Red Firs Carehome Limited

Strawberry Fields Care Home

Inspection report

Strawberry Hall Lane
Newark
Nottinghamshire
NG24 2EP

Tel: 01636700770

Date of inspection visit:
25 January 2018

Date of publication:
23 March 2018

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

We inspected the service on 25 January 2018. The inspection was unannounced. Strawberry Fields Care 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. Strawberry Fields accommodates up to 45 people in one building. On the day of our inspection, 35 people were living at the home, all of these were older people, some of whom were living with dementia. This was the first time we had inspected the service since they registered with us.

There was a registered manager in post at the time of our inspection. 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.

During this inspection, we found the service was not consistently safe. People were at risk of not receiving their medicines when needed, as there were not always trained staff available to administer medicines. We also found other issues with the management of medicines, which placed people at risk of not receiving their medicines as required.

People were not always protected from risks associated their care and support. Risks were not always identified and addressed in a timely manner and this placed people at risk of harm. Risk assessments were not always sufficient and guidance in place to reduce risks was confusing and resulted in inconsistent practice in some areas. There were enough staff employed, however staff were not always deployed effectively to meet people's needs and ensure their safety. Adequate steps had not always been taken to ensure people were protected from staff that may not be fit and safe to support them. There were systems and processes in place to minimise the risk of abuse and incidents were investigated thoroughly. The home was clean and hygienic. □

Where people had capacity to make decisions they were asked for their consent by staff. However, where people lacked capacity their rights under the Mental Capacity Act (2005) were not respected at all times. Overall, people were supported by staff that had the skills and knowledge to provide good quality care and support.

People were not always protected from the risk of poor food and fluid intake as monitoring systems were not effective. People provided mixed feedback about the quality and quantity of food served at the home. People were supported to attend health appointments. However, there was a risk people may not receive appropriate support with specific health conditions as care plans did not consistently contain sufficient information for staff to follow. There were systems in place to ensure information was shared across services when people moved between them, however these were not always effective. People's diverse needs had

been taken into account in the design and decoration of the building.

People told us staff were kind and caring but commented staff did not have time to spend with them. We observed interactions were limited and task focused. People's right to privacy was not always respected. People were not consistently provided with information in a way that was accessible to them and staff did not always demonstrate an understanding of how people communicated. People told us they were involved in decisions about their care and support, however we found this was not always the case. People had access to advocacy services if they required this.

People were at risk of receiving inconsistent support, as care plans did not all contain accurate, up to date information and staff did not always follow the guidance in care plans. People's social and recreational needs were not met as there were very limited opportunities for meaningful activity. This meant many people who used the service spent their time unoccupied. People's friends and family were welcomed into the home and were involved in the care and support of their loved ones. There were effective systems in place to investigate and respond to concerns and complaints.

Governance and audit systems at Strawberry Fields Care Home were not consistently effective. This meant some risks to the safety and wellbeing of people living at the home had not been identified prior to our inspection. Where areas for improvement had been identified effective action had not always been taken to address the issues raised. Accurate and up to date records were not kept of people's care and support. People, their relatives and staff were positive about the registered manager and they had opportunities to express their views in relation to how the service was run.

During this inspection, we found multiple breaches of the Health and Social Care Act 2008 regulations. You can see what action we told the 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 consistently safe.

Medicines were not always stored or managed safely.

People were not always protected from risks associated their care and support.

Staff were not deployed effectively to meet people's needs and ensure their safety. Safe recruitment practices were not followed.

There were systems and processes in place to minimise the risk of abuse.

The home was clean and hygienic.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's rights under the Mental Capacity Act (2005) were not respected at all times.

Systems in place to ensure people had enough to drink were not always effective and this placed people at risk of dehydration. We received mixed feedback about the food.

People were supported to attend health appointments. However, there was a risk that people may not receive appropriate support with specific health conditions.

People were supported by staff who received training and support.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People's right to privacy was not always respected.

People were not provided with information in a way that was

accessible to them and staff did not always demonstrate an understanding of how all people communicated.

People were not supported to be as independent as possible.

Staff were kind and caring, but interactions were limited and task focused.

People had access to advocacy services if they required this.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People could not be assured that they would receive the support they required as care plans did not all contain accurate, up to date information about the support people needed.

People were not provided with the opportunity for meaningful activity and many people who used the service spent their time unoccupied.

People were supported to maintain relationships with family and friends.

People were supported to give feedback about the service, raise issues and concerns and there were systems in place to respond to complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems in place to monitor and improve the quality and safety of the service were not effective.

Timely action was not always taken in response to known issues. Accurate and up to date records were not kept of people's care and support.

Staff felt supported and were able to express their views in relation to how the service was run.

Strawberry Fields Care 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, to look at concerns we received about the quality of the service and to provide a rating for the service under the Care Act 2014.

Prior to our inspection we reviewed information we held about the service. This included information received from local health and social care organisations and statutory notifications. A notification is information about important events which the provider is required to send us by law, such as, allegations of abuse and serious injuries. We also contacted commissioners of the service and asked them for their views. We used this information to help us to plan the inspection.

The inspection was undertaken 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. During our inspection visit we spoke with 12 people who lived at the home and five people's relatives. We also spoke with eight members of care staff, a member of the catering team, two members of the domestic team and the registered manager.

To help us assess how people's care needs were being met we reviewed all, or part of, seven people's care records and other information, for example their risk assessments. We also looked at the medicines records of four people, four staff recruitment files, training records and a range of records relating to the running of the service. We carried out general observations of care and support and looked at the interactions between staff and people who used the service. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We did not request a Provider Information Return prior to this inspection. 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.

Requires Improvement

Is the service safe?

Our findings

During our inspection we found several concerns relating to the management and administration of medicines.

People could not be assured they would receive their medicines when they needed them. Some people were prescribed medicines to be given 'as required', for pain relief and other health conditions. We found there was not routinely a member of staff on shift, at night, who was trained to administer these medicines. The registered manager told us this had been the case since November 2017 and said staff would call them to come into the service if needed. This meant there was a risk people may not receive 'as required' medicines in a timely manner. For example, one person was prescribed an 'as required' medicine to be given immediately in the event of chest pain. This person would have to wait for the registered manager to get to the service if they needed their medicine at night. This put them at risk of unnecessary pain and discomfort.

After our inspection visit we wrote to the provider and asked them to take urgent action to resolve this issue. They told us staff training was underway and gave us details of interim arrangements to ensure people could access their medicines at night if needed. However, it remains of concern this had not been addressed prior to our inspection.

People were not always given their medicines as prescribed. One person was prescribed a pain relief skin patch to be changed every seven days; however, records showed on one occasion there was a gap of 11 days between the application of patches. We also found an occasion where medicines had been signed for, but not administered. This failure to ensure medicines were given as prescribed meant people were at risk of unnecessary pain or deterioration of health conditions. When people were prescribed a pain relief skin patch, the manufacturer's guidance to reduce the risk of skin damage was not followed. This meant people were at risk of experiencing side effects such as skin irritation. There was not always guidance in place to inform the administration of 'as required' medicines. This meant that staff did not have clear information about when to give people these medicines and posed a risk that they may not be administered when needed. We also found a medicine was still in use beyond its expiry date, and so may no longer have been effective.

Risks to people's health and safety had not always been effectively assessed or managed, this has resulted in a failure to identify and address risks. For example, one person had moved into the home the week before our inspection. The assessment completed prior to them moving in cited they had limited mobility and were at high risk of falls. Despite these known risks, a falls risk assessment had not been completed and there was no information about how to support the person recorded in their care plan. We found staff were not aware of the risk of the person falling and action had not been taken to reduce the risk of falls. Records showed routine hourly checks were conducted at night but there were no other falls reduction measures in place, such as assistive technology (technology designed to maintain or improve people's independence). This posed a risk the person may fall in their room and not be attended to for up to an hour and this placed them at risk of harm.

After our inspection visit we wrote to the provider and asked them to take urgent action to resolve this issue. They provided assurances that falls reduction measures had been put in place for this person and also advised improvements were planned to ensure staff had the information they needed. We will explore the impact of these measures at our next inspection.

People were not protected from the risk of skin damage and pressure ulcers. Guidance on management of risks associated with pressure ulcers was confusing and contradictory, resulting in inconsistent practice. For example, one person had very fragile skin and their care plan contained contradictory information about the frequency at which they should be repositioned. One part of their care plan stated every one and a half hours and another stated two to four hourly. Repositioning charts showed the person was assisted every three to four hours with some gaps of up to five hours. In addition, this person had a specialist mattress to reduce the risk of skin damage. However, we found this was not set appropriately for their weight, which meant it may not be effective. This placed the person at risk of further breakdown of their skin.

Risks associated with bedrails were not effectively assessed. Two people had bedrails in use; however, there were no bedrails risk assessments for either person. This meant we were not assured the provider had considered risks, such as the person climbing over or entanglement. Where bedrail risk assessments were in place they were not effective in identifying risks. Another person had gaps at the top and bottom of their bedrail which posed a risk that they may become entrapped. This risk was not identified in the bedrails risk assessment and subsequently had not been mitigated. This failure to identify and address risks associated with bedrails placed people at risk of harm. We raised these concerns with the registered manager and they told us they would take action to address this.

All of the above information was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Feedback about staffing levels was varied. Although most people felt there were enough staff to keep them safe they commented that staff were often very busy and there were certain times, such as nights, where staff were not as readily available. Staff feedback about staffing levels was also mixed. One member of staff told us, "Staff, there's not quite enough really. If someone goes sick or there is a lot of holiday we struggle. However, there are enough staff to keep people safe. There are three or four downstairs and they really need the same upstairs too for people to have a good quality of life." The registered manager told us six staff members were deployed during the day and four at night. During the day three staff were upstairs and three downstairs, but the registered manager explained at busy times four staff may be required downstairs leaving two upstairs. This was of concern, as many people upstairs required the assistance of two staff, which would mean others would be left unattended in communal areas. This placed people at risk.

We recommend the registered manager reviews the deployment of staff within the home to ensure there are sufficient staff available in communal areas to ensure people's safety.

Adequate steps had not always been taken to ensure people were protected from staff that may not be fit and safe to support them. Pre-employment checks designed to help providers ensure staff were suitable to work at the service were not always completed. Two of the four recruitment files we looked at had shortfalls in safe practice. For example, applications forms for two staff had not been fully completed and were missing information about the staff member's employment history or their reason for leaving previous posts. This meant that the provider did not have all the relevant information to make a decision about the suitability of the staff members to work at the service. The Disclosure and Baring Service (DBS) check for one staff member evidenced that they had previous criminal convictions. DBS checks are used to assist employers to make safer recruitment decisions. There was no evidence in the staff file that the potential

risks to people who used the service had been considered to ensure the member of staff was safe to work with vulnerable adults. We spoke with the registered manager about this who told us they would address this.

All of the people we spoke with at Strawberry Fields Care Home told us they felt safe. One person told us, "I just feel confident in the people here." Another person commented, "I feel safe, I have no qualms about it and people are always around." People also told us about practical things which made them feel safe including call bells and security measures, such as the front door being locked. Processes were in place to minimise the risk of people experiencing avoidable harm or abuse. Staff and managers were clear about their responsibilities to protect people from the potential risk of abuse, they had a good knowledge of safeguarding processes and felt confident any issues they reported would be acted on appropriately. The registered manager had taken action to protect people from abuse by conducting in depth investigations of any concerns raised and making appropriate referrals to the local authority safeguarding adults team.

There were systems in place to review and learn from adverse incidents. The registered manager reviewed and responded to each incident to try to prevent the same from happening again. There was also a system in place to analyse and learn from patterns of incidents on a monthly basis

The home was clean and hygienic and effective infection control and prevention measures were in place. During our inspection we observed both bedrooms and communal areas were cleaned to a sufficient standard. Staff had access to plentiful supplies of personal protective equipment, such as gloves and aprons, to ensure good infection control practices. Records showed the majority of staff had up to date training in the prevention and control of infection. There was a team of domestic staff who took responsibility of the cleanliness of the home and the registered manager completed regular audits of the environment to identify issues and ensure good practice.

Requires Improvement

Is the service effective?

Our findings

People were not always protected from the risk of poor food and fluid intake. When people were at risk of losing weight, guidance on how frequently to weigh them was not always followed. For example, one person had lost a significant amount of weight and consequently their GP had recommended they were weighed fortnightly. However, records showed the person continued to be weighed monthly. This meant changes in the person's weight may not have been identified in a timely manner. In addition to this, fluid intake was not always appropriately monitored. For example, one person had been identified as being at risk of poor hydration and as a result the staff team were monitoring their fluid intake. However, the amount of fluid recorded on the fluid charts was not added up, which meant staff were not calculating their total daily intake. This meant it would not be identified if the person had enough to drink. A recent fluid chart that stated that they received a total of 450mls in one day which was significantly under the recommended amount. This had not been totalled by staff and there was no evidence that action was taken to promote increased fluids. This placed people at risk of poor hydration.

People who used the service and their relatives gave mixed feedback about the food served at Strawberry Fields Care Home. One person told us, "The quality of food has gone down," Another person said, "The menu is a bit repetitive." A third person commented, "The dinners are not bad but it is very English, I get by on them." During our inspection we observed a meal time and saw people were offered adequate sized portions of home cooked food. One person did not want what was served, they were offered alternative meals until they found something they wanted. People were provided with timely assistance when needed. People's cultural needs and dietary requirements were catered for and there were cold and hot drinks available throughout the day. We spoke with a member of catering staff who was knowledgeable about people's dietary needs and preferences and had systems in place to ensure these were catered for.

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 made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

People's rights under the MCA were not always protected as the Act had not always been correctly applied to ensure decisions were made in people's best interests. Whilst we saw that some mental capacity assessments had been completed to a high standard, mental capacity assessments had not been completed in all required areas. For example, one person had restricted access to cigarettes and expressed their dissatisfaction with this to us. The registered manager told us they thought the person 'probably' didn't have capacity to consent to this decision but confirmed they had not formally considered this under the MCA. We also found other areas where people's capacity to consent to restrictions on their freedom had not been formally assessed, such as, the use of bedrails and motion sensors. The registered manager told us they would address this.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests

and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager had made applications for DoLS where appropriate. There were no conditions imposed on any of the DoLS we viewed.

Where people had capacity to make decisions they were supported to make choices and were involved in decision making about their care. People told us they made choices about their daily routines, how and where they spent their time and what they ate. People said staff asked their permission prior to providing support. One person told us, "They explain things to me before they do it and tell me about things." Staff described consulting people about their care and support and said they understood the importance of gaining consent.

People told us they were supported with their health and well-being and staff made contact with relevant healthcare professionals as needed. People said they had good access to healthcare and could use their own GP if they preferred. The outcomes of appointments with professionals including GP's, dieticians and specialist nurses were recorded in people's care plans. However, when people had specific health conditions, care plans did not consistently contain adequate detail in order for staff to provide effective support. For example, one person had a specific health condition but, there was no detailed information about the impact of this condition on the person in their care plan. This lack of information placed people at risk of not receiving the required support. This was supported by some feedback we received. One relative told us, "Some of the staff know the health needs, but some don't."

Systems were in place to ensure information was shared across services when people moved between them, however these were not always effective. The provider conducted an assessment of people's needs prior to them moving in to the home, they then used a temporary care plan format for up to six weeks to gather further information about the person. However, we saw that these six week care plans were not always put in place in a timely manner and sometimes they were used for longer than the specified period. This resulted in staff not having access to detailed and personalised information about the people they supported. Following our inspection, the provider informed us they had planned improvements to their systems and processes to ensure peoples' care needs were known when they moved into the service. In contrast there were processes in place to share information with other services. The registered manager told us they had 'hospital passports' for each person living at the home. Hospital passports are designed to share information between care homes and hospitals, to ensure care is person centred.

People were supported by staff that had the skills and knowledge to provide good quality care and support. People told us they felt staff knew what they were doing. A relative told us, "I know they do training often and some are doing [qualifications]." Another relative commented, "I think they do know what they are doing." Records showed staff had received the relevant training to equip them with the knowledge and skills they needed to support people who used the service such as safeguarding, health and safety and infection control. New staff were provided with an induction period when starting work at the service. The registered manager told us staff induction included training and shadowing of more experienced staff. New staff had completed the Care Certificate. The Care Certificate is a nationally recognised set of standards for staff working in health and social care to equip them with the knowledge and skills to provide safe, compassionate care and support. Although staff told us they felt supported on an informal basis they had not been provided with regular formal supervision. Records showed many staff had not had individual supervision for approximately five months. The registered manager told us staff had supervision four times a year, although some staff had this they were not evenly spread across the year, resulting in long gaps. This meant opportunities to monitor staff performance and discuss development could have been missed.

Strawberry Fields is situated in purpose built premises. Consideration had been given to people's needs in the design and decoration of the building. For example, aids and equipment had been installed in some areas to enable people with mobility needs to navigate around the building and the provider had installed a call bell system to ensure people could request staff as required. There were communal lounge areas, with separate dining areas, on each floor which meant people had ample space to spend time socialising with friends and family. People's needs associated with dementia had been taken into account in the design and decoration of the environment. Dementia friendly signage was used throughout the building and colour was used to help people orientate themselves. We saw this had a positive impact on some people who were able to identify their bedrooms by the colour of the door.

Requires Improvement

Is the service caring?

Our findings

People told us they were involved in decisions about their care and support, however this was not always the case. Prior to our inspection we received information of concern that people were assisted to get up and dressed very early in the morning. When we arrived at the service at 6.30am, we found ten people were up and dressed, and the night staff were assisting two further people. The staff we spoke with told us all of these people had chosen to get up early. Most of the people who could tell us said they were able to choose when they got up. However, one person commented, "I have a choice when I get up, I get up early but I think they (staff) get the less able up to suit their regime." Another person said, "I am usually left to get up myself but I know you are supposed to be awake and getting up by 7am or 7.30am they (staff) often come to wake me up, not nastily." This meant we could not be assured that people's choices about their daily routines were always respected.

People's right to privacy was not always respected. Upon our arrival at the service at 6.30am, we observed 14 people's bedroom doors were wide open whilst they were asleep in bed, the corridor lights were on which meant people could be easily seen by others. We spoke with the registered manager about this and they told us some people preferred to have their door left ajar at night time. However, this was not always clearly detailed in people's care plans and where people could not consent the MCA had not been applied to ensure their rights were protected. The registered manager told us they would review this and advise staff not to turn corridor lights on to better respect people's privacy and to reduce the risk of prematurely waking people up. They also told us they would check people's doors were only open if this was their choice.

In contrast, people told us staff respected their privacy and said they could have privacy if they wished. One person told us, "They knock on the door before they come in, they are careful when helping me with dressing too."

Staff did not have a consistently good understanding of how people communicated. Although we observed staff had a good understanding of some people's communication needs, staff did not consistently demonstrate a good knowledge of how to communicate with people who had more complex needs. For example, three people had 'communication books' which were intended to be used to enable them to communicate their needs. Despite this staff were not aware of, or were not using, the communication books. We spoke with one member of staff who told us they were not aware of 'communication books' for anyone. This meant people might not be able to communicate their needs and wishes with all staff.

Some of the systems within the home did not take account of people's communication needs and therefore did not maximise their decision making ability or promote choice. For example, information about daily meals was displayed around the service in an attempt to communicate this to people. However, this information was incomplete or inaccurate. On the day of our inspection the menu board had not been updated for two days, this resulted in staff misinforming people about what was for lunch. This could have been confusing for people with memory impairments and confusion.

People were not always supported to maintain their independence. This was reflected in the feedback we

received from people and relatives. One person told us they had been supported to stand using equipment, but the member of staff had left and this support had stopped. They told us they thought they may have been more mobile if the support had continued. Another person told us they preferred to use a walking frame rather than a wheelchair but said staff often used the wheelchair. The relative of a third person told us there used to be activities to promote people's physical independence but these had stopped, this had resulted in their relation being less active than before. Another relative told us their relation was unable to use the toilet as the home did not have the equipment required to enable them to access it, so they had to use a commode. Furthermore, more information was required in some people's care plans to ensure people received consistent support to maintain their independence. This meant people were not always supported to be as independent as possible.

The above information was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives were positive about the caring approach of staff but commented staff were very busy. One person said, "They (staff) are very caring I am sure they do their best." Another person said, "They are very kind, they have more and more to do in less and less time. I speak to [registered manager] as the staff do not have time." A relative told us, "I think the staff are caring but they are very busy." During our inspection we found staff were kind and caring, but, interactions were limited and task focused. Although staff treated people with warmth and kindness, many of the interactions were focused on daily routines of personal care and meal times.

Most people told us they felt staff knew them well. One person told us, "They know me quite well they know my personality." Another person said, "Yes they should know me I have been here long enough but I don't think they have enough time (to spend with them)." People and their relatives spoke very positively about individual staff members. A relative told us, "There was one occasion when they were really caring to [relation]. They could not sleep so the member of staff sat on the bottom of their bed while they were asleep." Most people's care plans contained information about their background and their preferences. Further work was required to ensure all care plans reflected people's individual preferences.

An inconsistent approach had been taken to personalising the environment. For example, some people had memory boxes outside their bedrooms whereas other people did not. The registered manager told us they were planning to create memory boxes for everyone in the near future.

People were supported to maintain relationships with friends and family and people's friends and relations were welcome to visit Strawberry Fields Care Home. One person told us, "My friends came to see me they (staff) brought in extra chairs and offered tea and biscuits." Other people told us they were able to have meals with their relatives. The staff team had a good knowledge of who was important in each person's life and supported people to maintain relationships with family members. There were no restrictions upon visitors to the home. We saw people's relatives had been offered the opportunity to be involved with care plans and this was reflected in people's comments. A relative told us, "I see [relation's] care plan, I sign it regularly." Another relative said, "I have seen [family member's] care plan and gone through it."

The registered manager told us people had access to an advocate if they wished to use one and there was information about advocacy displayed in the service. Advocates are trained professionals who support, enable and empower people to speak up. One person was using an Independent Mental Capacity Advocate (IMCA) at the time of our inspection. IMCA's are a legal safeguard for people who lack the capacity to make specific important decisions.

Requires Improvement

Is the service responsive?

Our findings

The care and support provided at Strawberry Fields Care Home did not always meet people's needs or reflect their preferences. There was a significant lack of meaningful activity. People told us there were very few activities. One person commented, "There are no games here it's limited, we just sit here and watch the TV, there are no trips." Another person said, "I think there could be more activities and interests." A third person told us, "I spend most of my time in my room, we don't have much to do, no activities and things. I do go down to eat and that's it really." Staff also told us they had very little time to engage people in social activity. During our inspection we observed that many people living at the home lacked meaningful occupation, other than visits from friends and relatives. People's routines were dominated by meals and personal care and the remainder of the time people spent their time watching TV, sleeping or where able, they occupied themselves. We did observe staff engaging people in a game of bingo, however a member of staff told us this did not normally happen. This did not meet people's social needs and may have had an impact on their wellbeing.

We discussed the lack of meaningful occupation with the registered manager who was aware that people were not provided with any opportunities for activity. They told us they were in the process of recruiting an activity coordinator to improve opportunities for people living at the home.

People were at risk of receiving inconsistent support that did not meet their needs. Each person living at the home had an individual care plan; however the quality of these was variable. Whilst some parts of care plans contained sufficient information, other parts lacked detail and had not been updated to accurately reflect people's needs. For example, one person's pre-admission assessment documented they needed support with personal care, continence and their health. Despite this, they did not have a care plan to inform any aspect of their care and support. We asked a staff member how they knew how to support the person and they told us, "I am lucky I know them and the family." This did not assure us that all staff had access to clear guidance to inform the support provided. We also found that other care plans which lacked individualised information about how best to support them. Another person had a temporary care plan in place, this lacked detailed personalised information to inform staff support. This placed people at risk of inconsistent support.

In addition to this we found staff did not always follow guidance provided in care plans. One person's care plan specifically stated they should not drink from a certain type of cup. Despite this we observed this person was being assisted to drink using this type of cup. This failure to follow care plans placed people at risk of unsafe and inconsistent support.

The above information was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although the service did not support anyone who was coming toward the end of their life at the time of our inspection, people had been offered the opportunity to discuss their wishes for the end of their lives and this was recorded in their care plans. Staff also had a good understanding of their role and demonstrated

compassion and care for people. One member of staff told us, "I am really passionate about caring for people at the end of their life. I can spend an hour or an hour and a half making sure people are washed and dressed so their family can say goodbye. It is the last thing we can do for people and it is important that they have a dignified send off."

People's diverse needs were recognised and accommodated. Staff and the manager recognised the importance of respecting people's individual needs such as sexual orientation and gender identity. People's spiritual and religious needs were accommodated and people were supported to attend local places of worship and religious ceremonies were also held at the home. One person told us, "A priest comes about every 10 days to see me and sometimes a minister to give me communion."

The management team explained how they met their duties under the Accessible Information Standard by providing information in different formats as required. The Accessible Information Standard ensures that all people, regardless of impairment or disability, have equal access to information about their care and support.

There were systems and processes in place to deal with and address complaints. People told us they would feel comfortable telling the staff or registered manager if they had any complaints or concerns. One relative said, "Yes I have made a complaint they handled it well and did respond promptly." The registered manager told us they tried to address concerns promptly to avoid complaints, they said, "(I try to address things) before it gets to be a big issue that needs writing down. I try to stop little problems getting to be complaints." Staff knew how to respond to complaints if they arose and were aware of their responsibility to report concerns to the manager. Staff told us they were confident that the registered manager would act upon complaints appropriately. There was a complaints procedure on display in the home informing people how they could make a complaint. We reviewed records of complaints, these had been responded to in a timely manner and the registered manager had conducted in depth investigations and made improvements as needed.

Requires Improvement

Is the service well-led?

Our findings

Systems to monitor and improve the quality of the service were not consistently effective. Although the provider had a comprehensive audit system in place, this had not been effective in identifying or addressing the issues we found during our inspection. Medicines audits were completed regularly and reviewed by the registered manager, however the most recent medicines audit had not identified the issues we found during our inspection. There was a regular pressure ulcer audit in place to ensure the proper management of pressure ulcers. For the past three months this had recorded that no one living at the home had a pressure ulcer. However, during the course of our inspection we found evidence that two people had recently had pressure ulcers which had not been identified by the audit. This meant opportunities to identify and address issues and ensure good practice may have been missed.

Records relating to the care and treatment of people who used the service were not consistently accurate or up to date. Missing information in care plans and incomplete risk assessments put people at risk of receiving inconsistent and unsafe care. Care plan audits were not completed regularly and were not consistently effective in identifying areas for improvement. For example, we reviewed one person's care plan and found that it did not contain sufficiently detailed information to inform care and support. Although the care plan had been marked as being reviewed monthly by staff, it had not recently been audited and consequently the issues we found had not been identified. In addition, there were insufficient processes in place to ensure that adequately detailed care plans were implemented when people moved into the home. This had resulted in people being supported by staff who did not have enough information to inform the care and support. This failure to ensure that staff had access to accurate and up to date information about the people they were supporting put people at risk of receiving inconsistent and potentially unsafe support.

Effective action had not been taken in response to known issues. An audit had been conducted by the local authority in March 2017. This had highlighted a number of areas for improvement such care plans, the deployment of staff, the implementation of the Mental Capacity Act 2005 and medicines management. However, at our inspection we found continued issues in these areas. This meant we could not be assured improvements to the quality of the service would be made or sustained by the provider.

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

Despite the above, people and their relatives were, overall, positive about Strawberry Fields Care Home. One person told us, "I really never wanted to come into one of these places, I thought I wouldn't settle in, but I have just settled here. It is fabulous." A relative told us, "Overall, I am well impressed with it here," they went on to say, "I am not left to worry when [relative] is here." Another relative commented, "They give good quality care with the staff they have got."

There was a registered manager in post at the time of our inspection. The registered manager was very passionate about the home and had positive relationships with people living at the home and staff. People who used the service and their relatives told us the registered manager was approachable and friendly. One

person said, "It is well managed I think, they work so hard." A relative told us, "Yes sure it is well managed since the new company came. You cannot turn things round overnight, but it's a lot, lot cleaner and there are more staff." Records showed the registered manager visited the service out of hours to do 'spot checks'. Records showed these were undertaken either during the night or in the early hours of the morning and included a walk around the service and observations of practice.

Staff told us they felt supported by the registered manager and had confidence she would address any concerns raised in an appropriate manner. One member of staff told us, "[Registered manager] would always act and respond. It is well led here. We have a supportive manager and work well together as a team." Another member of staff said, "Best thing about the home is the manager, they have done the job and worked their way up the home from the floor, so they know what it is like." There were regular staff meetings, these were used to share news and information with staff and to raise and address issues of concern.

People living at the home and their relatives were given opportunities to provide feedback on the home. The registered manager told us meetings for people living at the home were held regularly Records of the meetings showed they were used to discuss areas such as concerns, activities, staffing levels and suggested improvements to the home. People were also able to share feedback in regular satisfaction surveys. A relative told us, "I have completed quite a few surveys." The results of the most recent survey were displayed in the foyer and were, overall, positive. Some areas for improvement in relation to activities, care plans the decoration of the building and laundry had been identified. People were provided with updates on progress at meetings.

We checked our records which showed the registered manager had notified us of events in the home. A notification is information about important events which the provider is required to send us by law such as serious injuries and allegations of abuse. This helps us monitor the service.

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 People were not always provided with care and support that was appropriate and met their needs. Regulation 9 (1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service were not protected from the risks associated with their care. Medicines were not managed or administered safely. Regulation 12 (1) (2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor and improve the quality and safety of the service were not effective. Action was not taken in response to known concerns. 17 (1)