Care Uk Community Partnerships Ltd

Foxbridge House

Inspection report

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Inadequate
Is the service caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Inadequate

Overall summary

The inspection took place on the 9 and 10 of March 2015 and was unannounced. At our previous inspection on 12 August 2014 we found the service was breaching several legal requirements. The provider sent us an action plan detailing the action they would take to meet these legal requirements by the 31 December 2014. We carried out this inspection to check the action plan had been completed and to provide a rating for the service.

You can read the report from our last inspection, by selecting the 'all reports' link for 'Foxbridge House' on our website at www.cqc.org.uk.

There was no registered manager in post at the time of our inspection, however a new manager was in post and was in the process of registering with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC to manage the service and shares the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

Foxbridge House provides residential and nursing care for up to 84 older people. The home is located in Orpington Kent and is a large purpose-built care home. At the time of our inspection there were 61 people living at the home.

During our comprehensive inspection we found that the provider had continued to breach several legal requirements. You can see what action we have told the provider to take at the back of the full version of this report.

Risks to people were not always assessed, documented or managed appropriately. People's malnutrition risk assessments were not completed accurately. Errors were also found in people's weight records.

Risks relating to pressure wounds were not always assessed, monitored and managed appropriately. People's pain management was not monitored to ensure people received the care and treatment required.

People at risk of falls were not assessed and monitored appropriately so the provider could take action to reduce the risk of further incidents.

Recruitment processes were not safe and did not protect people from the risk of unsuitable staff being employed by the service.

Staffing levels were not always enough to meet people's needs. People had to wait to be supported by staff as staff were busy assisting others. Staffing shortages were identified as a problem by permanent members of staff and we saw gaps in staffing rotas. People were not cared for or supported by staff who were appropriately supported to deliver care and treatment safely and to an appropriate standard.

Deprivation of Liberty Safeguards (DoLS) were completed by the local authority ensuring that people's freedom was not unduly restricted and where restrictions were in place for people's safety there were records to evidence this was done. However, there were no processes in place to assess and consider people's capacity and rights to make decisions about their care and treatment where appropriate and to establish best interests in line with the Mental Capacity Act 2005 (MCA 2005).

Records were not always accurate. People's care was not always assessed and reviewed in response to people's needs. People who were living with dementia did not have detailed care plans that reflected their life histories and social interests. Care plans showed little detail about people's likes and dislikes in relation to social interaction skills and activities and people were not involved in making decisions about their own care and lifestyle choices. There were no effective systems in place to assess and record people's end of life care needs and wishes.

The provider did not have an effective system in place to regularly assess and monitor the quality of service people received or the improvements required or actioned as a result of surveys and audits conducted. People, their relatives, staff and visiting professionals to the home told us of the instability in management at the home and how this had a negative impact on the quality of care provided.

There were appropriate medicines policies and procedures in place and we saw that medicines were managed and handled appropriately. Safeguarding adults from abuse policies and procedures were in place to protect people using the service from the risks of abuse.

There were systems in place to deal with foreseeable emergencies and we saw that equipment and systems in relation to the premises were maintained and checked regularly.

People were supported appropriately to eat and drink sufficient quantities to maintain a balanced diet and ensure well-being.

Staff responded to people sensitively when offering support. People told us that staff respected their privacy and dignity.

The home provided a range of activities that people could choose to engage in. People we spoke with told us they enjoyed some of the activities on offer at the home.

People's concerns and complaints were responded to and addressed appropriately.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks relating to peoples care, welfare and treatment were not always assessed, monitored and managed appropriately.

People were not protected against the risks of receiving care or treatment that is inappropriate or unsafe by means of applying appropriate and safe staff recruitment procedures.

Staffing levels were not always enough to meet people's needs. Staffing shortages were identified as a problem by permanent members of staff and we saw gaps in staffing rotas.

Medicines were managed and handled appropriately.

There were safeguarding adults from abuse policies and procedures in place to protect people using the service from the risks of abuse.

There were systems in place to deal with foreseeable emergencies and equipment and systems in relation to the premises were maintained and checked regularly.

Is the service effective?

Inadequate

The service was not effective.

People were supported by staff who were not appropriately supported to deliver care and treatment safely and to an appropriate standard.

There were no processes in place to assess and consider people's capacity and rights to make decisions about their care and treatment where appropriate and to establish best interests in line with the Mental Capacity Act 2005 (MCA 2005).

Deprivation of Liberty Safeguards (DoLS) were completed to the local authority ensuring that people's freedom was not unduly restricted and where restrictions were in place for people's safety there were records to evidence this was done.

People were supported appropriately to eat and drink sufficient quantities to maintain a balanced diet and ensure well-being.

Is the service caring?

Requires improvement

The service was not always caring.

Care plans and records showed little evidence that people were involved in making decisions about their own care and lifestyle choices. There were no effective systems in place to assess and record people's end of life care needs and wishes.

Summary of findings

Staff responded to people sensitively when offering support. People told us that staff respected their privacy and dignity.

Is the service responsive?

Requires improvement

The service was not always responsive.

People's care was not always assessed and reviewed in response to people's needs. People who were living with dementia did not have detailed care plans that reflected their life histories and social interests. Care plans showed little detail about people's likes and dislikes.

The home provided a range of activities that people could choose to engage in.

People's concerns and complaints were responded to and addressed appropriately.

Is the service well-led?

Inadequate

The service was not well-led.

The provider did not have an effective system in place to regularly assess and monitor the quality of service people received or the improvements required or actioned as a result of surveys and audits conducted.

The provider failed to ensure accurate and appropriate records were kept and maintained in relation to the care and treatment people received.

People, their relatives, staff and visiting professionals to the home told us of the instability in management and leadership at the home and how this had a negative impact on the quality of care provided.

Foxbridge House

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 checked whether the provider was 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.

We undertook a comprehensive inspection of Foxbridge House on the 9 and 10 March 2015 to inspect the service against the five questions we ask about services. We also completed this inspection to check if improvements had been made to meet the legal requirements for five of the breaches to regulations we found at our inspection on the 12 August 2014.

Prior to the inspection we reviewed information we had about the service. This included reviewing the provider's action plan from the previous inspection and looking at statutory notifications and enquiries. A notification is information about important events which the provider is required by law to send us. We spoke with local authorities and health clinical commissioning groups who are commissioners of the service and local safeguarding teams including other health and social care professionals to obtain their views.

The inspection was unannounced and consisted of a team of eight members. The team included four inspectors, one inspection manager, a specialist advisor a pharmacy inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. There were 61 people using the service on the days of our inspection. We spoke with 26 people using the service and 16 visiting relatives. We looked at the care plans and records for 14 people using the service and six staff records. We spoke with 25 members of staff including the regional manager, manager, unit managers, team leaders, nursing staff, care staff, maintenance workers, chef and kitchen staff, domestic workers, activity co-ordinators and volunteers.

Not everyone at the service was able to communicate their views to us so we used the Short Observational Framework for Inspection (SOFI) to observe people's experiences throughout the day. SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

As part of our inspection we looked at records and reviewed information given to us by the regional manager, manager and other staff members. We looked at care plans and records for people using the service, medicine records and records related to the management of the service including audits and incidents logs. We also looked at areas of the building including all communal areas and outside grounds.

Inadequate

Is the service safe?

Our findings

At our inspection on 12 August 2014, we found that people's care and treatment was not always planned and delivered in a way that was intended to ensure people's safety and welfare and people were not always protected from the risk of abuse. Medicines were not stored safely or recorded appropriately. The provider sent us an action plan detailing the action they would take to address the breaches in legal requirements by 31 December 2014.

Most people using the service told us they felt safe living at the home. One person said "They [staff] are very concerned hear about keeping me safe." Another person told us "Yes I feel very safe although I'm not able to venture out without support". Comments from visiting relatives were mixed. One relative said "I am assured that they check on my relative regularly. When we come into visit staff often say that they've checked on them recently". Another relative told us of an incident where their spouse suffered an injury due to poor manual handling. They were informed that equipment would be modified, however they said "About 6 months ago, they said they would fix the problem to stop injuries but even now, it's still not done". Although some comments from people using the service and visiting relatives were positive we found that people were not always safe.

Risks to people were not always assessed, documented or managed appropriately. The provider had two methods for creating, assessing, documenting and storing people's care needs and risks. People using the service had a care plan which was recorded by hand and kept in a paper file and another which was kept on an electronic computer based programme. For each care plan and records we looked at we checked both paper file and computer based records.

People were at risk of malnutrition because risk assessments were not accurately completed and action was not always taken to address risks. Staff told us that malnutrition universal screening tool (MUST) assessments were completed to assess the risk of malnutrition for people using the service. There were electronic copies of assessments; however no paper copies were available. We reviewed four people's MUST assessments and found that in two cases there were significant discrepancies between people's height and weight scores over a period of a few days. We also found other errors in the weight records. MUST scoring is calculated using the person's height and these errors posed a risk that the overall score may not have been correctly calculated and appropriate care may not have been provided. One person had contradictory information about their weight on their care plan and risk assessment.

There was potential that people's risk of malnutrition was under estimated. Staff we spoke with were unable to account for the discrepancies we found in risk assessment scores. One person's care plan documented that any weight loss should be reported to the GP and a referral made to the dietician. However we could not see any reference to referrals or any professional advice being incorporated into the care plan which had last been reviewed on 09 February 2015.

People were not adequately protected from the risk of experiencing pain because pain assessments were not completed in line with the providers care plan guidance. One person who was described as being unable to assess their needs had three care plans on the electronic care record that stated staff should use a pain assessment tool in order to assess the person's experience of pain.

We were unable to find a record of any completed pain assessments and the nurse in charge confirmed staff had not carried out a pain assessment although the person was receiving pain control medicines on a continual basis. The nurse took immediate action to start a pain assessment record for this person; however we were unable to assess the impact as the actions were not completed at the time of our inspection.

Another person was prescribed regular pain medicine and their GP had recently increased this medicine as staff and the person's relative was concerned the person was experiencing pain. There was a note on the paper records stating staff should complete a pain scale first thing in the morning and when the person was in pain to assess their levels of pain. However there was no reference to pain scales being used to assess pain in any of the person's care plans, including their end of life care plan and medicine's care plan. There was a risk this person's pain was not being assessed or monitored on a regular basis.

Risks relating to pressure wounds were not always assessed, monitored and managed appropriately. For example one person's wound care dressing instructions documented in their paper file were not followed correctly which resulted in a different type of dressing to the one

recommended being used on consecutive dates in November 2015. Staff we spoke with told us this different type of dressing had been applied by an agency member of staff. From the 18 February 2015 until the 6 March 2015 there was no documented record of photographs taken of the wound or records of the person's pain rating and management as instructed by the wound evaluation chart. This meant there was a risk that the person's wound was not being assessed or treated appropriately and their pain was not being managed or assessed on a regular basis.

Another person's care plan recorded they had a Grade 2 pressure wound. However documents required in their wound care plan were missing. No body map or wound evaluation was in place to monitor any healing or deterioration. There was a wound care photograph dated 1 March 2015 which recorded 'dress wound every 3 days' however only one date for dressing application was recorded on 6 March 2015. It was unclear when the pressure area had started. Care plans recorded that the person required turning every two hours, however we found no repositioning charts in use to ensure two hourly repositioning had been completed which was confirmed by a team leader.

Staff did not always document the use of prescribed creams to treat people's skin conditions. For example, there was a paper record in one person's room which contained guidance on how frequently to apply three different creams, and where these should be applied. We found gaps in the records on several days in February and March 2015 and it was not possible to be sure that the creams had been applied as instructed. This meant there was a risk that people may not receive the treatment they required for their skin condition.

Risks identified with regards to swallowing or choking were not documented appropriately and guidance on how to prevent or manage identified risks was not provided. For example one person's care plan contained advice from a speech and language therapist which recorded the need to use thickened fluids. The person's care plan also documented that they were at high risk of choking. The risk assessment in place for choking contained little documentation and guidance for staff on what to do if the person choked.

People were not protected from the risk of falls. For example one person was assessed on 19 January 2015 as being at high risk of falls. The person had fallen on 18 February 2015 and sustained a cut to their head. The person's care plan which guided staff in managing the risk of falls had not been updated since 14 January 2015 despite being due for review on 11 February 2015. Following the fall, the person's relative had made a request for different equipment to be used to support the person's mobility and maintain their safety. Although there was a record that this request had been received and staff told us the equipment had been ordered, there had been no further action to assess the benefits of using this equipment or put the equipment into use.

Another person's risk assessment tool had recorded their risk of falls as medium on 02 February 2015. However there was no falls risk assessment in place to offer staff guidance on how to manage the risks. On the 5 March 2015 it was recorded on the electronic system that the person had fallen but there was no record of an incident and accident report being completed on either the electronic system or paper file and the care plan had not been updated. We spoke with the manager who confirmed that this had not been reported or recorded. This meant there was a risk that the person may not have received the appropriate care, treatment and support.

This was in continued breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 (1) (2) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff recruitment procedures were not safe. During our inspection we noted an agency nurse was not wearing any identity badge and when we asked the provider for proof of the agency staff's identity, including their picture, their nursing and midwifery council PIN and proof of their disclosure and barring checks (DBS) we found that this information had not been provided to the home's management by the agency. Although the staffing agency subsequently sent the information through to the home whilst we were present this agency nurse had been working at the home as the only registered nurse on duty on the nursing unit since 8:00am on 10 March 2015 without the provider confirming their identity and qualifications prior to this.

We requested confirmation that the home verified agency staff's qualifications, identification and criminal records checks prior to them working at the home. We spoke with the manager and member of staff who manage the staffing

arrangements. They were unable to provide us with confirmation that these checks were conducted until the second day of our inspection. However, information held by the provider only related to five agency staff rather than eight supplied by one agency. We drew this omission to the attention of the manager.

We were told that there was an induction checklist the home developed which was given to all new staff working at the home. We requested to look at this; however staff were unable to find this information at the time of the inspection. Staff we spoke with told us that often one agency worker handed over to another agency worker and there was no one familiar with the unit and the people using the service to provide a detailed induction to them. This meant there was a risk that people were cared for and supported by staff who were not familiar with or aware of people's needs.

This was in breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Comments we received from people and their relatives about staffing levels within the home were mixed. One person said "I've had to wait 20 minutes sometimes for someone to come and help me". Another person said "You don't wait long, their timing is reasonably good". And another person told us "Sometimes we have to wait a long time for help, up to half an hour". They told us they felt that staff were supportive and very nice, but there were not enough of them. A visiting relative told us "There's not always enough staff around, even though they say there is". Another relative said "Staffing levels seem to change a lot. Sometimes I come and there are enough, other days there are very few and at weekends it always seems to be agency staff".

There were not always enough staff to meet people's needs. On several occasions we saw that people had to wait to be supported by staff as staff were busy assisting others. Staffing shortages were identified as a problem by permanent members of staff whom we spoke with. One member of staff told us "Sometimes people have to wait a while for help as we are busy particularly if there are staff absences or sickness". Another member of staff said there were particular shortages at weekends. We asked staff how this impacted on their work and were told how having so many agency staff, including nurses, meant that a lot of time was spent explaining how the unit functioned. One staff said "It puts carers under stress and people who need less attention get less attention. For example, some people are lonely and want to chat, but there is no time for that most of the time".

Staff told us they could not always get people out of bed at the time the person preferred due to staff shortages. Another staff member told us that there was no nurse on one of the units recently and they were told that the agency worker booked to work did not turn up. We asked to see the staffing rota for this day but it could not be located. However, we looked at the rota for February 2015 and noted that there was no nurse rostered in for 27 February 2015 on one of the units. We pointed this out to the person responsible for the rotas who said "A nurse from another floor will have covered". There was no amendment made on the rota to confirm this. This also meant the removal of one nurse to cover the absence of another would have involved them leaving their own floor short staffed.

When we reviewed staffing rotas we found other gaps for qualified nurses on three days in the week at the time of our inspection. There were two further dates which recorded a member of staff as working when in fact they would not be available. We brought this to the attention of the home's new manager and the member of staff responsible for staff cover and rotas. We were told that they would get agency cover and that they were both new to their roles and were getting to grips with the shifts permanent staff were able to cover. We also noted that the home employed two chefs. We were told that there were problems with regards to covering sickness and holidays as they were not supposed to use an agency. As a result we found that one chef was working 7 days during the week of our inspection.

We spoke with the manager about current staffing levels within the home. They told us that staffing levels were determined by the number of people using the service and their needs. However when we asked how staffing levels were calculated and analysed we were told that they had no formal process of doing that or a process for reviewing staffing levels. We were told by the regional manager that the provider had a tool for calculating staffing levels which would be introduced into the home.

Inadequate

Is the service safe?

This was in breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection on the 12 August 2014 we found medicines were not managed safely. We asked the provider to ensure improvements were made. On this inspection we looked at the arrangements in place for the management of medicines which included observing medicines rounds, speaking with people using the service, staff administering medicines and looking at medicines records.

There were appropriate medicines policies and procedures in place. Details of these included self-administration of medicines and a self-administration process, witnessing of controlled drugs administered by staff and the agreement process for the use of covert medicines. Medicines were safely stored in locked medicine cabinets and trolleys and controlled drugs were safely kept in locked cabinets that only trained staff had access too. Medicines that required refrigeration were kept in lockable fridges in clinical rooms and the temperatures of fridges and clinical rooms were monitored to ensure medicines were safe to use. Medicines were disposed of appropriately and collected regularly by an external contracted company.

We observed medicines rounds conducted by trained staff on each floor of the home. Staff administering medicines that we spoke with told us they had received training in the management of medicines. They said they were not permitted to administer medicines until they had been observed and deemed competent to do so. Records we looked at confirmed this. People using the service who wanted to administer their own medicines were supported to do so following a risk assessment to ensure people's safety and records we looked at confirmed this.

We looked at the medication administration records (MAR) for 26 people using the service on different floors within the home and found these had been completed correctly. We saw the home monitored and audited MAR records and the use of medicine to ensure the safe administration of medicines and for governance and quality assurance purposes. These were conducted on a regular basis. We also noted that a visiting pharmacy conducted an audit of medicines used and administered at the home.

At our last inspection on the 12 August 2014 we found people were not protected from the risk of abuse. On this inspection we looked at the arrangements in place to safeguard people from the risk of abuse and found improvements had been made.

There were safeguarding adults from abuse policies and procedures in place to protect people using the service from the risks of abuse. This was reviewed by the provider in January 2015. We also saw a procedure to raise concerns flow chart that was displayed to offer guidance to staff on how to respond and report concerns. Staff we spoke with demonstrated good knowledge on how to report concerns appropriately and understood the provider's policies and procedures regarding safeguarding adults from abuse and how to use the providers whistle blowing policy.

Incidents involving the safety of people using the service were recorded and acted upon appropriately. We saw evidence to show that the provider had identified concerns and taken appropriate action to address concerns and minimise further risk of potential harm. For example one care plan we looked at documented that two people using the service had been involved in an incident between them causing injury and distress to both individuals. We saw that action to support the individuals was taken and a referral to the local authority safeguarding team was made to protect both individuals.

There were systems in place to deal with foreseeable emergencies. The provider had prepared a local fire plan and an emergency evacuation plan to ensure people's safety and that the premises conformed to fire safety standards. Plans provided guidance on a range of foreseeable emergencies and staff we spoke with knew what to do in the event of a fire. Records showed that staff participated in weekly fire alarm tests and monthly checks on fire extinguishers and the alarm system were conducted to ensure they were in working order.

We saw that equipment and systems in place in relation to the premises were maintained and checked regularly. For example, boilers and laundry equipment, sanitary fittings and flushing systems, fire alarms and emergency lighting, wheel chairs, hand rails and bed rails. Legionella and portable appliance electrical testing checks were carried out by external contractors and records we looked at were up to date. The disposal of clinical waste was contracted to

Inadequate

Is the service safe?

an external company for safe regular disposal. We noted that the premises were kept clean and were adequately maintained. People's rooms and communal areas were tidy and free from odours.

Inadequate

Is the service effective?

Our findings

At our inspection on 12 August 2014, we found that the provider failed to ensure that staff received regular formal supervision and appraisals. The provider sent us an action plan detailing the action they would take to meet this legal requirement by 31 December 2014.

Visiting relatives we spoke with made comments about staff support and competency. One relative said "The majority of staff are excellent, but one or two are somewhat lacking". Another relative told us "The are lots of agency staff and they are not always good in communicating with residents. One of them must have said 20 times to one lady, 'come to lunch' and I said, 'she can't understand you'. Finally, someone else got her up for lunch".

People were not cared for or supported by staff who were appropriately supported to deliver care and treatment safely and to an appropriate standard. Staff had not had annual appraisals. During our inspection we were unable to locate appraisal records in any of the files despite confirmation from administration staff that this is where they were stored. Staff we spoke with who had been employed by the provider for more than 12 months confirmed that they had not had an appraisal since working at the home. Staff did not have regular supervision. For example one registered nurse file contained only one supervision record dated 23 October 2014 and another file had no supervision records despite the person's appointment at the home since 2013. Care staff supervision records also showed a lack of frequent supervision and guidance. Staff we spoke with about the frequency of supervision confirmed that they had not received support on a regular basis. One staff member told us they had only received one supervision some months ago and that no one had discussed their new specific role and duties with them. Staff were unsure about the frequency of supervision and the provider's policy did not say how often staff should be supervised.

Staff had not received appropriate training. For example, training records identified that only 50% of staff had completed safeguarding training, 42% had completed Infection prevention and control training, 7% had completed moving and handling people and 53% had completed fire training at the time of our inspection. This meant that staff were not suitably trained to deliver care and support to people safely and to an appropriate standard.

This was a continued breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider did not have processes in place to assess and consider people's capacity and rights to make decisions about their care and treatment where appropriate and to establish their best interests in line with the Mental Capacity Act 2005 (MCA 2005). MCA is law protecting people who are unable to make decisions for themselves or whom the state has decided their liberty needs to be deprived in their own best interests. Care plans did not always contain mental capacity assessments where people's capacity to consent to make decisions was in doubt. Decisions such as use of an air mattress to prevent pressure sores and the use of bed rails we found no completed mental capacity assessments in place. The provider showed us a folder which contained only a few completed assessments and did not represent the number of people using the service where their capacity was in doubt. This meant that people may be at risk of receiving unsafe or inappropriate care and treatment as an assessment of their capacity to make decisions had not been conducted.

On the nursing floor we saw reference to relatives of people using the service with regards to lasting power of attorneys in two of the care plans we reviewed. We asked the manager if they had received confirmation of these legal arrangements and were told this had not yet been put into place. This meant there was a risk that people's rights may not be upheld because the provider had not confirmed who could legally give consent on behalf of the person using the service.

Staff had not always received up to date training on the MCA 2005 and some staff we spoke with were unable to explain the process to follow if they were in doubt that someone was unable to consent and make decisions about their care and treatment. This meant that people may be at risk of receiving unsafe or inappropriate care and treatment as staff were not knowledgeable to assess or support people where appropriate.

Inadequate

Is the service effective?

This was in breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A regional support manager had responsibility for making applications for Deprivation of Liberty Safeguards (DoLS) to the local authority. Appropriate referrals to local authorities were completed ensuring that people's freedom was not unduly restricted and where restrictions were in place for people's safety there were records to evidence this was done. We found that people had representatives in place to help them express their views with regards to the decision to place restrictions on these people to maintain their safety.

People's nutritional needs and preferences were not always met. Comments from people about the food served at the home were mixed. One person told us "'It's not as good as it was. You can't please everyone". Another person said "The food is a disappointment. Staff problems and a series of chefs, mean it is worse now". A third person said "'The food varies. There's not much consideration for special diets. I end up with just veg on occasions. The breakfasts are the best". A fourth person told us "'The food is fine, but there's not much choice. You can always have an omelette".

Accurate records of people's dietary requirements were not available to the kitchen staff. We were told that the head chef may have taken a folder home which contained some information. We asked how kitchen staff would know about people's allergies or medical needs and preferences and they were unsure. The manager was also unable to locate the information requested.

There were printed menus displayed on tables within dining rooms, however there were no pictorial menus available for people who required support to express their choices. We also saw a notice on one lounge door asking people to tell staff about their food intolerances. This was in small print and not available in an easy read or pictorial version for people who had difficulty in expressing choice or who had dementia.

These issues were in breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We visited the main kitchen and spoke with the chef and kitchen staff. We were shown three weekly menus that had recently been revised. The chef told us they had support from care staff when requesting people's food preferences and used these for menu planning. We saw there was a choice of main meals and people were offered sandwiches or omelettes as an alternative if they did not want the meal options. We noted that alternatives were vegetarian options although the chef was unsure how many people were vegetarians. If people wanted something to eat and drink outside of meal times fridges on each of the units had sandwiches and fruit in them which were regularly topped up by hostesses on each floor.

The kitchen was cleaned daily and we saw cleaning schedules which were up to date. Fridge and freezer temperatures were also up to date and food temperature checks were conducted as food was delivered. We noted the service had scored a rating of 5 from the Food Standards Agency who visited the home in December 2014.

The chefs attended residents and relatives meetings to seek feedback from people about the food. Hostesses would also feedback any complaints and would speak with people to try and resolve issues. People were supported appropriately to eat and drink sufficient quantities to maintain a balanced diet and ensure well-being. We observed lunch time in two of the dining rooms. People were offered choices and staff chatted with them whilst serving meals. People were sat either with a member of staff, visiting relatives or another person using the service and did not eat alone. Staff supporting people with their meals provided conversation, encouragement and consulted with people before offering support.

Requires improvement

Is the service caring?

Our findings

People and their relatives we spoke with generally commented positively about the care and support they received. One person told us, "They are all helpful, the cleaners, the maintenance man, the laundry staff and the carers really care". Some people gave examples of their care being thoughtful. One person said "They are considerate. They take me to the dentist with a carer and sent regards when I was in hospital". A visiting relative told us "'They talk to him as an adult with an opinion, not a child. He's not too aware, but he's chipper, and singing, we are very happy". A visiting friend told us "They remember little things that are important to her, like her earrings. Her hair and nails are done as well". However we found that people were not always enabled to make or participate in making decisions and choices relating to their care and treatment.

Care plans and records we looked at showed little evidence that people were involved in making decisions about their own care and lifestyle choices. For example one person's care plan detailed how they had been transferred from hospital direct to the home. There were no preadmission assessments of their needs and their care plan did not record their wishes. We noted that the care plan had not been signed or dated by the person or their relative in agreement with the proposed plan of care. Another care plan showed no evidence of the person or their relative's involvement in their care plan development or reviews that were subsequently conducted.

The provider did not have effective systems in place to assess and record people's end of life care needs and wishes. We spoke with the manager who told us that the home had just started to work with a local hospice on end of life care that would ensure people's wishes and choices were respected.

This was in breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff responded to people sensitively when offering support. We saw staff interacted positively with people and that people responded well to staff and appeared comfortable with them. People who were unable to verbally express their views or wishes appeared comfortable with staff who supported them. We observed one person smiling and touching a member of staff when they approached them to offer support. Staff we spoke with demonstrated a good understanding of people's life histories and preferences and were able to tell us about important events in people's lives and about people's individual personalities and behaviours.

People told us that staff treated them well and respected their privacy. We observed staff knocked on people's bedroom doors before entering and sought permission before entering. Bedrooms were single occupancy which promoted peoples independence and dignity and we saw people were supported to personalise their rooms with furniture and personal belongings. There were areas for people to spend time with their relatives if they wished and a ground floor communal coffee shop which served tea, coffee and biscuits throughout the day.

Requires improvement

Is the service responsive?

Our findings

People's care was not always assessed and reviewed in response to people's needs. The majority of care plans we looked at were not detailed and did not identify actions required to respond to people's care needs. Where people's behaviour challenged the service care plans did not always provide guidance to staff on how they should respond to any such behaviour.

We also saw that where guidance was available, staff did not always follow it. For example one care plan detailed work that was conducted with the local community mental health team which monitored the person's behaviour and identified reasons for their behaviour. Guidance from the team detailed approaches staff should take when supporting the person. However we noted that the monitoring was not consistently carried out and was only completed for short periods of time. This meant it was not possible to identify patterns of behaviour and to put in place effective interventions to address them and support the person appropriately.

People who were living with dementia did not have detailed care plans that reflected their life histories and social interests. Care plans did not identify how people's dementia affected them and what actions were required by staff to support their physical and mental well-being.

Care plans showed little detail about people's likes and dislikes in relation to social interaction skills and activities. We saw some information recorded about people's level of social interaction and communication but outcomes for people in relation to their participation in activities were not documented or reviewed on a regular basis. It was therefore not possible to determine if people were participating in activities that were meaningful to them.

These issues were in further breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 (1) (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home provided a range of activities that people could choose to engage in. People we spoke with told us they enjoyed some of the activities on offer at the home. One person commented "I find my friend in the lounge and we sit outside on nice days to see the rose trees and rabbits".

Another person said "I like the weekly pub outings on Wednesdays. I've been a couple of times and enjoy it but you can be sat there quite some time before you come back".

Relatives spoke positively about activities on offer. One relative said "It's buzzy here, there are always things going on. We like to sit in the café area and also like the entertainment that comes to the home such as musicians". Another relative told us "My relative was offered 1-1 activity time as they are unable to get to communal areas with ease but they declined".

We saw that copies of the weekly activities programme were displayed around the home so people were kept informed of social events and activities they could choose to engage in. We saw that activities on offer included painting, cinema club, virtual horseracing, quizzes, live entertainment from external entertainers and 'fun, fit and fabulous' with a physiotherapist.

People and their relatives told us they were aware of how to raise a concern and felt it would be dealt with. One person told us "I would go to the manager without reservation. She's already had a long chat with me and my daughter". Another person said "The senior carer will deal with any concerns I have". A third person said "Any issues I have had has been resolved quickly".

People's concerns were responded to and addressed. The manager showed us the complaints file which included a copy of the provider's complaints policy and procedure, complaints monitoring record and individual complaints received and recorded actions taken.

Complaint record showed that when concerns had been raised these were investigated and feedback given to the complainant. We saw that six complaints received by the provider had been investigated and responded to in line with the provider's policy and procedure. However, we noted that one complaint exceeded the providers response times by three days which required a senior manager's involvement to resolve the concerns. We noted there was no complaints information booklet or poster displayed in the communal areas or the reception area of the home. We spoke with the manager and recommended that they displayed their complaints policy and procedure in an appropriate format for people and their relatives.

Inadequate

Is the service well-led?

Our findings

Since our last inspection in August 2014 there had been one temporary manager and two permanent managers in post at Foxbridge House. The third manager was in the process of registering with CQC. People, their relatives, staff and visiting professionals to the home told us of the instability in management and leadership at the home and how this had a negative impact on the quality of care provided. People's comments included "A lack of management at the weekends, and a lack of carers too", "'No surveys or opportunities to feedback", "There are relatives meetings but it's a bit random", "There was a relatives' meeting just before Christmas. It was fiery. There were many complaints", "There are no meetings. I went to see a manager when they hadn't introduced themselves", "The person who is supposed to be in charge doesn't seem to be here" and "Five managers in a year. I've never spoken to a manager and I'm here three times a week".

The provider did not have an effective system in place to regularly assess and monitor the quality of service people received or the improvements required or actioned as a result of surveys and audits conducted. For example, only two clinical risk meetings were held in September 2014 and none after or before these dates. At these meetings issues in relation to swallowing difficulties, weight loss, diabetes support, tissue viability, falls and incidents involving behaviour that may challenge were discussed. Following these meetings an action plan was implemented but no records were available to show what action had been taken, when and by who to resolve issues identified.

Staff meeting records demonstrated that only one palliative care meeting was held in September 2014 and issues were identified and actions proposed but there was no evidence of actions taken or completed as a result. We also noted that no further palliative care meeting were held before or after this date. Staff meetings that were held in February 2015 indicated that only 13% of staff had received fire awareness training and we noted no action plan was implemented to address the identified staff training needs.

A health care assistant meeting was held in December 2014 to discuss issues around staffing levels during weekends and staff swapping shifts on the staffing rota. However, there was no action plan developed to show how, when and who was responsible to take the appropriate action to address the issues identified.

There were only two registered nurse meetings held which took place in August and October 2014. Both meetings raised issues concerning updating care plans, medicine management, GP rounds and night staff tasks. However there was no action plan developed to monitor the improvements made and it was recorded that a third meeting was to be held on 23 October 2014 which we noted did not take place.

Residents meeting were held in the months of October and November 2014 and again in February 2015. Meetings raised concerns in relation to individual's care needs, staffing levels and the use of agency staff, catering, laundry and activities. An action plan was developed and improvements were reported. However, there was no recorded information or explanation why residents meeting were not held in December 2014 and January 2015 as recorded.

The provider did not have systems in place to conduct residents' satisfaction surveys to gain feedback from people using the service. However there were systems in place to conduct relatives satisfaction surveys. Results of the most recent relatives' satisfaction survey showed that relatives thought the quality of the service had deteriorated compared to survey results from 2013 to 2014. There was no action plan developed in response to these issues to show how the identified concerns would be resolved.

There was a service level agreement between the provider and a local GP surgery, which stated that GP's would visit the home for three hours on every Tuesday and Friday. However it was found that the allocated time was insufficient and was putting unacceptable pressure on GPs. We also found from the results of the relatives satisfaction survey of 2014 that the local GP service provided to people at the home had deteriorated by 13% since 2013. The provider had planned to review the service level agreement in 2014, but at the time of our inspection this had not been reviewed. The manager told us they were waiting for a member of staff from their governance team to confirm a date for the meeting.

The provider's own audit conducted in November 2014, found the service required improvements in areas of safe, caring, responsive and well-led. As a result of this audit an action plan was developed however there was no record of actions taken as planned. Another audit in February 2015

Is the service well-led?

identified that improvement were required. However there was no action plan developed to make the required improvements and to monitor the progress of actions taken.

This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider failed to ensure accurate and appropriate records were kept and maintained in relation to the care and treatment people received. The provider used a computer based records system and a paper file system to ensure records were accessed by staff should the computer system fail. However paper files and records were not accurately maintained, updated and reviewed in line with the provider's policy, were disorganised in relation to the file index, had large proportions of the contents missing and records were not kept securely within nursing stations on all levels of the home. Senior members of staff told us that paper records were approximately one month behind the computer based records due to issues with printing documentation. Therefore this system made it difficult for new, temporary and agency staff to obtain an up to date picture of people's needs and support they required.

Computer stored care plans were inadequately maintained and hard to navigate through the system. Staff told us they found it difficult to obtain requested information and to see what follow up actions had been taken when issues were identified in people's care needs. During the inspection we were unable to access some requested information due to the computer system and equipment not working appropriately. On two floors of the home we found printers were not operational for staff to use to update peoples care plans in line with the providers policy. Staff we spoke with told us that it was a frequent problem and some of the printers had been out of action for several months. Staff told us they had reported the issues but the problems were persistent. We brought this to the attention of the manager who contacted the provider's computer support team. We were informed that these issues would be resolved but we were unable to assess the impact, as the actions were not completed at the time of our inspection.

We also noted that some staff members had restricted access to certain documents. We spoke with the manager who told us that staff did not have access to computer based mental capacity assessments and risk assessments as these documents were stored on another computer system which only the manager could access. This meant that people may be at risk of inappropriate care and support as staff may not be aware of people's identified needs.

There was an agency staff login process for computer stored care plans and records. However on the 9 March 2015 an agency nurse and care worker were unable to gain access into the computer system as this was not working on the nursing floor of the home. Agency staff were booked to provide cover to the units on the 10 March 2015 and we were not confident they would be able to access the electronic records and update them accordingly. Staff we spoke with told us agency staff could not always access the system.

This was in breach of regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 (2) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite the lack of staff supervisions, staff we spoke with told us there were daily meetings held for various departments within the home to come together. This provided staff with an opportunity to communicate issues or concerns and develop ways in which these could be resolved.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **Regulation 12 (1) (2) (a) (b) (3) (a) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **The provider did not take proper steps to ensure that people were protected against the risks of receiving care or treatment that is inappropriate or unsafe.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision **Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **The provider did not regularly assess and monitor the quality of the service provided to identify, assess and manage risk relating to the health, safety and welfare of people using the service.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs **Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.** **People were not protected against the risks of inadequate nutrition and dehydration. People's nutritional needs and preferences were not always met.**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have suitable arrangements in place to ensure people participated in making decisions relating to their care or treatment.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have suitable arrangements in place to obtain or act in accordance with people's consent.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records Regulation 17 (2) (c) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not ensure that people were protected against risks arising from a lack of appropriately stored information and accurate and up to date records.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not operate effective recruitment procedures to ensure the health, safety and welfare of people using the service.

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not take appropriate steps to ensure that at all times there were sufficient numbers of suitably qualified, skilled and experienced staff.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff Regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider did not have suitable arrangements in place to ensure staff were appropriately supported in relation to their responsibilities.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **The provider did not take proper steps to ensure that people were protected against the risks of receiving care or treatment that is inappropriate or unsafe.**

The enforcement action we took:
The registered person must take proper steps to ensure that each service user is protected against the risks of receiving care or treatment that is inappropriate or unsafe.
Regulation 9 (1) (a) (b) (i) (ii) (iii)
We have issued the provider with a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The provider did not operate effective recruitment procedures to ensure the health, safety and welfare of people using the service.**

The enforcement action we took:
The registered person must operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying on a regulated activity unless that person is of good character, has the qualifications, skills and experience which are necessary for the work to be performed.
Regulation 21 (a) (i) (ii) (iii) (c) (i) (ii)
We have issued the provider with a warning notice.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff **The provider did not have suitable arrangements in place to ensure staff were appropriately supported in relation to their responsibilities.**

The enforcement action we took:
The registered person must have suitable arrangements in place in order to ensure that persons employed for the purposes of carrying on the regulated activity are appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard.

This section is primarily information for the provider

Enforcement actions

Regulation 23 (1) (a) (b) (2) (3) (a) (b)
We have issued the provider with a warning notice.