Silver Healthcare Limited

Fulwood Lodge Care Home

Inspection report

379b Fulwood Road
Ranmoor
Sheffield
South Yorkshire
S10 3GA

Tel: 01142302666
Website: www.silver-healthcare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 5 July 2017 and was unannounced. This means prior to the inspection people were not aware we were inspecting the service on that day.

Fulwood Lodge is a 42 bed home providing personal and nursing care to older people with a range of support needs, including people living with dementia. It is located in the Ranmoor suburb of Sheffield. On the day of our inspection there were 25 people living in the home.

The manager had worked at the service for six weeks and had not completed their registration with the Care Quality Commission (CQC.) A registered manager is a person who has registered with the CQC 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.

Our last inspection at Fulwood Lodge took place on 16 December 2016 and the service was placed in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

People living at Fulwood Lodge and their relatives told us they liked living at Fulwood Lodge.

There were enough staff employed to meet the needs of people living at Fulwood Lodge. The manager reassured us they would be able to increase staffing levels as and when required.

We found effective systems were in place to ensure medicines were managed and administered in a safe way. However, improvements were still required with regard to the safe storage of medicines and the use of PRN (as and when) required medicines.

Staff were confident about how to protect people from harm and what they would do if they had any safeguarding concerns. They were confident any concerns would be taken seriously by management.

Effective care based on best practice, from staff with knowledge and skills they need was not always delivered for people requiring pressure area care.

Staff were suitably trained, and received supervisions and appraisals. However, the frequency of these was not consistent across the service.

People living at Fulwood Lodge and their relatives told us they enjoyed the food served at Fulwood Lodge, which we saw took into account their dietary needs and preferences. This meant their physical health was

promoted and their choices were respected.

The manager and staff were aware of the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). DoLS are put in place to protect people where their freedom of movement is restricted.

People living at Fulwood Lodge and their relatives told us staff were caring. However, we saw people did not always have their privacy and dignity respected.

We saw and heard positive interactions between people and staff throughout the inspection. Staff clearly knew people well.

There was a range of activities on offer to people living at Fulwood Lodge. People told us they enjoyed taking part in the activities.

Risks to people had been identified and plans put in place to keep these risks to a minimum. However, we found these did not always accurately reflect the current level of care and support the person needed.

More quality assurance systems needed to be introduced to look at the quality of the service provided. Those that were in place were not fully effective at identifying shortfalls in order to improve practice.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in; Regulation 10, Dignity and respect; and Regulation 17, Good governance. We also found a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, Notification of other incidents. 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 always safe.

We saw there were enough staff on duty to meet people's health and support needs. This will need to be kept under close review as the home moves towards reaching its full capacity of supporting 42 people.

Recruitment processes were in place to ensure staff had a DBS check before working directly with people.

We found systems were in place to make sure people received their medicines safely. However, these were not always followed. Medicines were not always stored at the correct temperate to ensure they were effective.

Is the service effective?

Requires Improvement

The service was not always effective.

Effective care based on best practice, from staff with knowledge and skills they need was not always delivered for people requiring pressure area care.

Staff were suitably trained, and received supervisions and appraisals. However, the frequency of these was not consistent across the service.

The service was meeting the requirements of the Deprivation of Liberty Safeguards. Staff had an understanding of, the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards.

Is the service caring?

Requires Improvement

The service was not always caring.

People's dignity was not always considered when providing care and support. Confidential information about people's health and care needs was not always securely locked away.

People living at Fulwood Lodge and their relatives told us the staff were caring.

The service was committed to providing appropriate end of life care through links with the local hospice.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The service had a complaints policy and procedure, which needed updating to include the details of the current management structure.

Everyone's care plan had been updated in the last three months to reflect the current level of care and support they needed. Although this was not always clear.

An activities coordinator had been in post since January 2017 and there was a programme of activities available each week.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The quality assurance and governance processes in place were not always effective in ensuring they provided people with a good service.

The service's policies and associated procedures were out of date. This meant they may not reflect current legislation and good practice guidance.

The managers met regularly with people living at Fulwood Lodge, their relatives and staff to ask for their views on the service and for them to communicate any changes.

Fulwood Lodge 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, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 5 July 2017 and was unannounced. The inspection team was made up of two adult social care inspectors and a specialist advisor. The specialist advisor was a nurse with experience of pressure area care.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help with the planning for this inspection and to support our judgements.

Prior to the inspection we reviewed the information we held about the service, which included correspondence we had received and any notifications submitted to us by the service. A notification must be sent to the Care Quality Commission every time a significant incident has taken place. For example, where a person who uses the service suffers a serious injury.

Before our inspection we contacted members of Sheffield City Council contracts and commissioning service and the NHS Sheffield Clinical Commissioning Group. They told us they had been jointly monitoring the service and trying to support the provider to improve as they had concerns regarding the quality of support provided to people who used the service.

During the inspection we spoke with five people who lived at Fulwood Lodge and five relatives who were visiting. We met with the manager, deputy manager and area manager. We spoke with an additional eight members of staff. We spent time looking at written records, which included six people's care records, five staff files and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

We checked the progress the registered provider had made following our inspection on 12 December 2016 when we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing. This was because there were insufficient numbers of suitably qualified, competent, skilled and experienced persons working in the home at all times. We found improvements had been made in this area.

On the day of our inspection there were 25 people living at Fulwood Lodge. There were three care workers employed from 8am to 8pm to support people living on the ground and first floor. There were two care workers employed from 8am to 8pm to support people living on the second floor. In addition there was a registered nurse employed to cover all three floors. The nurse had responsibility for administering medicines to people during this time. We were told the busiest medicines time was during the morning and people were encouraged to have their breakfast in the main dining room on the first floor. This was the most efficient way to ensure everyone was supported to take their medicines. Other times of the day were less busy for medicines to be administered and as a result we saw some people also used the dining room on the second floor for their lunch and evening meal. We spoke with the manager about this who told us as more people moved into Fulwood Lodge staffing levels would increase accordingly. There would be two registered nurses employed to manage people's medicines and both dining rooms would be used for all meals. We were told there were two care workers and one nurse employed to cover the night shift between 8pm and 8am.

We were told by the manager the service employed a cook and three domestic assistants every day and they were in the process of recruiting a kitchen assistant. On the day of our inspection one of the domestic assistants was off work due to ill health. An activities co-ordinator, maintenance person and receptionist were also employed every week day. The manager and deputy manager were supernumerary to staff, although we were told the deputy manager did cover for care workers in their absence.

We asked the manager whether any staffing dependency tools were used to work out at what point staff numbers needed to increase or decrease. We were told they were not aware of any and the registered provider with the area manager decided when staffing levels needed to change. The manager was able to agree temporary increases in staff in the absence of the registered provider. The manager told us they were in the process of recruiting additional nurses and care staff.

A member of staff told us they felt there were adequate staff rostered on duty to provide the care people needed with the current numbers of people using the service. They said the activities coordinator and the deputy manager helped at meal times. They said they were sometimes short of staff when there was short notice sickness however, the deputy manager provided assistance. We saw mealtimes were relaxed with plenty of staff available to support people as required. At the time of our inspection we saw there were enough staff to meet people's care and support needs. The manager agreed with us that as the home moves towards reaching its full capacity of supporting 42 people, staffing levels will need to be kept under close review.

We checked the progress the registered provider had made following our inspection on 12 December 2016 when we found a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe care and treatment. This was because people's risk assessments did not always contain sufficient information for care staff to be able to protect people. We found incidents and accidents were recorded and analysed by the manager each month However, there was no further information about what actions should be taken to keep the person safe. No records of any fire drills completed could be found which meant people could be put at risk of harm. During this inspection we found some improvements had been made in each of these areas.

We saw individual risk assessments had been completed to identify risks to people's health such as pressure ulcer risks, falls and nutritional risk. We saw these risk assessments were regularly reviewed and updated. Each risk assessment linked to the person's care plan which identified actions to be taken to reduce the risks. For example, a care plan for a person with a high nutritional risk score of being malnourished stated they should be weighed weekly, their food should be fortified and additional snacks should be offered between meals.

The service kept an 'Accident and Falls' log. This included a monthly analysis of falls and accidents including any patterns, such as falls happening at similar times in the same place. A record of any action to be taken to reduce the risk of reoccurrence was now recorded.

We saw risks to people's safety in the event of a fire had been identified and managed. For example, fire risk assessments were in place, fire drills took place and fire extinguisher and fire alarm checks were up to date. The care records we looked at contained brief personal evacuation plans for the person concerned in the event of a fire. The manager told us the service now undertook a fire drill every two weeks. The recommended minimum timescale was every three months. However, as new staff were being recruited and new people moving into Fulwood Lodge they felt the increased frequency was currently required.

We checked the progress the registered provider had made following our inspection on 12 December 2016 when we found a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Fit and proper persons employed. We found some improvements had been made.

We checked five staff personnel files to see if the process of recruiting staff was safe. The files related to a mixture of long standing members of staff and staff who had been employed since the last inspection. We found not all the required information as specified in Schedule 3 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 were in place, this includes acceptable references to confirm suitability in previous relevant employment, proof of identity, including a photograph and a Disclosure and Barring Service (DBS) check. A DBS check provides information about any criminal convictions a person may have. This helps to ensure people employed were of good character.

We saw all staff now had a completed DBS check. The manager told us where a DBS was returned with any cautions or convictions listed a risk assessment was undertaken. Based on this the registered provider then made a decision whether to proceed with employment or not. We saw evidence of this decision making process.

Three of the staff files only contained one reference. In one of these files it was a personal character reference and not from the member of staff's previous employer. There were also gaps in this worker's employment history which had not been followed up for an explanation as to why. Further improvements were required in this area to ensure staff recruitment processes helped keep people safe.

We checked to see whether medicines were stored securely and dispensed safely. We saw processes were in place for the timely ordering and supply of medicines. We saw medicines were stored in locked trolleys, cupboards and a refrigerator. However, we saw the room used to store the medicines trolley on the ground floor was not locked during the morning when medicines administration was taking place. However, we observed the medicine trolleys were locked when unattended. The medicines trolleys and medicines were stored in three separate rooms. The temperature of one of the rooms, where additional medicines, controlled medicines and the refrigerator were stored was recorded daily. However, the temperature of the two rooms where the medicines trolleys were stored were not recorded. The room temperature which was recorded was taken in the early morning and indicated that the room temperature was higher than recommended on several occasions within the previous month. The temperature of the room would have further increased during the day as the room did not have any temperature control mechanisms, such as a fan or air conditioning unit. We also saw the refrigerator temperature was operating at above the recommended limits. This can shorten the shelf life of medicines and affect their efficacy. No advice had been sought from the pharmacist in relation to this. Improvements were required in this area.

Some people living at Fulwood Lodge were prescribed controlled medicines. Strict legal controls are needed for these medicines. This is because they may cause serious problems like dependence and harm if they are not used properly. Controlled medicines include some strong painkillers, for example morphine. We saw controlled medicines stock checks were carried out approximately every two weeks. We checked the number of two controlled medicines and found the number remaining corresponded with the number recorded in controlled medicine record book. This meant checks were in place to ensure controlled medicines were stored safely. We saw topical medicines and liquid medicines were labelled with the date of opening. This is good practice as it reminds staff when these types of medicines are due to expire and therefore need to be replaced.

We saw the nurse checked medicines against the person's medicines administration record (MAR). MARs contained a photograph of the person to aid identification, a record of any allergies and their preferences for taking their medicines. When transdermal patches were prescribed there was a record of the site of application of the patch to enable rotation of the site. When people were receiving medicines that required monitoring to ensure the medicine could be given safely, we saw these checks were undertaken. We saw the nurse stayed with people until they had taken their medicines. The nurse was expected to sign the person's MAR on every occasion the person was supported to take their medicines, or record a reason why it had been declined. We did not see any gaps in recording. This meant people were supported to take their medicines as prescribed.

However, we observed a member of staff walking around the service carrying a syringe and open ampoule in their hands. This posed a safety risk to the member of staff; the ampoule should be left in the medicines room and the syringe should have been transported in a dish or similar. A person nearing the end of their life was prescribed two medicines for which the dose of the medicines was prescribed within a set range to enable staff to increase the dose if this was required. We observed the person was receiving these medicines regularly but the dose of the medicine administered was not always clear. This could lead to confusion about the amount of each medicine the person had received. When medicines were prescribed to be given only as and when required (PRN), protocols were in place to provide the additional information required to ensure they were given consistently and safely. We did however see on one person's MAR they were prescribed a sedative medicine and a PRN protocol was not in place. Improvements were required in this area.

A member of staff told us they had completed medicines training when they commenced employment and had their competency in this area checked. Their most recent competency check had been carried out by

the manager.

Staff told us they had completed safeguarding training and were able to identify the signs of abuse. They told us they would report any concerns to the manager and they were confident it would be dealt with. They were aware of the role of the local authority safeguarding team and said the telephone contact numbers were available in the home. They said they had not observed anything which would give them cause for concern.

The service kept a record of safeguarding concerns raised with the local authority. We saw five had been raised since our last inspection. Two of the five were regarding the same person, but different issues. CQC had not been notified of any of the five incidents and no outcomes were recorded. The manager told us they had only just notified CQC of the most recent safeguarding concern and a notification to this effect was received shortly after the inspection visit. From speaking with the manager we were aware action was taken by the service in response to these concerns. However, as this was not recorded there was no overall analysis of outcomes, or any lessons learnt to improve practice. Improvements were required in this area.

The premises were undergoing a period of refurbishment. One relative told us, "[There has been] lots of redecoration in the last six months which has improved the environment. There is a lovely outside seating area." We saw some carpets had been replaced and others still needing replacing. The reception area displayed empty photo frames which we were told were going to be used for photos of every member of staff. There were handrails in the corridors and the corridor walls were painted a lighter colour at the top and darker at the bottom. This can help orientate people living with dementia. We saw there was a photo of the person on the door of the bedroom they occupied, so people knew whose room it was.

Staff told us they had sufficient equipment to meet people's needs and we did not see any delays in care provision due to people waiting for appropriate equipment to be found. When people required a hoist for moving and handling, their care plan stated the size and type of sling required and people were allocated these individually.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection concerns regarding the care provided to people in relation to pressure area care had been raised by commissioners. Safeguarding concerns had been raised with the local authority between February 2016 and January 2017. At a recent safeguarding case conference with the area manager in attendance we were reassured these concerns had been addressed. During this inspection we saw eight people remained in wheelchairs throughout the morning and during lunch time. Although they were sitting on pressure relieving cushions, we did not see any of them being stood or being re-positioned for over four hours.

A high proportion of people living at Fulwood Lodge had pressure ulcers or wounds. Seven out of 25 people were identified by the nurse to have skin integrity issues. We spoke with the nurse about this and they told us several of these issues were caused by scratching due to people's skin being irritated and by moisture lesions. This could be an indication continence aids are not changed frequently enough and/or whether there are any common factors which might be causing skin irritation such as washing powder.

People with pressure ulcers were reviewed by the community tissue viability nurse (TVN) who gave advice on people's care needs. However, we observed this advice was not always followed. For example, in April 2017 the TVN recommended a person should not sit for more than an hour with a pressure relieving cushion in place. We did not find any more recent instructions to indicate this advice had changed. The person was sitting in their wheelchair all morning without the pressure being relieved. The records completed to demonstrate when they had been assisted to re-position indicated they were in a wheelchair for 9 hours on the 1st July 2017 and in a lounge chair for over four hours on 3rd July 2017. The documentation for another person we reviewed stated they should be assisted to move position every two hours and they should go back to bed for bed rest in the afternoon. This advice was provided on the day prior to the inspection. However, the person's position was changed four hourly during the night and they were sat in the lounge during the afternoon. A third person's care plan stated they should be assisted to re-position hourly at night. They had suffered a previous pressure ulcer on their sacrum and currently had a grade 3 pressure ulcer on their heel. We found a record of hourly checks at night but no record of re-positioning.

The documentation completed during the day for those people who were at risk of developing pressure ulcers and did not stay in bed, indicated whether they were in a wheelchair, lounge chair or in the dining room but did not record when and if they had received care to relieve pressure. For example, it was unclear whether a person stayed in their wheelchair when they were in the dining room and we saw on occasions the record indicted they were in a lounge chair and in a wheelchair at the same time. The deputy manager told us the documentation had only recently been introduced and staff were still getting used to it.

When people had pressure ulcers photographs were taken of the wound on a regular basis and there was information about the care of the wound. However, a wound progress chart to systematically assess wound healing was not always in place.

Records of the application of skin creams were not completed consistently and it was therefore difficult to

assure ourselves that creams were being applied regularly. Given the number of people for whom moisture lesions and scratching were an issue, adherence to the regular application of creams was not evidenced. In addition, we checked the settings on eight pressure relieving mattresses and found five were not set correctly for the weight of the people using them. For example one mattress was set at the highest setting designed for a person weighing 160Kg when the person weighed 60Kg, and another was set at 110Kg when they weighed 48Kg. This meant they were too firm for the person using them and may have increased rather than decreased the risk of the person developing pressure ulcers.

At 12.45pm on the day of the inspection we saw no food and fluid charts for the people whose records we reviewed had been completed for that day even though the charts started at 8am. We also saw records completed during the night for repositioning were generally documented as being carried out at 2.00am and 6.00am consistently. These findings suggest records were not completed at the time events took place.

When fluid balance charts were used to record a person's fluid intake, a fluid target was set and most records indicated people had a good fluid intake. However, one person whose records we reviewed did not have a separate fluid balance chart, although their care plans stated their food and fluid intake should be monitored. The record of fluid intake on their food chart indicated they had received under 450mls for four consecutive days. On average people need to drink 1500mls per day. Throughout the day of our inspection we saw people being offered drinks frequently, and being encouraged and supported to drink. Therefore it is likely this was a documentation issue rather than accurately reflecting poor fluid intake.

These examples demonstrated the service had not always assessed, monitored and mitigated the risks relating to people's pressure care, and had not maintained an accurate and contemporaneous record in respect of each service user this was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance.

We checked the progress the registered provider had made following our inspection on 12 December 2016 when we found a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Staffing. This was because staff did not receive effective support through regular supervisions and appraisals. We found some improvements had been made in this area.

Appraisals are meetings between a manager and staff member to discuss the next year's goals and objectives. These are important in order to ensure staff are supported in their roles. Staff told us they had recently had an appraisal with the deputy manager. The deputy manager confirmed these had all been completed in May and June of this year.

Supervisions are meetings between a manager and staff member to discuss any areas for improvement, concerns, or training requirements. The service had a 'Staff Supervision Policy' which did not stipulate how often supervision should take place. Some of the staff we spoke with told us they received regular supervision and the deputy manager told us it should be held every two months. The staff files we looked at showed the frequency of supervision was inconsistent. Supervision records were held centrally and later filed on the staff member's personnel record. We could not find evidence that every member of staff had received supervision so far this year. Improvements were required in this area.

Staff told us they had received an induction at the start of their employment at Fulwood Lodge. The manager told us the induction for new care staff consisted of care certificate training, shadowing more experienced staff for up to two weeks before working as part of the rota and signing up to complete the mandatory training sessions. The Care Certificate is a set of standards that social care and health workers follow in their daily working life. These are the minimum standards that should be covered as part of

induction training of new care workers. We saw evidence of new care workers completing an induction on their personnel files.

The service provided eleven mandatory training subjects for all care staff to complete at the start of their employment and refresher sessions throughout their employment. This included training on safeguarding vulnerable adults and safe moving and handling practices. The deputy manager told us the registered provider bought in classroom style teaching by a private company. Staff were tested at the end of each session to confirm whether they had understood what they had been taught. There was further specialist training for nurses in areas such as catheter care and venepuncture (taking blood).

We observed breakfast being served in the main dining room during the morning. It was a relaxed experience. We saw staff supporting two people to eat their breakfast and this was done at the person's pace. Staff chatted with the person and provided encouragement to maximise the amount they ate. We saw people were offered a good selection of options to eat at breakfast. This included cereals, porridge, bacon and eggs. Music was playing softly from a radio in the background. People were enjoying this as they were happily singing along. There were tablecloths and condiments on each table. There was a menu board in both dining rooms listing the food options for the day ahead. There were also pictures of food staff could use help people choose what they wanted to eat. People were asked during the morning when a drink and snacks trolley went round to everyone what they wanted to eat for lunch. The cook told us people could change their minds if they wanted to and they were able to accommodate this.

We saw menus were planned on a four week cycle. The main meal of the day was served at lunchtime and consisted of two choices. On the day of our inspection lasagne, chips and salad or fish pie with vegetables were offered. Both options looked appetising and people clearly enjoyed eating their food. Comments included, "The food given to [Name of relative] is very appealing. The new menus have their favourites on. Fresh fruit is always available" and "Yes I enjoyed my meal, the food was lovely." We saw people were offered a choice of drinks with their meal and were regularly offered refills. People were asked if they would like to wear an apron to protect their clothes and staff wore disposable aprons. One person wasn't feeling well and they chose to have their meal in their room.

A nutritional risk tool was used to assess people's nutritional risk and care plans were in place detailing the support they needed to eat and drink and their dietary requirements. Care plans also provided some information about their particular food preferences. People's weight was monitored on a weekly or monthly basis dependent on their level of risk. We saw a person was referred to a dietician when there was concern the person was losing weight. Some people were on special diets that required them to have soft food to eat. The cook told us they had recently met with a modified food specialist, who was able to give advice about new products and how to present soft food so it looked appetising. Plate guards, easy grip cutlery and straws were all available to people to enable them to eat and drink as independently as possible.

This meant people were supported to eat and drink to promote a healthy, balanced diet.

The Mental Capacity Act 2005 (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.

People can only be deprived of their liberty so that they can 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. There was a keypad code required to open the front door if anyone wanted to leave or enter the building. Double handles with a simultaneous twist movement were required to open the doors between floors within the building. This meant people's liberty at Fulwood Lodge was potentially being restricted. There were people residing at Fulwood Lodge who were living with dementia and we were told 12 people were currently subject to a DoLS authorisation. The service kept an electronic record of this and we saw some DoLS had been authorised since our last inspection. The registered provider had not notified CQC of this as per the regulations.

We saw people's capacity to consent to care was assessed within their care plans. When a person was able to make decisions about their care and treatment, they had signed a document to provide consent to information sharing with other professionals and decisions such as the use of bed rails to prevent them falling out of bed. When people were unable to make specific decisions for themselves we saw mental capacity assessments and best interest decisions were completed. For example, for the administration of medicines.

We were told that all staff received training in the principles of the MCA. Care staff we spoke confirmed this and understood the importance of involving people in making decisions.

We were told all the people using the service were registered with one GP practice and the local GP visited the service weekly. We saw evidence in people's care records of regular GP reviews. Care records showed evidence of the involvement of a dietician, tissue viability nurse and other health and social care professionals. This meant people were supported to access health and social care services when required.

Requires Improvement

Is the service caring?

Our findings

We checked the progress the registered provider had made following our inspection on 12 December 2016 when we found a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Dignity and respect. This was because people's dignity and confidentiality were not always respected.

During our inspection we saw the medicines room downstairs was not always locked. This room was used to store people's care records as well as medicines. Even when the medicines trolley was in use outside of the room it meant anyone could gain access to people's care records. Throughout the day we saw sections of people's care records left unattended for periods of time on tables in the communal areas. During these times it meant confidential information about people's health and care needs could be accessed by anyone in the building.

We saw people's dignity not always respected. We saw one person given an injection of insulin in the dining room. This person was not asked if this was alright with them or given the option to go somewhere more private. During the afternoon we saw another person having their blood pressure taken in the dining room. The member of staff did not explain what they were doing or give any options to go somewhere quieter.

This continued to demonstrate a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Dignity and respect.

Overall comments from people living at Fulwood Lodge and their relatives were positive. We were told, "Staff are fabulous," "It's alright here, staff are alright," "It's brilliant care here, the staff are very patient and very responsive" and "Staff are very good at giving [Name of relative] choices. For example whether he wants to listen to music, watch TV or go to bed. They [staff] take him out during the week."

We saw staff interact positively with people. They talked to people in reassuring tones, initiated lively conversations, and were able to calm people if they became agitated. We saw staff pull up chairs and sit down next to people so they could talk with them at their eye level. We saw staff explain to people what they were planning to do to support them before actually doing it. For example, explaining to someone they were going to assist them to sit in their wheelchair so they could take them to the dining room for lunch.

Throughout our inspection we saw staff talking light heartedly with people using the service and their relatives. Staff knew people well. They knew people's likes and dislikes. We heard staff remind people of family visits when they were expected and they chatted with people about things they knew were of interest to them.

We saw evidence in care records to indicate the person was involved in the development of their care plan. The deputy manager told us people living at Fulwood Lodge and their relatives were invited to participate in care plan reviews.

A relative told us their family member living at Fulwood Lodge received excellent care at the end of their life. They told us the staff made their family member's last days as comfortable as possible. They gave us examples of staff regularly checking on them, repositioning them regularly and moistening their lips. They told us their family member had their dignity and privacy maintained at all times. They knew because they visited from early morning to late at night and had been welcomed at all times.

The deputy manager told us the service had signed up to Project ECHO (Extension for Community Healthcare Outcomes). This is a collaborative model of medical education and care management that empowers clinicians everywhere to provide better care to more people, right where they live. In this case it linked expert specialist teams in end of life care from a local hospice with nurses and care workers directly providing care to the person at Fulwood Lodge.

Requires Improvement

Is the service responsive?

Our findings

The service had a complaints policy and we saw it was on display in the reception area. It gave addresses and telephone numbers of who to contact to make a complaint and who to contact if people were unhappy with the original response. The procedure needed updating to reflect the current management structure.

A member of staff told us they were not aware of any complaints about the service. They said if a person raised a complaint they would, "Check the facts to see whether it was true" and then try to remedy it. They were not aware of a complaints form to record complaints.

We saw the service held a complaints file and the manager told us there had not been any complaints since the last inspection. However, we found a recent complaint from May 2017. This was from a friend of a person living at Fulwood Lodge and was regarding people not being treated as individuals and being treated without dignity or respect. There was a response on file which took the form of bullet points and not a letter to the complainant. This was marked as resolved and dated. However, there was no response from the complainant recorded and no record of any action taken. Improvements were required in this area.

The registered provider had employed an activities co-ordinator since our last inspection. People living at Fulwood Lodge and their relatives spoke positively about this appointment and were pleased there were now more things for people to do. Comments included, "One of the improvements in the last six months is the activities programme."

The activities coordinator told us they supported people with their breakfast each weekday morning before embarking on a programme of activities. This included arts and crafts, skittles, bowling, memory games, and board games. We saw people congregating in the lounge on the first floor after breakfast to take part in games of hoopla and bowls. We saw posters advertising a summer fayre, which was being organised for later in the year. We were told singers were booked to perform at the home throughout the year.

This inspection took place on a warm day and people living at Fulwood Lodge had access to a large communal garden with a decked area people could sit out on. Some people living at Fulwood Lodge and their relatives sat outside and ate their lunch outdoors. The service did not have access to a minibus but the activities coordinator told us they used taxis to take small groups of people out to local amenities, such as Weston Park museum and the botanical gardens. They told us they aimed to organise trips out twice a week and tried to make sure it was different people each time so everyone had a chance to go out if they wanted to.

We looked at six people's care records. Pre-admission assessments were completed but were basic and did not provide any personal detail as tick boxes were completed but there was no additional written information. Documents to record each person's life story and a social profile were included in the care records. Some were completed with more details than others, but did give a sense of the person's social history, likes and dislikes.

Care plans were in place to provide information on people's care and support needs. They had all been rewritten within the previous three months and we saw all were reviewed monthly. The care plans provided adequate detail about the care and support required and personalised information about the person's needs and their preferences in relation to their care. However, we saw one instance where one care plan stated the person should be assisted to re-position four hourly and another care plan which stated the same person required re-positioning two hourly. The handwriting in some of the care records we looked at was very difficult to read.

Requires Improvement

Is the service well-led?

Our findings

We checked the progress the registered provider had made following our inspection on 12 December 2016 when we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance. This was because the systems and processes in place for good governance were ineffective in practice.

The manager in post at the time of our last inspection had left the service. The current manager had been in post for six weeks at the time of this inspection and had not completed their registration with CQC. The deputy manager had been in post since January 2017. We found some improvements had been made in this area.

People living at Fulwood Lodge and their relatives spoke positively about the manager and deputy manager. Comments from relatives included, "I get positive vibes from [Name of manager]. She is never flustered and always calm. [Name of deputy manager] is always on top of things."

Comments from staff about the manager included, "[Name of manager] is easy to talk to, she listens and is fair" and "[Name of manager] is approachable, she is fine, no problems." We found not all staff were as positive about the deputy manager.

We asked if people living at Fulwood Lodge and the staff that worked there were asked for their views on the service provided and if they were able to make any suggestions for improvements. Staff told us they had regular staff meetings with the managers. One member of staff told us a staff meeting was held after the current manager started at the service. They found the meeting useful and said the manager was looking at how the service could be improved. We saw minutes of these meetings. The most recent meeting was held in May 2017 and the minutes were pinned to a noticeboard in the staff room. We saw the next staff meeting was scheduled for later in July 2017. Staff who were unable to attend were expected to read the minutes and sign to confirm they had understood them. We saw the future dates for bi monthly meetings with people living at Fulwood Lodge and their relatives were displayed in the reception area. We were told the minutes from these meetings were posted out to all relatives.

We looked at the arrangements in place for quality assurance and governance. Quality assurance and governance processes are systems that help providers to assess the safety and quality of their services, ensuring they provide people with a good service and meet appropriate quality standards and legal obligations. The manager told us a health and safety audit was undertaken every three months. This covered areas such as food hygiene and electrical safety. We saw evidence of care plan audits taking place each month. However, it was unclear how managers were sure any identified actions were followed up. In addition we found contradictory information in a care plan during our inspection which suggests the audit wasn't completely effective.

The manager told us daily 'walk rounds' of the home were undertaken to monitor progress and identify areas for improvement. This included checking communal areas, equipment, and bathrooms. The manager

was expected to comment and sign off each area when seen. We saw this had been completed once in May and three times in June 2017. The manager told us this was correct as the outcomes were not always written down. This meant any actions to be taken were not always recorded and therefore couldn't be tracked through to completion.

We checked the maintenance records for the premises and equipment and found they were satisfactory. We saw Portable Appliance Testing (PAT); gas servicing; water safety and electrical installation servicing records were all up to date. Risks to people's safety in the event of a fire had been identified and managed, for example, fire risk assessments were in place, fire drills took place, and fire extinguisher checks were up to date.

The service had a file containing 'Care Home Provider's policies' in the manager's office. These were all dated September 2014 so may not have reflected the most recent legislation and good practice guidance. The policies were generic and not specific to Fulwood Lodge. For example, 'Service User's records will be kept in a secure location' with no further detail as to where the secure location was in the building. We spoke to the manager about this who told us there had been a recent meeting about updating all of the service's policies.

Although we found some improvements had been made in this area we found a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Good governance. This was because the systems and processes in place for good governance were not always effective in practice.

A notification should be sent to the Care Quality Commission every time a significant incident has taken place. During this inspection we were made aware of a number of safeguarding concerns raised with the local authority, which CQC should have been notified of. We were also made aware of a number of DoLS authorisations granted since the last inspection which CQC had not been notified of. This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009, Notification of other incidents.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 Registration Regulations 2009 Notifications of other incidents A notification should be sent to the Care Quality Commission every time a significant incident has taken place. During this inspection we were made aware of a number of safeguarding concerns raised with the local authority, which CQC should have been notified of. We were also made aware of a number of DoLS authorisations granted since the last inspection which CQC had not been notified of.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 10 HSCA RA Regulations 2014 Dignity and respect People's dignity and confidentiality were not always respected.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The systems and processes in place for good governance were not always effective in practice. The service had not always assessed, monitored and mitigated the risks relating to people's pressure care, and had not maintained an accurate and contemporaneous record in respect of each service user.