take to become compliant with these regulations. At this inspection we found the quality assurance systems had improved; for example, the systems for monitoring staff training and supervision were well organised. However, further time was needed for other systems, such as those relating to medicines management and fluid intake monitoring, to become fully effective and embedded in practice.

The quality assurance process included a structured range of audits by the manager and one of the providers of key aspects of the service. These included infection control, the management of medicines and care planning. In most cases, the audits had been effective in identifying improvements and addressing the issues immediately or by placing them on a rolling action plan that was being actively progressed. For example, the health and safety audit had identified essential repairs to the fabric of the building and these had been completed. However, other audits were not so effective. For example, audits by the manager and one of the providers indicated that medicines management procedures were working effectively, but we found staff did not always follow them; and audits of people's fluid intake showed staff were still not completing records accurately.

A condition of the provider's registration required the service to be managed by a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run. At the time of the inspection a registered manager had not been in place at the service for nearly a year, although the manager had applied to be registered with CQC and their application was being processed.

Following inspections, CQC issue ratings, which providers are required to display conspicuously on the premises and on their website, together with a link from their website to the inspection report on the CQC's website. We saw the previous inspection rating was displayed on a notice board in the hallway of the home for people and visitors to see. However, the rating was not displayed on the providers' new website and there was no link for people to navigate to the inspection report on the CQC's website. We discussed this with one of the providers, who told us they were not aware of the requirement. They took immediate action by taking down their website from the internet until further work could be completed to comply with the regulation.

Providers are also required to act in an open and transparent way when mistakes occur. This requires them to notify relevant people in writing when people come to harm. We viewed records of two cases where the manager had provided written information to people following accidents in the home. In one case, the person lacked capacity and the necessary information was given correctly to the relevant person. However, in the second case, the person had capacity, so should have been given the information directly, but this had been sent to a family member instead, who did not have authority to act on the person's behalf. We

discussed this with the manager, who clarified her understanding of the legislation and undertook to notify the correct person in future.

People told us they were happy living at the home and had confidence in the management. One person said, "Everyone here is very good, and [the manager] is the top; you won't get another one like her." Other people and family members described the manager as "very pleasant" and "very good." A family member said of the management, "They communicate well with the families here, this is key." Another family member told us, "I enjoy coming here to visit and always get offered a cup of tea." A doctor who had regular contact with the home provided written feedback expressing their personal opinions. They said, "My experience is that my patients are very happy [at Fallowfields]." They added, "Should I need to place an elderly relative of my own in residential care, I would not hesitate to seek a place for them at Fallowfields."

There was a clear management structure in place. This comprised of the providers, the manager, the deputy manager and senior care staff. The providers and manager were working closely with an external consultant and a social care professional from the Clinical Commissioning Group (CCG) to develop and improve the service. The providers, the manager and staff were responsive to feedback during the inspection and demonstrated a shared commitment to working hard improving the service. One of the providers told us, "We cannot do any more, physically, than we are doing." A staff member said, "I think there have been a lot of changes here over the last year or so; most of them have been for the better."

Staff enjoyed working at the home and spoke positively about the management. Comments from staff included, "[The providers] very approachable and [the manager] is approachable and supportive"; "I feel I can go in the office and talk to [the manager] about anything"; "I like the manager, she mucks in and helps us out"; and "There's good team work." Staff meetings were held regularly and provided an opportunity for staff to express their views and make suggestions for improvements. A staff member told us, "I suggested some changes to working practices in supervision and in staff meetings and they have been adopted."

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The providers had failed to ensure that medicines were managed in a safe way. Regulation 12(1) & (2)(g).

The enforcement action we took:

We followed our enforcement pathway and continued to monitor the service closely.