Miss Lucy Craig

West Farm Care Centre

Inspection report

West Farm Avenue
Newcastle Upon Tyne
Tyne and Wear
NE12 8UT

Tel: 01912189626

Date of inspection visit:
24 April 2018
25 April 2018
26 April 2018

Date of publication:
05 June 2018

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 24, 25 and 26 April 2018. Day one of the inspection was unannounced. This is the first rated inspection of West Farm Care Centre with the provider Miss Lucy Craig.

West Farm Care Centre is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

West Farm Care Centre can accommodate 50 people in one adapted building across two floors. At the time of the inspection 48 people were resident. The first floor, known as the Shore unit, is for people living with a dementia, although some people living with a dementia also resided on the ground floor.

The service did not have a registered manager. The current manager had been in post since December 2017 and had not made an application to register with the Commission. The provider had notified us that the previous registered manager had left, however, they had not submitted an application to cancel their registration.

A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During this inspection we found five breaches of regulations we inspected against.

An electronic care planning system was used. Care records contained generic information that was pre-populated by the system. In some cases, the information was not accurate, nor was it specific to the person. Care records were not detailed and did not provide staff with accurate and up to date information on people's needs.

Risks were not always assessed or included within people's care records. Specific information and guidance from healthcare professionals was not always used to update care plans and risk assessments.

Consent to care and treatment was not always sought in line with the Mental Capacity Act 2005 (MCA).

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; however, care documentation in the service did not support this practice.

Some incidents, including those staff found challenging, had not been investigated or analysed for themes or triggers for the behaviour. This meant care plans were not in place to support staff to manage the behaviour and minimise risks.

Safeguarding incidents had not always been reported to the local authority safeguarding team or notified to the Commission.

Quality assurance systems had not been effectively implemented to assess, monitor and improve the quality of the service provided to people.

You can see what action we told the provider to take at the back of the full version of the report.

Care staff knew people well and had developed dignified, respectful and compassionate relationships with people. People were complimentary about the care and support they received.

Staffing levels were appropriate to people's needs and robust recruitment procedures were in place. Staff said they felt supported and had attended the training needed to make sure they could meet people's needs.

Positive relationships had been developed with visiting care professionals.

Activities were currently being managed by the care staff and we saw people enjoyed socialising and engaging with each other.

A refurbishment plan was in place to develop the Shore unit so it was more dementia friendly. People had been involved in the decision making and plans were in place to minimise any disruption to people whilst the work was completed.

Meal times were a pleasant experience and people were offered a choice of freshly made meals using fresh ingredients. Staff were vigilant in offering people drinks and snacks in between meals.

The administration of medicines was safe. However, the documentation in relation to time specific medicines was not always completed.

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 safe.

Systems had not been operated effectively to investigate, and report allegations of and incidents of abuse and poor care.

Risks to people were not appropriately assessed or mitigated.

Fire extinguishers had not been serviced and action had not been taken in a timely manner to manage this.

Staffing levels were appropriate to meet people's needs.

Medicines were administered safely.

Is the service effective?

Requires Improvement

The service was not effective.

The principles of the Mental Capacity Act 2005 were not always followed.

Staff said they felt supported and had received appropriate training.

People were complimentary of the meals and dietary requirements were met.

People had access to health care professionals however advice and guidance was not always used to update electronic care records.

Is the service caring?

Good

The service was caring.

Staff treated people with respect and dignity.

Relationships between people and staff were warm, compassionate and caring.

People were supported to maintain their independence.

Is the service responsive?

Requires Improvement

The service was not responsive.

An electronic system was used for care planning. Care plans were not always personalised and detailed.

Care records did not always reflect people's current needs and preferences.

Care staff supported people with a range of activities.

Complaints were investigated but the outcome of the investigation was not always shared with the complainant.

Is the service well-led?

Requires Improvement

The service was not well-led.

There was no registered manager in post and the previous registered manager had not applied to the Commission to cancel their registration.

Not all incidents requiring a statutory notification had been submitted to the Commission.

Audits were completed; however, they had not been effective in assessing, monitoring and improving the quality of the service.

West Farm Care Centre

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 24 April 2018 and was unannounced. This meant the provider did not know we would be visiting. Further inspection visits took place on 25 and 26 April 2018 which were announced.

The inspection team was made up of three adult social care inspectors.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to let us know about. The provider did not meet the minimum requirement of completing the Provider Information Return at least once annually. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. The most recent Provider Information Return was received in November 2016. We took this into account when we made the judgements in this report.

We contacted the local authority commissioning team and the safeguarding adult's team. We contacted the local Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

During the inspection we spoke with five people living at the service and three relatives. We spoke with the manager, the unit manager/acting deputy manager, two operations managers and the nominated individual/owner. We also spoke with four care workers, a second unit manager, three members of ancillary staff, a visiting community nurse and a representative from the provider of the electronic care planning system.

We looked at care records for five people and medicine administration records for a further give people. We reviewed seven staff files including recruitment, supervision and training information. We also reviewed

records relating to the management of the service.

We looked around the building and spent time in the communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During the inspection we asked the manager to provide us with further information in relation to Deprivation of Liberty Safeguards and some specific safeguarding concerns. The information was shared with us by the required date. In addition, the manager also shared an action plan resulting from the site visit. We also asked for confirmation of the action taken by the provider to ensure the previous registered manager applied to cancel their registration. This has not been received.

Requires Improvement

Is the service safe?

Our findings

A safeguarding file was in place which included some incidents that had been raised with the local authority safeguarding team. For example, incidents of neglect and abuse. These incidents had been investigated and action taken to minimise the risk to people. However, they had not always been notified to the Commission.

Care documentation recorded multiple occurrences of behaviour which was described by staff as being 'aggressive'. These incidents happened between people and also towards staff. Some incidents had been alerted to the safeguarding team and necessary action taken to investigate concerns. However, other incidents had not been reported. These included person on person altercations, some of which had resulted in physical contact. No analysis or investigation had taken place to identify triggers or warning signs or develop distraction strategies for when people were distressed and anxious. Nor had they resulted in safeguarding alerts or notifications.

One person's daily notes showed they had been distressed on specific days, for example by being verbally aggressive. Staff had not reviewed the daily notes or themes or patterns to the behaviour and therefore there was no detailed care plan or risk assessment in place to support the person at these difficult times.

Some people told us they felt scared and didn't like some other people's behaviour. One person said, "I don't like it when they shout." They added, "They are always getting at me, I just go outside when this happens." Another person said, "On the whole its very good, but I don't like the arguments [between people]."

We discussed this with the manager who acknowledged our concerns in relation to safeguarding people, minimising the risk of reoccurrence of incidents and reporting procedures.

These concerns were a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safeguarding service users from abuse and improper treatment.

Accidents and some incidents were documented. We found a significant number of incidents were unwitnessed falls that had occurred overnight. Whilst action had been taken in response to some individual falls, there was no overall analysis to identify trends and triggers, for example to review if staffing levels overnight were appropriate and sufficient to meet people's needs.

Risks had not always been appropriately assessed and included in care documentation. For example, one person had been assessed by the speech and language therapy team as being at risk of aspiration pneumonia. However,' this information was not detailed in their care plan nor was there a risk assessment in place.

Some people, when upset or anxious, displayed behaviour which was described as challenging. When incidents occurred, specifically around people's behaviour that could be seen as challenging, although the daily records were up dated, we noted that behaviour records and incident forms were not complete. This

meant that it would not be clear for staff to identify trends of behaviour and risk assess them from happening in the future. Without tracking behaviours and incident patterns we could not be assured the service was doing all that was possible to mitigate risks people's behaviours posed. A document titled 'Behavioural management strategies' was in place which included an assessment of the degree of risk. The detail of these were confusing and minimal. For example, one person's record stated 'behaviour can be predicted and managed by trained staff who are able to maintain a level of conduct that does not pose a risk to myself or others. I nearly always comply with care.' The risk was recorded as high and it was reported that the person was, 'vocal and has recently grabbed another resident arm and hitting staff member.' We spoke with the manager and regional manager about this who acknowledged our concerns.

We walked around the premises with the maintenance staff member who confirmed with us that seven water fire extinguishers had not been serviced annually. The labels on the fire extinguishers documented that the last service date was May 2016 or June 2016. The fire log book documented that the maintenance person had contacted the contractors on a monthly basis from January 2018 to advise them that the extinguishers had not been serviced appropriately. A document titled 'HM Government Fire Safety Fire Risk Assessment Residential Care Premises' states, 'Maintenance by a competent person should be carried out annually.' We shared this information with the fire service. Following the inspection we received confirmation that the extinguishers had been serviced.

These concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment.

Equipment checks, such as electrical items and hoists, were up to date. The home was clean with no malodours. Domestic staff had a visible presence on both floors and were observed to be cleaning communal areas and people's bedrooms in a thorough manner.

The kitchen was organised and clean and had been awarded a Level 5 Certificate in Food Hygiene. Items of food were dated when they were placed into the fridge however, the 'use by' date was not recorded. We spoke with the chef about this who said, "Staff know when items needed to be used by." This was shared with the manager during the inspection.

Most people told us they felt safe living at West Farm Care Centre. One person said, "I'm looked after well, it's done me good, my daughter doesn't have to worry as I'm safe." A relative confirmed they also felt their family member was safe and well looked after.

Staff had received training in safeguarding and were able tell us about signs they would look for which may indicate a person may have experienced abuse. For example, one staff member said, "People may be withdrawn or change character or there's the more obvious like bruising."

We saw there were sufficient staff to spend time with people and to appropriately meet their needs. Staff responded to call bells in a timely manner and we did not see people having to wait for support.

A dependency tool was used to calculate how many staff hours were needed and staffing levels were in excess of those indicated. The manager said, "If I think we need more staff I can go ahead and use them, there's no concerns with staffing." One staff member said, "There's always three carers upstairs. We need the three carers now as people's needs are developing." Another staff member said, "There's enough staff. Quite a few people need to use the hoist and there's never less than four staff."

Robust recruitment procedures were in place. Appropriate pre-employment checks, including an

application form, interview and reference checks had been completed. An enhanced disclosure and barring service check (DBS) had been completed before people commenced in post. A DBS check is used to help providers ensure only suitable staff are recruited to support vulnerable adults.

During the inspection we saw medications were safely administered and signed for after people had accepted them. People received their medication from staff who were appropriately trained for the task. Training for the administration of medicines and staff competencies related to this were all up to date.

Times were not always recorded for time-specific medicines. Care plans had not been updated with the details of any food and drinks that people had to avoid while taking some medicines. Also, this information had not been recorded on a dietary requirements board for kitchen staff. This information is important as some food and drink affect the performance of certain medicines. This was highlighted to the manager during the inspection and action was taken to address this straight away.

One person at the home self-administered their medicines. There was a clear protocol in place for staff to follow if they noted any missed doses of medicine and a system was in place for ensuring medication was stored safely in the person's room.

Some people were prescribed medications on an 'as required' basis. We found that some staff recorded on the back of the medication administration recording (MAR) sheet the times that these medicines were given but others did not. It was raised with the manager during our inspection that a clear protocol was required for all staff to follow.

Prescribed creams and ointments were recorded as administered on topical medicines application records (TMARS) and body maps to highlight where staff should apply the creams and ointments were in place. This meant staff had access to information about how and where to apply prescribed creams in line with the instructions on people's prescriptions. TMARS we viewed were up to date and had been completed accurately.

Requires Improvement

Is the service effective?

Our findings

Needs assessments were completed before people moved into West Farm Care Centre. However, the information was not detailed or specific to the person. Their needs and preferences were not always included in the assessment and some information was contradictory. Where specific needs had been identified these were not always included in care plans and risk assessments, for example in relation to one person's dietary requirements.
These concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment

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 authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Records indicated that one person had an authorised DoLS in place. However, when we asked to see the letter of authorisation we were told that it had expired in 2017 and had not been applied for again as it wasn't needed. There was conflicting information in the records as to the person's capacity. One document stated they had capacity and had given consent, another said they lacked capacity and had a DoLS authorisation in place. No one was able to confirm who had made this decision and there was no mental capacity assessment in place. Since the inspection it was confirmed to us that a DoLS application had been made in January 2018 but there was no supporting paperwork available.

We discussed capacity with the manager. They were unable to provide documentation that applications had been made to deprive people of their liberty if they lacked capacity. They were unable to provide evidence that assessments of capacity had been made where it was thought people lacked the capacity to make particular decisions.

Care records in relation to consent were confusing and contained pre-populated phrasing due to the care records being held electronically. For example, for one person who had capacity it stated their advocate had given consent for information to be shared with specific agencies and for photographs to be taken for medical and care reasons. It also stated that the person had, 'Expressed a wish that my Confidential Personal Information (CPI) should not be accessed by any relevant regulatory body.' We discussed this with the manager who queried why an advocate was providing consent as the person had capacity. We also raised a concern that their care records had been shared with us when they had expressed a wish that this

did not happen. The operations manager and the manager both stated that they thought this was pre-populated text which staff had not understood.

It was documented that one person had a lasting power of attorney. A lasting power of attorney (LPA) is a legal document that lets you appoint someone to help you make decisions or to make decisions on your behalf. This gives you more control over what happens to you if you have an accident or an illness and can't make your own decisions because you lack the capacity to do so. Documentary evidence of LPA was not available at the time of the inspection. We raised this with the manager as without this information we could not be sure the provider was acting in accordance with the LPA. Since the inspection it has been confirmed that this person did not have a LPA. The regional manager confirmed the error was as a result of pre-populated information from the electronic care planning system not being removed.

Another person had a Do Not Attempt Cardio Pulmonary Resuscitation order (DNACPR) which did not detail that the person had been involved in the decision making. The manager was able to confirm that the person had capacity but as the form did not indicate they had been involved we could not be sure this reflected the person's wishes. Since the inspection we have received confirmation that the manager raised this with the GP who has since visited the person and updated the DNACPR with their involvement.

These concerns were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Need for Consent.

Staff had some understanding of people's rights in relation to capacity. For example, one staff member said, "It's what people can do for themselves." Another said, "It's about keeping people independent and supporting them to make their own decisions and the choices that suit them."

Staff spoke with us about their training. One staff member said, "I've done the care certificate, moving and handling, oral hygiene, safeguarding and mental capacity assessment. I've also done renewal training." The care certificate is an agreed set of standards that sets out the knowledge, skills and behaviours expected of staff working within health and social care. Another staff member said, "I've done moving and handling recently and safeguarding with North Tyneside Council which included a little bit on mental capacity."

The nominated individual explained that the induction process included the care certificate. They said, "It's great but there's always extra and we keep the person-centred training as face to face, it includes dementia and dignity training." A training matrix was in place which detailed the training staff had attended. Where it had been identified that training was out of date individual training action plans had been put in place which detailed the timeframes staff had to complete the training.

Staff said they felt well supported and had regular supervision meetings where they could raise any concerns or seek support. One staff member said, "The management are absolutely fabulous, brilliant, they are easy to approach, any cause for concerns is taken up immediately, they are so caring about staff and the residents." Another staff member said, "The management are lovely, supportive and always happy to hear any concerns. I feel listened to, nothing goes unnoticed, they have their eyes and ears open, they are responsive and have made changes."

A supervision log was in place which detailed that staff had attended one supervision meeting in 2018 and were scheduled to attend a second. New starters were completing the care certificate and so had regular meetings with the manager or unit manager/acting deputy. Although staff told us they felt supported and the manager was providing regular supervisions and appraisals, the manager confirmed that they were unable to locate any records of appraisals or supervisions in 2017, therefore the historical information was

unavailable.

The staff and management told us one of the strengths of West Farm Care Centre was the way staff worked together. One person said, "The staff work well together." We saw external health care professionals were involved and people received ongoing support to ensure their health needs were met. A visiting professional spoke of a positive working relationship and that staff were always helpful. They said, "Staff are always courteous and helpful and work well together as a team."
However, the guidance and advice offered by health professionals was not always documented within the electronic care records and were stored in separate 'personal files.' This meant staff did not have access to the detailed guidance so we could not be sure people were receiving the appropriate care.

People were very complimentary of the food. Meals were prepared using fresh ingredients and staff worked together to make sure people's meals were well presented. One person said, "The food is good." Another person said they seemed to get a variety of food and although they had never had to ask for anything different, they were sure if they did "that it would be okay". Staff asked people if they had had enough to eat and drink at meal times. Staff could explain who had any specific dietary requirements and they ensured people's needs were met. People were supported to choose which meal they wanted as they were shown plated options to choose from.

The dining experience was planned to meet people's needs and the environment where meals were served was arranged nicely. People told us that the food they received was tasty. Snacks and drinks were offered to people throughout the day taking account of people's likes and dislikes.

Some environmental adaptations had been made to support people living with a dementia. For example, some communal toilets had contrasting grab rails and toilet seats and some doors were of a contrasting colour to the walls. This approach was not consistent across the upstairs Shore Unit though. One staff member said, "It's a simple layout and easy to navigate, we are moving to two lounge dining areas so people have a choice of a quieter space or a more lively space. We are just waiting for the plans to be finalised." The management team spoke with us about the design and decoration of the premises. The manager explained there was to be a refurbishment in June 2018. This would allow for the changes to the lounge and dining areas as well as further development of the environment. People had been involved in choosing the colours and textures of materials that would be used for the refurbishment.

The management team had considered what impact the refurbishment work would have on people and they explained plans were in place to minimise disruption. The unit manager/acting deputy said, "People could spend the day at a sister home or we would be out on day trips." The nominated individual [owner] said, "We are updating the environment to bring in a more dementia friendly environment. We have mood boards and people have been included."

Good

Is the service caring?

Our findings

People were positive about the care they received. One person said, "I would like to say that I loved all of the staff. They (staff) are really, really good." Another person said, "The girls all know us and are pretty good with us." Other comments from people included, "It's lovely, we love each other" and "They look after us well and take an interest in everyone." Another person told us, "Understanding is one of the most important things, it's critical in life."

Visitors we spoke with said the care their relative received was good. One visitor said, "I think it's great, [person's name] looks really well and she is eating and sleeping well. I think [person's name] is doing marvellous since moving here'.

The atmosphere was very welcoming and homely. Seating arrangements were such that it encouraged social interaction which supported people to make and maintain friendships. People clearly had their own social groups who they chose to spend time with. There was lots of chatter and laughter observed, especially in the downstairs lounge area.

We observed staff supported people in a caring and compassionate manner, making sure people were comfortable and had everything they needed. During lunch time staff took the time to settle people before offering them a choice of drinks and meals. Staff were courteous and kind whilst supporting people with their meal, chatting with them in a relaxed way during lunch. Another person had asked staff if they would bring their lunch to their room as they were watching a television programme and didn't want to miss it. Staff arranged for this to happen.

The dining room was a calm and bright environment with lots of room to move around. The tables were set with differing colours of tablecloths, cutlery, serviettes and condiments. Food was well presented and portions were adequate. One member of staff asked a person if they had enjoyed their lunch and the person said, "Lovely, but there was a bit too much."

The outside area of the home had a small patio area which had chairs and parasols. People commented they had been sitting outside when it had been sunny and they had enjoyed this.

People we spoke with took pride in their appearance and staff were encouraging of this. One person said, "The laundry are marvellous, everything is clean and well pressed, it's even put away in my drawers." People were well presented and had taken care of their appearance, wearing coordinated clothing and having regular appointments with the visiting hairdresser. One relative we spoke with said, "Staff are really helpful and the home is always nicely kept. Clothes are always clean and washed".

Staff explained how they promoted independence and engaged with people about their choice of clothing either by asking or showing people. One staff member said they would often support people to choose what they would like to wear the next day. This meant the person could, if they wished, get up and get dressed by themselves the next day.

If people were a little disoriented or upset staff approached them with kindness and respect, taking the time to have a chat, offer reassurance and support them to where they wanted to be. Staff spoke with us about ensuring people were treated with dignity and respect. One staff member explained how important it was to ask people's permission before supporting them with anything. They described how they maintained people's dignity and privacy by asking before supporting with personal care and ensuring people were appropriately covered to minimise the risk of the person feeling exposed and vulnerable. A dignity champion was in place and a dignity file was used in the home.

Relatives' meetings were held and one relative had shared that their family member enjoyed reading. This was responded to and the person now had access to books and magazines which they enjoyed.

Staff were aware of the need to support family members as well as the person living with a dementia. One staff member said, "Sometimes it needs to be explained to people about dementia care. If family members want to be involved that's great, but if they don't want to that's fine too."

The manager informed us that one person living in the service was being supported to continue to live their lives as they had done before moving into West Farm Care Centre. During a trip out in the community one person had met a family member who they had not seen or many years. With both people's permission staff now supported them to keep in regular contact with each other.

Lots of thank you cards had been received in recognition of the care staff had provided. Comments included, 'Very big thank you for all the care,' 'Thank you so much for your care kindness and understanding,' and '[Person] felt safe and well care for and enjoyed all the laughs.'

Requires Improvement

Is the service responsive?

Our findings

The provider used an electronic system for care planning, which included risk assessments and social profiles. One staff member said, "We are getting used to it and finding our way around. We do check the care plans but we have a file that's updated monthly with any changes." Another said, "It's easy to navigate, all the information needed is there and can be found quite quickly." They added, "I've had training on the system but no training on how to write a care plan."

The process for care planning was that all the information was inputted onto the electronic system and then care plans were generated using this information. The system included some standard pre-populated text which was not specific to the person and therefore was not person centred. For example, in relation to nutrition and hydration needs the action plans for people stated, 'Ensure I am positioned appropriately for eating/drinking' and 'Consider additional factors which may affect nutritional intake e.g. swallowing oral health problems, dentures etc.'

We spoke with the manager about this and they confirmed that people did not need to be positioned correctly nor did they have any additional factors which needed to be considered in relation to nutritional needs. They said, "It's the pre-populated information, it can be taken out if it's not needed."

Other areas of care records also included pre-generated text which had not been removed or amended to ensure the information was specific to the person. We also found that information recorded in one part of the care record often contradicted what was written in another part. For example, one person's waterlow score, which assesses the risk of the development of pressure sores, was low however their overall health care plan stated they used a foam cushion to relieve pressure. Further examples included that one person attended to all their own personal care needs, however it also stated they required the assistance of one care worker. There was no information as to what that support entailed.

Care plans provided limited information on how to meet people's needs. For example, one person's plan in relation to pressure care and skin integrity stated they were at medium risk. The action plan included that this 'indicates that one or more of the following should be considered: inspect skin including heels and document daily or weekly as required. Review mattress and seating surfaces – replace with pressure reducing alternatives as appropriate'. It also stated, 'I have areas of broken skin which require further examination and a therapeutic treatment regime.' There was no further information in relation to the monitoring of the person's skin integrity, whether any specialised equipment was needed or had been provided, or who was involved in treating the areas of broken skin. This meant staff did not have the relevant level of detail to ensure the person's needs were being met. This placed them at risk of poor care and treatment.

Standard phrasing was used to describe people's mobility. The following was documented in two people's care plans, 'I have good physical ability and am able to walk very long distances with a steady and certain motion. I can easily walk over uneven ground with plenty of ground clearance.' Another stated, 'I have some limitations with physical ability, I am able to walk very long distances with a steady and certain motion. I can

easily walk over uneven ground with plenty of ground clearance.' It went on to state that this person was at moderate risk of falls, could become anxious when moving due to low confidence, they had difficulty with balance and stability, used a walking frame, occasionally used a wheelchair and needed support from care staff from walking and had a significant visual impairment. This meant the mobility statement was incorrect and misleading as it did not reflect the actual needs of the person.

Some care plans had not been updated to reflect people's current needs. For example, one person's nutrition plan stated they needed a soft diet, to avoid certain textures of foods and to have fluids thickened. An evaluation stated they had been prescribed a food supplement 'for some time,' and continued to need a soft diet but no longer needed thickened drinks. This meant care staff needed to read the evaluations to access the full information on the person's current needs. We spoke the manager about this and they updated the care plan during the inspection.

Emergency admission packs were in place for if people had an unexpected admission to hospital. One person's stated that they were widowed however their 'Life Story' documented their husband as being the person who knows them best. Care records also indicated people had some significant health conditions or specific dietary requirements but these were not detailed on the emergency admission pack.

We spoke with the manager about people's needs and how staff were kept up to date with people's changing needs. They spoke with us about someone who they felt was declining, they described the person's behaviour and mentioned that it was a possibility they had an infection so a dip test had been completed over the weekend. They also said a referral had been made to the behaviour team. We found no documentary evidence in the person's care records to support a decline in their wellbeing or a test for an infection. Nor did we see evidence of a referral to the behaviour team.

We spoke with the manager about our concerns and they said, "I can't say they're alright as they obviously aren't. The staff are good at what they do but it's not represented in the care plans." The manager and the regional manager explained that there was training planned for staff in the use of the electronic system. However, we identified that the system had been in use for over 12 months and would therefore have expected staff to have been trained previously.

These concerns were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 – Safe care and treatment

At the time of inspection there was no one living at the service who required end of life care. The electronic care record system included sections on last wishes and advanced care planning. People's last wishes were recorded as, 'I am willing to review my last wishes again in the future' or 'I am unsure if I wish to review my last wishes again in the future.' It was unclear from the information whether people had shared any last wishes or whether they did not want to discuss it at that specific time, but may want to do so in the future.

The provider's policy on end of life care focused on the need to ensure people who were diagnosed with a terminal illness or who were in the end stages of that illness needed 'total care, including emotional care and frequent attention.' It documented that this would be achieved by drawing up an end of life care plan with the help of the medical team involved. It also referenced that people's wishes in respect of their religious or cultural practices should be respected. It stated that, 'in most cases the home is aware of these as they will have been recorded previously in their service user plan of care or as an advanced directive.'

People and their visitors told us they had no complaints. One person said, "I've no complaints at all." Complaints received had been investigated and outcomes were noted however it wasn't always

documented that the outcome of the complaint had been shared with the complainant. The complaints policy had clear guidelines on expectations with regards to communication with complainants and that the outcome should be shared with them.

The activity coordinator's post was currently vacant but had been advertised. In the meantime, the care staff were taking the lead with activities.

We observed staff actively engage people in activities and we noted a variety of activities were on offer to people. Staff showed warmth, compassion and kindness to people at times and if they became upset. During the inspection we watched staff engage people in a quiz. One person said, "They (staff) are very good here and are very kind. I've always done things and I still do". A relative told us, "There is always something going on if people want to join in". Some people told us they did not get involved in activities preferring to stay on their own and did not like the activities on offer.

One staff member said, "We have fiddle mats which are made by a family member of an ex-resident. We also have memory boxes related to flowers and gardening, they are all themed and include prompts and pictures, sensory items. They are really good and provide a talking point for people." On the second day of inspection people were engaged in a game of bingo which they appeared to enjoy. It was observed that the activities board on the first floor had an entire week's activities listed and one of the days was incorrect. This could be confusing for people so the unit manager amended the board so that only the current day's activity was shown. Following the inspection it was explained that there is normally only one day's activity written on the activities board.

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager in post at West Farm Care Centre. The provider notified us in November 2017 of a change to the registered manager. The registered manager who left their post had not made an application to the Commission to cancel their registration. The current manager has been in post since December 2017 and had not made an application to register with the Commission.

Various audits were completed such as health and safety, infection control, medicines and care plans. We found that whilst some were effective at identifying areas for improvement there was not always detail of who was responsible to make the improvements or when they should be completed by. In addition, it was not clear that where actions had identified as being needed, that they had been completed. For example, individual training plans identified specific training that certain staff needed to complete within two weeks. The action plan was not dated so it was not known whether these improvements had been made within the required timeframe.

Audits of care records had been completed. We spoke with the manager about the audit process and they said, "They are done by the deputy." They added, "Audits were done by [previous deputy] who didn't pass the audits to staff." This meant if any areas had been identified as needing to be updated the improvements had not been made as the audits were filed and not seen by anyone else. More recent audits had been shared with staff to make any necessary improvements but they had not identified the concerns noted during the inspection in relation to the quality, completeness and accuracy of recording.

Audits of 25% of medicine records were completed on a weekly basis. This was more of a stock check of medicines than an audit. No one had signed the audits so there was no accountability, and entries had been crossed out and written over so they were difficult to read. When we looked at the audits we found that care staff on the Shore Unit completed them one way and the ground floor staff completed them another way. We spoke with the manager about them who said, "I don't understand them either." A more in-depth medicine audit had been completed on 27 February 2018 which had identified areas for improvement but there was no detail on the action plan of the action to be taken or when it was to be completed by.

Additional concerns noted during the inspection included a failure to monitor DoLS applications and ensure paper work was stored securely so it was accessible when needed. There was also a failure to ensure accurate, compete and contemporaneous records were kept in respect of people's care needs.

Care records were completed electronically, however some confidential personal information was stored in small offices on each floor. We found both these offices were unlocked and accessible during the inspection. In addition to personal information, there was also access to staff personal belonging and electrical panel boxes. The electrical panels were locked but the keys were in the key hole. Another store cupboard, which was not directly accessible by people, was also unlocked and contained laundry detergent and cleaning products. This was brought to the attention of the manager who took immediate action to rectify the situation.

We spoke with staff about contingency plans for the electronic care records. One staff member said, "If there's a power cut we can't access any information, it went off at the weekend and we had no access." The regional manager said, "Staff had rung the manager and been advised to hand write information regarding people." They also confirmed the power cut had been rectified almost immediately by the electricity company.

The manager said, "I know it's all stuff that needs to be done, I've been in post 16 weeks and I've done [performance investigations and disciplinaries], manual handling train the trainer and QUIPs." QUIPs are the local authority commissioning team's quality assurance visit. They acknowledged the feedback shared and said, "Me and [unit manager] need to put care plans on [electronic system] until we are confident the staff are confident to do them." They also said, "I've learnt a lot about processes, systems need to have an end. We've started work off with good intentions but have got distracted."

These concerns were a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Good Governance

The manager had informed CQC of some significant events, changes or incidents which had occurred at the home in line with their legal responsibilities by submitting the required notifications. However, we found that in some instances of abuse or allegations of abuse these had not been submitted.

These concerns were a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (Part 4) Notification of other incidents.

Following the inspection, the manager produced an action plan which they shared with the Commission. This identified that some current processes needed to be improved. For example, it detailed that care plans were not personalised and contained inconsistent and contradictory information. The action to be taken was to inform staff of training, and provide one to one training on the competion of daily notes and personalised reporting. It also specified that audit processes were not robust enough to identify issues and that falls and accident monitoring not being adequate.

Night time visits had been completed by the manager who documented whether routine checks had been completed by staff, ensured people were comfortable and cared for appropriately and observed how busy staff were. The manager said, "Night staff find management more approachable now, the relationship has changed." They explained they were always in at 7am so they could see night staff and offer any support.

Feedback from quality surveys were on display and they detailed the key findings from the 2017 surveys. Comments included that communication could be improved but people and relatives were happy with the commitment shown from the management team, care and support was very good, but nails could be cleaned more. All other comments were positive and included, 'From day one the staff has included us in our [family member's] care. They were supportive of us emotionally and still are. They can offer us practical advice when needed and always respond to requests. They help [family member] stay in touch with family enabling her to use the phone,' and 'Staff regularly check with us that we are happy with the care and offer opportunities for us to make comments.'

The manager said, "My responsibilities are to keep people safe, make sure we're fully staffed, compliant, meeting the regulations and guidelines and to provide management leadership." They added, "It's about duty of candour, transparency, safeguarding any incidents and accidents and notifying you of serious injuries, deaths, abuse."

The manager spoke with us about how they kept their knowledge up to date. They said, "I go to the providers' meetings. I use the internet, training, I joined an email group for mental health awareness, dementia friends. I network with other home managers."

The manager told us they felt well supported. They said, "[Operations manager] is absolutely fabulous, I have supervisions monthly and if I need anything I can just pick the phone up. [Owner] visits about once a month and spends time with the staff and looking around, they always ask if I need anything."

The operations manager said, "We have planned training for [electronic care planning system] and staff meetings to discuss it. We are very open and want improvements, we are more than willing to take things on board as we want to be the best. We have an exceptional staff team."

The owner offered gifts to staff for going 'above and beyond.,' The regional manager said they were, "To personally thank the staff for their constant hard work, dedication and good care deliverance that they provide for our residents on a daily basis." For example everyone received a chocolate trophy for going the extra mile when there was a recent bout of sickness at the home and for making sure they attended work during a spell of bad weather in the winter. The operations manager said, "Our saying is, a good happy staff team results in excellent care; it's reflected in residents and their families. They have faith that things will be dealt with."

The operations manager said, "We are about to send the annual quality assurance questionnaire out for feedback, we also have relative's meetings."

Staff could not think of any improvements that were needed. One staff member said, "There are no improvements needed, any changes have been made." They added, "Moral support for the staff has increased since [manager] has been here. We were worried about changes but she has lifted that and increased the moral support." One person said, "[Manager] has made it more lively. It has a brighter outlook." Another staff member said, "It's the best place I've worked in, people are entertained and settled, it's the best I've been in."

West Farm Care Centre recently won a bronze 'Better Health at Work' award. The award recognises the efforts of employers in promoting healthy lifestyles and considering the health of their employees.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of service users was not always provided with the consent of the relevant person. Regulation 11(1)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a consistently safe way. There was a failure to assess and mitigate risks to the health and safety of service users of receiving care. Regulation 12(1); 12(2)(a); 12(2)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Service users were not protected from abuse and improper treatment. Systems and processes had not been established and operated effectively to prevent abuse. Systems and processes had not been operated effectively to investigate, immediately upon

becoming aware of, any allegation or evidence of abuse.

There was a failure to act in accordance with the Mental Capacity Act 2005 Deprivation of Liberty Safeguards: Code of Practice and the Mental Capacity Act 2005 Code of Practice.

Regulation 13(1); 13(2); 13(3); 13(5)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes had not been established and operated effectively to ensure compliance. There was a failure to assess, monitor and improve the quality and safety of the services provided. There was a failure to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. There was a failure to maintain securely an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user and of decisions taken in relation to the care and treatment provided. Regulation 17(1); 17(2)(a); 17(2)(b); 17(2)(c)