Bupa Care Homes (ANS) Limited

Freelands Croft Nursing Home

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

Freelands Croft Nursing Home provides accommodation and personal and nursing care for up to 64 older people who are frail or are living with dementia. Accommodation is provided over two floors. At the time of our inspection 56 people were using the service.

We received concerns about people's safety and undertook an unannounced inspection on 9, 10, 12 and 16 June 2015 to look into these concerns.

During the inspection, we identified a number of serious concerns about the care, safety and welfare of people who received care from the provider. We found five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have taken enforcement action in relation to the regulatory breaches identified. We imposed a condition on the provider's registration in respect of the regulated activity, Accommodation for persons who require nursing or

Summary of findings

personal care, they carry on at Freelands Croft Nursing Home. The provider must not admit any new service users to Freelands Croft Nursing Home for the purposes of this regulated activity without the prior written consent of the Care Quality Commission.

The overall rating for this service is 'Inadequate' and the service is therefore in 'Special measures'.

The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

A registered manager was not in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered person'. 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. The management of the service had changed in the past month following concerns identified by the provider about the quality of the service provided at Freeland's Croft Nursing Home. A new deputy manager, acting home manager and area manager had been appointed to address these concerns. The provider had started recruiting for a new registered manager. We had not received a notification to cancel the previous manager's CQC registration and therefore their name still appears on the CQC website as registered manager for the service.

The provider had not effectively implemented their quality and risk systems and routine monitoring processes had not been completed in the past six months. The previous area manager had raised concerns about the management of the service and undertook a Home Review Audit of the service on 10 March 2015. Widespread shortfalls, similar to the ones we found at this inspection, were identified and a basic action plan was developed to address these concerns. Some action had been taken but the provider's monitoring system had failed to ensure action was taken in line with their action plan. Significant improvements had not been made and people remained at risk of receiving inappropriate or unsafe care

Action had not been taken by the provider to ensure the information in people's care records were accurate and could effectively be used to evaluate and identify the correct treatment and care required for people. Nurses could not be assured from the records that people had received their medicines as required. The provider had not taken action to improve the quality of record keeping which they had identified as a significant concern during the internal audit on 10 March 2015. People remained at risk of receiving inappropriate or unsafe care through the provider's failure to maintain accurate, complete and contemporaneous records in respect of their care and treatment.

People's individual risks were not managed safely. Risks had not been fully assessed and staff had not received sufficient guidance on how to support people to minimise risks where possible. Skin pressure relieving equipment including air mattresses, were not monitored to ensure they were used in a safe appropriate manner.

The provider did not ensure that there was enough suitably competent and experienced staff to meet people's needs safely. The provider had ensured that agency nursing staff had been engaged to support the staffing levels in the home. However, there were insufficient numbers of nursing staff who understood people's individual needs and the support they needed to stay safe. The provider had not identified the impact that temporary staff, who did not know people, would have on the deployment of regular staffing levels. The skills and knowledge mix of the staff had not been reviewed continuously and adapted, to keep people safe.

Staff did not receive regular support and supervision to enable them to identify solutions to problems, improve care practices and to increase understanding of work based issues. Agency nurses had not been inducted effectively to ensure they had the necessary knowledge of the provider's policies, care practices and people's needs to care for people in the home appropriately.

People's health needs were not always understood. People who lived with diabetes were not consistently supported in line with nationally recognised guidelines to

Summary of findings

adequately manage their blood glucose levels so as to protect them against diabetes-related complications. Making appropriate treatment decisions for people were complicated by care plans not providing health professionals with up to date and accurate information about people's treatment histories and how people's health had deteriorated or improved over time.

There were shortfalls in the support people received to meet their nutritional and hydration needs. People were at risk of aspiration and/or choking as clear support guidelines, based on Speech and Language Therapy (SALT) recommendations, were not available to staff when supporting people with swallowing difficulties. Where records indicated potential shortfalls in people's fluid intake, nurses failed to investigate and take appropriate action to ensure people had enough to drink.

Staff understood their responsibility to follow the Mental Capacity Act 2005 (MCA) code of practice to protect people's human rights. Two people were subject to Deprivation of Liberty Safeguards (DoLS) and the DoLS team was processing a further 12 applications for people living at Freeland's Croft Nursing Home. The service was reviewing everyone using the service to assess whether further DoLS applications were required. Best interest decisions were being made to agree restrictions in people's care plans, with input from family who knew people, enabling staff to keep people safe whilst awaiting the outcome of the DoLS applications.

Staff demonstrated kindness and compassion but some did not understand and support people living with dementia appropriately. A lack of a clear consistent approach and understanding on current good practice, at times, resulted in staff acting in an uncaring way. They did not pick up on people's attempts to make contact or take part in activities resulting in opportunities to engage with people living with dementia being missed.

Staff did not always have the information they needed to meet people's needs and preferences. Needs assessments had not always been used to plan people's care in a timely manner following their admission to the service. People's care plans were not always reviewed monthly in line with the provider's policy to ensure people's changing needs were identified and their care adjusted accordingly.

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

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.

People at risk of falls did not always receive the care they required to stay safe. People at risk of developing pressure ulcers were provided with appropriate equipment. However, air mattresses were not routinely monitored to check if they were being used in a safe appropriate manner.

Nurses could not be assured from the records that people had received their medicines as prescribed.

There were insufficient numbers of nursing staff who understood people's individual needs and the support they needed to stay safe.

Is the service effective?

Inadequate

The service was not effective.

Staff did not receive regular support and supervision to enable them to improve care practices. Agency nurses had not been inducted effectively and they did not have the necessary knowledge of the provider's policies, care practices and people's needs, in order to care for people appropriately.

There were shortfalls in the support people received to meet their nutritional and hydration needs. People who lived with diabetes were not consistently supported in line with nationally recognised guidelines. Their condition was not managed effectively to minimise the health complications related to variable blood glucose levels.

Staff understood people's right to make choices about their care and the requirements of the Mental Capacity Act 2005.

Is the service caring?

Requires improvement

The service was not always caring.

Staff demonstrated kindness and compassion but some did not understand and support people living with dementia. Staff lacked a clear consistent approach and understanding on current good practice when supporting people living with dementia. At times this resulted in staff acting in an uncaring way and opportunities to engage with people living with dementia were being missed.

People's privacy was respected.

Is the service responsive?

Requires improvement

The service was not always responsive.

Summary of findings

Staff did not always have the information they needed to meet people's needs and preferences. Needs assessments had not always been used to plan people's care in a timely manner following their admission to the service or as their needs changed.

There were systems in place to investigate and suitably respond to complaints.

Is the service well-led?

Inadequate

The service was not well-led.

When asked to describe the culture of the service both staff and relatives told us the service had been struggling to maintain consistency of staff which had made it difficult to develop a service based on consistent good practice.

The provider had systems for assessing and monitoring the quality of the service. A comprehensive audit of the service was completed in March 2015 following concerns and a wide number of areas needing improvement were identified. Insufficient action was taken to address the issues raised and improve the service people received.

Staff told us because communication was not always clear they did not always understand their roles and responsibilities on each shift.

People's care records were not always accurate and comprehensive making it difficult for nurses and visiting professionals to make appropriate treatment decisions.

Freelands Croft Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory function. This inspection was planned to check 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.

This inspection took place on 9, 10, 12 and 16 June 2015 and was unannounced. Two CQC inspectors undertook the inspection.

Prior to our visit we reviewed the information we held on Freelands Croft Nursing Home. This included previous inspection reports, any concerns raised about the service, safeguarding meeting minutes and notifications. Notifications are information about important events which the service is required to send us by law which gave us information about how incidents and accidents were managed.

We did not request a Provider Information Return (PIR) at the time of our visit as the provider would not have had time to complete one. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We obtained this information during the inspection.

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.

We spoke with six people who used the service and four people's relatives. We spoke with the acting home manager, the area manager, deputy manager and a visiting Admiral Dementia Nurse. We also spoke with the quality manager, cook, area trainer, a relief home manager covering the service for four days, five nurses, three team leaders, activity co-ordinator and seven care workers.

We also spoke with the specialist community nurse for nursing homes, the Advanced Clinical Nurse Specialist for Tissue Viability and the Continuing Health Care Lead Nurse to gather their views of the care people received.

We reviewed 10 people's care records and documentation in relation to the management of the service. This included staff training and recruitment records, quality auditing processes and policies and procedures.

The service was last inspected in November 2014 and was given a GOOD overall rating.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living in Freelands Croft Nursing Home. One person said "I feel safe here, there is always someone to help me". However, relatives told us they were concerned about the high turnover of nursing staff and felt nurses did not always know what support people required to stay safe.

People were not consistently protected through the effective assessment, identification and management of risks to their health and safety. People identified as at risk of falls did not always have robust plans in place to ensure staff would know how to support people to mobilise safely in the home. For example, one person had been assessed at medium risk of falls and had previously fallen. However, they had no care plan in place to provide staff with guidance on measures to take to reduce their risk of falling. Another person had fallen on a regular basis since January 2015 and was admitted to hospital following a fall on 26 May 2015. A referral had not been made to the specialist falls prevention team for assessment and advice to ensure all had been done to manage this person's risk of and resulting harm from falls.

People were at times exposed to risk of harm when they fell. The acting manager told us it was the provider's policy when un-witnessed falls occurred or people hit their heads, that they be checked at regular intervals after a fall. Though incident forms had been completed for two people who had fallen in June 2015 they had not been monitored at regular intervals over the 24-48 hours following their fall in line with the provider's good practice guidance. People had not received post-fall monitoring and were at risk of delayed signs or symptoms of injury, such as a fracture not being identified and responded to promptly.

A system was not available to support staff to enable them to promptly identify when equipment was not being used properly so that they could make the necessary adjustments required to keep people safe. People at risk of developing pressure ulcers were provided with appropriate equipment including pressure relieving air mattresses to ensure the pressure on their skin would be reduced. The mattresses worked by redistributing the person's body weight so as to protect them from developing pressure ulcers when they were in bed. To provide sufficient protection the mattress setting needed to be calculated according to each person's weight and maintained at the appropriate setting for as long as the person required its use. The use of people's air mattresses were not routinely monitored to ensure the equipment was functioning correctly and was set at the correct setting to protect people's skin. Staff did not know what the mattress monitoring arrangements were. The acting manager told us she would expect an air mattress monitoring system to be in place but was not sure if a system was in place at Freelands Croft Nursing Home. We found a person's mattress setting had been altered by another person using the service without staff's knowledge. This person was at increased risk of developing pressure sores as their preventative equipment had not been used in a safe manner.

People did not always receive the appropriate care and support they required to keep them safe. People were not always protected from the risk and harm from falls and equipment was not routinely checked to ensure it was used safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

The provider had developed a tool for determining how many staff were required for each shift. This was primarily based on the number of people living at the home and not on people's individual needs or dependency. The area manager told us the provider had recently asked services to complete a dependency tool to calculate the staffing numbers and roles required per shift, based on people's individual needs. There was no evidence that this new staffing tool had been used at Freelands Croft Nursing Home. The area manager told us they would be completing and implementing the dependency staffing tool by end of July 2015.

The area manager told us that the service was short of permanent staff due to care and nursing staff who had recently resigned. The provider was managing this risk by continuing to recruit new staff and was using more agency nursing staff. The area manager told us they tried to keep agency nurses consistent however, agency nurses we spoke with had only worked between one and three shifts each. Agency nurses told us that they did not know people and relied on the other staff on their shift to assist them in best supporting people's needs.

Staff told us there were enough staff to meet people's needs however, only in the event that they were experienced, knew people well and the shift was well co-ordinated so that each staff member knew what was to

be expected from them. They told us this was not the case at the time of the inspection as team leaders and care workers had to spend significant time supporting new agency nurses who did not know people. For example, care workers were supporting agency nurses to identify people when administering medicines so that the right medicine was going to the right person at the right time. We observed team leaders supporting agency nurses throughout the day explaining procedures to them and checking they were following these for example, in relation to insulin administration recording, appropriately. Care staff had to interrupt their care duties to assist agency nurses to understand people's behaviour and what their actions may mean. People who were asking after their visitors or about meal times were left waiting, interrupted and at times not responded to.

One relative told us they felt staffing was very inconsistent particularly with the agency nursing staff and who often did not know who people were. Another relative told us they had concerns that agency staff did not know their loved ones support needs during meal times. They told us they had to rely on care staff who knew the person to inform agency nurses of any changes in their condition.

The management of Freelands Croft Nursing Home did not routinely take into account the needs and dependency of the people living in the home or the skills and experience of available staff when planning and deploying the staffing for each shift. When agency staff, unfamiliar with people's need and preferences or the service's operating procedures were used the provider had not made, the necessary adjustments to ensure people's needs would still be met. We did not see how the provider had routinely made adjustments to staffing levels, the way shifts were organised or the allocation of daily duties to ensure people's care would not be impacted upon by staff that did not know them.

Our observations and discussions with staff and relatives indicated that lack of consistent staff was impacting on people receiving care in a timely and person centred manner. For example, people living with dementia who required reassurance or support when they became confused about the time of day were repeatedly asking nurses for support. Nurses spent time trying to find care workers that knew people to assist them. We observed people getting frustrated and more confused when staff missed the opportunity to respond in a meaningful way.

The provider had ensured that agency nursing staff had been engaged to support the staffing levels in the home. However, there was insufficient nursing staff deployed with the skills, experience and knowledge of people's needs and the support they needed to stay safe. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were safe procedures for the management of medicines however staff had not always followed these accurately and consistently in relation to recording. Medicines were stored safely in locked fridges, cupboards or trolleys. Keys to medicines cabinets were kept securely to minimise the risk of unauthorised access. It was not always clear from the fridge temperature record whether medicines had been stored within the required temperature range and what action had been taken when recorded temperatures exceeded the acceptable 8 degrees Celsius.

There were clear protocols for the administration of medicines, however staff did not always complete records in full to show when people had taken or refused their medicine. We found three people's medication administration records (MAR) were incomplete. We noted some blank spaces where we would expect to see initials for administration or a code for non-administration. Where written changes were made to people's MAR these were not always double signed as per best practice guidance. When people stopped taking prescribed medicines there was not always an explanation for this or signed by the nurse making the change recorded on the MAR. Nurses could not be assured from the records that people had received their medication as required.

The provider did not ensure that people's medication administration records were always accurately completed. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before some medicines could be administered there was a requirement for staff to test people's blood and we saw these tests had been carried out accurately, at the right time and by trained staff. Staff checked medicine stock levels and ensured these balanced, including for those medicines controlled by legislation, known as 'controlled drugs'. There was a complete record of decision making when people were given medicines covertly, for example hidden in food. Records showed that this was done only after a mental capacity assessment judged the person was

Inadequate

Is the service safe?

not able to make a decision about their medicines, and a best interest discussion with the GP and family members had taken place, as appropriate. Information was available to staff to ensure "When required medicines" were given in a timely and consistent way by the nurses.

The management of medicines had been audited by the provider on 16 June 2015. This audit had identified areas of concern and we received a copy of the service's medicines improvement plan with a deadline for completion of 21 July 2015.

The provider had systems to help protect people from the risk of abuse. All of the staff we spoke with knew about the different forms of abuse, how to recognise the signs of abuse and how to report any concerns. Staff said they had never witnessed anything of concern in the home. One

member of staff said "We know people really well and would recognise any changes in their behaviours that were out of character. If I had any suspicions I would speak with the manager and if necessary call the local authority safeguarding number". Training records showed all staff received annual refresher training in safeguarding to make sure they were up to date with the latest information. The training manager told us there were plans in place to ensure all staff had completed their annual refreshers by end of July 2015. Safeguarding and whistleblowing policies were also available for staff to refer to. The provider ensured agency staff received copies of these policies as part of their induction. Whistleblowing is a way in which staff can report misconduct or concerns they have within their workplace.

There were effective recruitment and selection processes to reduce the potential risks to people using the service. Recruitment was organised through the provider's central human resources department. Appropriate checks were undertaken to identify if applicants had any criminal convictions or had been barred from working with vulnerable adults. Staff were not allowed to start work until satisfactory checks and references were obtained.

Inadequate

Is the service effective?

Our findings

People's relatives said they felt care workers had the skills and experience needed to support their loved ones effectively. They had high praise for the team leaders' knowledge of people and their needs. However, they told us they did not always feel assured that agency nurses understood people's needs well enough to support them effectively. One relative said "My mum needs a lot of encouragement to eat. The nurse I spoke with did not know this. I worry that they would not know to check if care workers had encouraged my mum to eat in the right way and that she had enough to eat".

We asked the deputy manager what arrangements were in place to induct new agency nurses to ensure they had essential knowledge of the people they were providing care for and knew the provider's processes, such as emergency evacuation. The deputy manager told us new agency nurses received a copy of the safeguarding and whistleblowing policy. They also completed a safety checklist as their induction to Freelands Croft Nursing Home. Agency nurses we spoke with told us they did not find the induction sufficient to enable them to provide safe and appropriate care to people living in the home. They told us some people had complex health needs and they were not always sure what was expected from them in order to support these people effectively. Nurses we spoke with were not familiar with their responsibilities in implementing for example, the provider's falls, diabetes, early warning and records management procedures. The provider had ensured that agency nursing staff had been engaged to support the staffing levels in the home but had not inducted agency staff effectively to ensure they had the necessary knowledge of the provider's policies, care practices and people's needs to care for them effectively.

We looked at the arrangements in place to support staff through the use of supervisions. Staff told us they understood that the provider would ensure they received supervision every two months. This was confirmed by the quality manager.

However, staff told us they had not been supported through a system of appraisals and supervisions to deliver effective care. They did not routinely have an opportunity to provide feedback on the systems in place so as to inform the provider when processes were not working or required amending. Staff were concerned they were not receiving the support they needed to develop and maintain their care practices. They had not received regular supervision in the last six months and none could remember the last time they received supervision. The acting home manager and deputy manager had not had the opportunity to supervise staff in the short period they had been working in the home. The acting home manager told us she had found supervisions notes in some staff's supervision files but was not assured that all staff had received regular supervision in the past six months. The provider did not provide support and supervision to staff to enable them to identify solutions to problems, improve care practices and to increase understanding of work based issues.

Staff did not always receive appropriate support and supervision as was necessary to enable them to carry out the duties they were employed to perform. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living at Freelands Croft Nursing Home had a complex range of health needs, relating to both their physical, emotional and mental well-being. People who lived with diabetes were not always supported in line with nationally recognised guidelines. People were not supported by staff to adequately manage their blood glucose levels so as to protect them against diabetes-related complications resulting from variable blood glucose levels, such as circulation problems.

We looked at the care two people living with diabetes received. They both required regular monitoring of blood glucose levels to ensure staff would take action to protect them against health risks, when their blood glucose readings went higher or lower that their normal range. One person's care plan instructed nurses to increase the frequency of blood glucose monitoring to identify any fluctuations promptly. There was a delay in nurses implementing the care plan and staff had not always monitored this person's health as required.

Another person did not have a diabetes care plan in place to inform staff of their acceptable blood glucose levels and what action to take if their levels were higher or lower than their normal range. Nurses we spoke with were not familiar with the provider's Management of Diabetes policy. They were not aware they needed to implement the provider's hyperglycaemic protocol if a person's blood glucose reading was higher than 11mmol/l as noted in the diabetes policy. Both people's blood glucose readings were at times

higher than 11 mmol/l. Care staff and nurses could not tell us whether action had been taken to manage the risk resulting from a possible hyperglycaemic episode or whether guidance from the diabetic team had been requested on these occasions. We saw some records which showed that staff had contacted health professionals about their concerns with these two people's blood glucose readings. However, staff could not tell us and records did not show what the outcome of these raised concerns were and if there had been any identified actions required as a result. Though specialist input had been sought to evaluate people's diabetes care it was not always evident how people's care had been adjusted to ensure they consistently received diabetes care in line with nationally recognised guidelines and the provider's instructions.

People did not always receive appropriate support to manage their health risks. This was a breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

We looked at the arrangements made to support people with swallowing difficulties to eat and drink appropriately. The acting home manager told us they would refer people with swallowing difficulties for a Speech and Language Therapy (SALT) assessment to ensure they received appropriate support to eat and drink. Staff told us some people with swallowing difficulties required their food to be pureed and their drinks to be thickened. This was to reduce their risk of choking and/or aspiration. Aspiration is the medical term for inhaling small particles of food or drops of liquid into the lungs. The first sign of aspiration may be trouble breathing or signs of pneumonia.

One person had been discharged from hospital on a puree diet and thickened fluids, following treatment for pneumonia. Care staff told us this was following a SALT assessment, however we could not find a copy of the assessment. Staff could not tell us the detail of the SALT recommendations and it had not been incorporated into their eating and drinking care plan. Staff had not received guidance informing them for example, of the proper positioning before, during and after meals for this person They were also not made aware whether that person required supervision when eating or needed to have a drink with their meal. A risk assessment had not been completed for staff to understand the risks this person faced when eating and drinking and why they would require pureed food and thickened fluids. Records showed and staff confirmed that this person was refusing thickened drinks. We asked what action staff were taking when this person refused. Staff gave conflicting answers with some saying they would offer him un-thickened fluids and others saying they would persist with the thickened fluids. A team leader said they would refer the person to the SALT for re-assessment to determine what fluids would be safe for them to drink. On 16 June 2015, the last day of our inspection, staff were not able to confirm whether this SALT referral had been made. People were at risk of developing aspiration or choking if they were not appropriately supported in line with SALT guidelines.

People at risk of dehydration and those with unitary tract infections did not always receive sufficient amounts of fluid to stay healthy and support their recovery as indicated by their treatment plans. Two people we looked at had Fluid Intake/Output Recording Forms in place to monitor whether they were drinking sufficient amounts to remain hydrated. Nurses and care staff told us they aimed to ensure both people drank between 1200 -1500ml per day. The completed Fluid Intake/Output Recording Forms showed that people had drunk less than the target amount staff told us was required. Two people's records showed that they had not been offered sufficient amounts to drink to remain hydrated.

We asked the home manager what the arrangements were to monitor whether people had drunk enough to support their health needs. She told us the nurse on each floor was responsible for checking the forms at the end of each shift to see if the total amount people had drunk corresponded with their fluid requirement. They also had responsibility to take appropriate action where shortfalls were identified. We did not see that this check had been completed and asked the nurses if they had completed these on their previous shifts. The nurses told us that they were not aware that they had to undertake these checks. They also did not know whether the amounts recorded on people's Fluid Intake/Output Recording Forms were a correct reflection of the amounts people had drunk. Staff we spoke with told us they could not be assured that people were being provided with enough to drink. They told us they were not always able to make sure that people were being offered sufficient amounts of fluids to drink.

One person had developed a urinary tract infection (UTI) and his treatment care plan noted, 'Care staff to assist with

adequate hydration throughout the day and night'. Nurses had not checked his Intake/Output Recording Forms and it could not be established that this person had received sufficient amounts to drink throughout the day and night as instructed in their UTI treatment plan. Where this person had refused fluids nurses had not ensured that appropriate action had been taken and records showed that this person might have gone 20 hours without drinking any fluids and had not been offered any for 17 hours. This shortfall had not been identified by nurses and no action had been taken to determine whether this was a record keeping error or whether people had indeed not had any fluids over this period. Where records indicated potential shortfalls in people's fluid intake, nurses failed to investigate and take appropriate action.

People did not always receive the support they needed to ensure their nutritional and hydration needs were met. This is a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities).

The provider trained staff in the requirements of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff understood their responsibility to follow the MCA code of practice to protect people's human rights. The MCA provides the legal framework to assess people's capacity to make certain decisions at a certain time. Mental capacity assessments had been undertaken when there was doubt about a person's ability to make decisions about their care or treatment.

Deprivation of Liberty Safeguards (DoLS) provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely.

A system was not in place to support the acting home manager to easily monitor the progress of DoLS applications made to the local authority to ensure restrictions were only placed on people with the appropriate legal authorisation.

During our inspection the acting home manager contacted the local authority's DoLS team to determine the number and status of applications made for Freelands Croft Nursing over the past year. Two applications had been granted and the DoLS team was processing a further 12 applications for Freeland's Croft Nursing Home. The service was reviewing everyone to assess whether further DoLs applications were required. Best interest decisions were being made to agree restrictions in people's care plans for example if they required regular supervision, whilst awaiting the outcome of the DoLS applications.

Requires improvement

Is the service caring?

Our findings

People living at Freelands Croft and their relatives gave us mixed views about the service. They told us most staff were caring and cheerful but they felt better understood and supported by staff who had worked at the service for the past six months and knew people. One person told us ‘‘Most of the time I do not know the nurses here at all and I wait till I see someone I know to talk to’’. One relative said ‘‘Staff that know my mum are so much better at reassuring her when she gets upset and know how to motivate her to eat’’.

During the course of the inspection we saw people received inconsistent responses to their questions and varied levels of reassurance when they were unsettled. We saw when people asked for support or pressed their call bells staff responded promptly to provide the support needed. However, when people living with dementia asked questions to make sense of their day or became anxious staff had an inconsistent approach. Staff who knew people well and understood people’s behaviour responded promptly with answers to their questions and offered reassurances. However, staff who did not know people, missed opportunities to comfort people in a timely manner and we saw people becoming frustrated and more confused as a result.

During the inspection a mini farm visited the service. This activity had been arranged by the provider and was an opportunity for people living with dementia to get involved in a meaningful sensory activity. People had been encouraged by staff to attend and participate. We observed staff and people during the activity and saw people who found it difficult to initiate contact or ask for contact with an animal were left unsupported. Two people stood watching the animals and stretched their hands out whilst moving closer to the pen, however staff did not pick up on this during the 30 minutes we were observing the activity. These two people then became disengaged and had missed out on an opportunity to exercise some control over their lives and experience a sense of enjoyment and participation.

We spoke with a visiting Admiral Nurse about opportunities for people to be involved in meaningful and enriching day to day activities. Admiral Nurses are specialist dementia nurses who support services to develop their practice in working with people living with dementia in line with nationally recognised guidelines. They told us staff were receiving training in how best to support people living with dementia but work was still needed to create appropriate activities for people.

People’s privacy and dignity were respected. People had their own rooms and these were personalised with their belongings and memorabilia. Staff knocked and asked for permission before entering their rooms and spoke courteously with people. Staff gave examples of how theysupported people in a dignified way when assisting with personal care, by ensuring doors were closed and drawing curtains when necessary.

Requires improvement

Is the service responsive?

Our findings

An assessment of people's needs had been undertaken prior to people being offered a place at Freelands Croft Nursing Home. Assessments provided staff with information about people's needs including their skin, nutrition, sleep, personal care and mobility needs. However, the assessments had not always been used to plan people's care in a timely manner following their admission to the service.

People were at risk of receiving care that was not appropriate to their needs and did not reflect their preference as staff did not have the information they needed to meet people's needs and keep them safe. For example, one person was admitted to the service on 2 June 2015 for end of life care following an assessment of their needs on 27 May 2015. When we inspected the service on 9 June 2015 the person did not have a plan of care in place to inform staff how to support them to manage their skin integrity, continence, nutritional, hydration and wellbeing needs as identified by the initial assessment.

This person's skin integrity had changed and they developed a pressure ulcer on 10 June 2015. Following this change a skin care plan was still not put in place. A skin care plan was only completed on 16 June 2015 following a visit from the Advanced Clinical Nurse Specialist for Tissue Viability on 15 June 2015 when she graded the person's pressure ulcer as Grade 4 and requested a skin plan was put in place. Healthcare professionals use several grading systems to describe the severity of pressure ulcers. Grade 4 indicates the most severe the injury to the skin and underlying tissue and people are at risk of developing infection. Staff had used the person's initial assessment to provide for their needs however this was not responsive to this person's changing health needs and did not provide staff with the information they needed to provide individualised care.

The provider promoted the use of 'resident of the day programme' in order to review people's care plans monthly. This meant that each person was assigned a specific day in the month when their care plan would routinely be reviewed. This process involved the person, nurse and any family members. Staff told us and records showed the 'resident of the day'' reviews had not always taken place and staff did not always have up to date information about people's changing needs as a result.

Some people required support to complete their personal hygiene tasks to the level they wanted. Daily personal care records did not always show whether all the planned activities had been completed for each person. We looked at the personal care record for a person who had visited the dentist. The dentist had raised concerns about their teeth care. Their personal care record did not show that they had consistently been supported to maintain their teeth hygiene as instructed in their care plan. Staff had not checked the records at each shift to ensure people's personal care tasks had been completed appropriately. We could not be assured that all people had received their planned care.

The provider was in the process of changing people's care plans to anew format. However this had not been completed for every person and made it difficult to identify what people's needs had been at assessment and how their planned care had changed over time. Care workers who worked in the service for over six months were able to provide a history of people's personal care needs, and how these needs and their support had changed over time. However, agency nurses could not provide us with an oversight of people's present and past clinical needs. They told us even though they received written handover information at the start of each shift to inform them of people's needs this did not always include all the core aspects of people's care for example, people's history of wounds or falls. The specialist community nurse for nursing homes and the Advanced Clinical Nurse Specialist for Tissue Viability told us care plans did not provide people's clinical histories to inform their treatment decisions when planning people's health care. Health professionals being able to make appropriate treatment decisions were hindered by not having up to date and accurate information about people's treatment histories and how people's health had deteriorated or improved over time.

People's assessments had not always been used to plan and deliver their care. People could therefore not always be assured that they would receive person centred care appropriate to their needs and preference. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were a range of ways people and visitors could comment on the service. The acting home manager and deputy manager welcomed people to speak with them directly if they had concerns or worries. Relatives told us

Requires improvement

Is the service responsive?

they would speak to one of the managers if they had any concerns. An annual satisfaction survey was undertaken and the area manager told us they were waiting for the provider's report from the last survey. They told us actions required following this survey would be incorporated in the service improvement plan. Relatives and resident meetings were held every three months. The last one held in May 2015 showed that relatives had concerns about the lack of consistent nursing staff.

The new management team had ensured all concerns were logged, investigated and responded to in line with the provider's complaints policy. The concerns had been primarily about relatives being unsure about the impact the departure of the previous manager would have on the service as well as inconsistent nursing staff. The area manager told us they had already identified this trend in relatives concerns. As a result a meeting would be held in July 2015 to provide the opportunity for relatives to raise their concerns. This was also seen as an opportunity for the provider to give reassurances and explain how they would be addressing these concerns. At the time of our inspection one complaint was being investigated in line with the provider's complaint policy.

Inadequate

Is the service well-led?

Our findings

The management team had changed in the month before the inspection following concerns identified by the provider about the quality of the service being provided at Freelands Croft Nursing Home. A new deputy manager, acting home manager and area manager had been appointed to address these concerns. The area manager told us the provider had identified that quality monitoring systems had not been implemented effectively resulting in risks not always being identified or acted upon.

We looked at the steps the provider had taken to assess, monitor and improve the quality and safety of the services provided to ensure they met the requirements of the regulations. We found arrangements in place to check on the quality of care and support provided to people had not been effectively implemented. People were at risk from unsafe or inappropriate treatment which had not been identified. When areas of concern had been identified these had not been managed appropriately.

The provider had systems in place to enable the manager to monitor the quality of nursing care provided to people and to enable them to identify risks to people's health and welfare. The acting manager told us this included a daily risk meeting, a Daily Clinical Walk Around check, weekly clinical review meetings as well as a monthly Home Manager Quality Metrics Report review. The acting home manager and area manager told us that they had found evidence that the daily meetings took place regularly, however the clinical review meeting had taken place sporadically and they could only confirm that clinical review meetings had taken place on 17 March 2015, 25 March 2015 and 10 April 2015. The provider had not effectively implemented their quality and risks systems and people were at risk of inappropriate treatment which had not been identified.

The provider's quality assurance manager undertook a comprehensive Home Review Audit of the service on 10 March 2015 in response to the concerns raised by the previous area manager. The Home Review Audit found the service was not meeting the provider's minimum standards. This audit was effective in identifying all the concerns we found except for the concerns relating to the monitoring of pressure relieving equipment.

Following the Home Review Audit of the service on 10 March 2015 a basic action plan was developed to address the identified concerns. The area manager told us this action plan had not been sufficiently robust to ensure improvements would be made. Progress against this action plan was monitored on 28 May 2015 and the provider found a significant number of actions had not been completed in the required timeframe. We found arrangements that were in place to check on the quality of care and support provided to people were not effective. People remained at risk from unsafe or inappropriate treatment because the provider had not taken steps to mitigate the risks they had identified in their audit. For example, they had not taken robust action to implement their Maintenance of Skin Integrity and Pressure Ulcer Management policy to improve their practice so as to ensure people were sufficiently protected from developing home acquired pressure ulcers.

At the time we started our inspection the provider did not have a system in place to monitor CQC notifications or DoLS applications. The provider failed to inform CQC, as required by law, so as to ensure people could be protected appropriately. For example, they failed to inform CQC of two DoLS applications that had been authorised in December 2014. Following our inspection the acting home manager had identified these statutory notifications had not been sent and informed us retrospectively on 12 June 2015. The acting home manager was taking action to implement the notification system at the service.

The provider did not maintain a complete record in respect of each person's planned and received care and treatment. We found several examples which did not include a record of the care and treatment provided to people and evidence of decisions which had been taken in relation to their care and treatment. Agency staff, including nurses, and staff that did not know people could not rely on people's care plans or the written handover information provided. This meant that they were unable to develop a good understanding of people's identified needs and risks and what action they needed to take to support people appropriately.

The provider had not ensured that records kept to inform care decisions including, daily Fluid Intake/Output diaries, Food diaries, positional change recording forms and wound plans were monitored in accordance with their policy. Action had not been taken to ensure the information in those records were accurate and could effectively be used to evaluate people's treatment and care

Is the service well-led?

and accurately inform treatment decisions. They provider had not taken action to improve the quality of record keeping once they had identified this as a significant concern during the Home Review Audit of the service on 10 March 2015.

People were being put at risk of inappropriate or unsafe care through the provider's failure to maintain accurate, complete and contemporaneous records in respect of people's care and treatment. For example, one person's wound care plans were confusing and it was not easy to judge from the records how many wounds they had, which ones had healed and what type of treatment they had effectively responded to. Nurses and the visiting Advanced Clinical Nurse Specialist for Tissue Viability told us they also found the wound care plans difficult to follow and could not develop an oversight of this person's wound treatment over time so as to inform their current treatment.

The provider did not implement their systems in place to improve the quality of the service provided and did not maintain accurate records. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People, relative and staff we spoke with told us they were worried and unsettled with the management changes and the lack of consistent nursing staff. Staff told us there was some task delegation during shifts, but that the effectiveness of this varied according to the nurses on duty. During our inspection we saw some staff who lacked direction and seemed to be rushing from one task to another. Communication systems to ensure that staff had the information they needed to provide good care and support were not always effective. One staff member told us, "Communication is difficult, I feel I do not always have all the information I need to do my job. That means doing things can take a long time. You don't know what you might have missed." Staff were not clear of their roles and responsibilities and nursing leadership was lacking with team leaders taking on the role of co-ordinating staff tasks and informing nurses of when nursing input was required.

When asked to describe the culture of the service both staff and relatives told us that the service had been up and down struggling to maintain consistency of staff which had made it difficult to develop a service based on consistent good practice. One staff member told us "We haven't had the opportunity to develop a culture, a solid way of working. We have been firefighting for so long and just when things get better managers change again, nurses leave and we start from scratch. It is very demoralising". We found staff were committed to providing people with good care but were demoralised, confused and tired from the lack of consistency in the leadership of the service.

The provider had arrangements in place to ensure the care practices remained up to date and incorporated nationally recognised guidelines. A specialist Admiral Dementia Nurse visited the service regularly to audit the homes performance against national dementia guidelines including the design guidance for dementia-friendly health and social care environments. The Admiral Dementia Nurse had completed an audit in January 2015 and identified areas for improvement for example, in relation to activities and care planning. However though some progress had been made these actions had not been completed.

The new management team had a good understanding of the areas that required improvement and the action required. They had started to address the concerns and the provider had made additional resources available to drive improvements. For example, during our inspection a training manager was providing training updates, the quality manger was undertaking service audits and experienced nurses form one of the provider's other services were reviewing care plans. The area manager had provided us with an interim action plan detailing how their concerns would be addressed including ensuring agency nurses received the required training and induction.

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements 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 (RA) Regulations 2014 Person-centred care People's care was not planned promptly following assessment to ensure it would be appropriate and meet their needs. Regulation 9 (1) (a) (b) (c) (2) (3) (a) and (b)

The enforcement action we took:
We imposed a condition on the provider's registration in respect of the regulated activity, Accommodation for persons who require nursing or personal care, they carry on at Freelands Croft Nursing Home. The Registered provider must not admit any new service users to Freelands Croft Nursing Home for the purposes of this regulated activity without the prior written consent of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People who use services and others were not protected against the risks associated with unsafe care and treatment because risks to people had not been assessed and mitigated. Staff did not always know how to keep people safe and equipment was not monitored to ensure it was used safely. Regulation 12 (1) and (2) (a) (b) (c) and (e)

The enforcement action we took:
We imposed a condition on the provider's registration in respect of the regulated activity, Accommodation for persons who require nursing or personal care, they carry on at Freelands Croft Nursing Home. The Registered provider must not admit any new service users to Freelands Croft Nursing Home for the purposes of this regulated activity without the prior written consent of the Care Quality Commission.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs Systems were not implemented effectively to ensure people with swallowing difficulties received support to eat in drink in line with specialist guidelines. People did not receive enough to drink. Regulation 14(1) and (2)(a) 4 (a) and (d)

This section is primarily information for the provider

Enforcement actions

The enforcement action we took:
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Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems to ensure compliance with the regulations were not implemented effectively to identify and act on risks and quality concerns. Accurate comprehensive records were not kept of people's care and treatment decisions. Regulation 17 (1) (2) (a) (b) (c) and (f)

The enforcement action we took:
We imposed a condition on the provider's registration in respect of the regulated activity, Accommodation for persons who require nursing or personal care, they carry on at Freelands Croft Nursing Home. The Registered provider must not admit any new service users to Freelands Croft Nursing Home for the purposes of this regulated activity without the prior written consent of the Care Quality Commission.

Regulated activity	Regulation
	Regulation 18 HSCA (RA) Regulations 2014 Staffing There was insufficient nursing staff deployed with the skills, experience and knowledge of people's needs and the support they needed to stay safe. Staff did not always receive appropriate support and supervision as was necessary to enable them to carry out the duties they were employed to perform. Regulation 18 (1) (2) (a)

The enforcement action we took:
We imposed a condition on the provider's registration in respect of the regulated activity, Accommodation for persons who require nursing or personal care, they carry on at Freelands Croft Nursing Home. The Registered provider must not admit any new service users to Freelands Croft Nursing Home for the purposes of this regulated activity without the prior written consent of the Care Quality Commission.