Eastfield Farm Residential Home Limited

Eastfield Farm Residential Home Limited

Inspection report

Eastfield Farm
Southside Road
Halsham Hull
Humberside
HU12 0BP

Tel: 01964671134

Date of inspection visit:
07 June 2017
09 June 2017
16 June 2017

Date of publication:
16 August 2017

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 7, 9 and 16 June 2017 and was unannounced.

Eastfield Farm Residential Home Limited is a renovated farm house situated in open countryside in the village of Halsham, close to the seaside town of Withernsea in East Yorkshire. The service was originally built to provide residential care to the farming and rural community in an environment they were used to. It offers care for up to 26 older people, some of whom may be living with dementia. On the day of the inspection there were 23 people living at the home.

During our inspection we were supported by a registered manager. 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. The registered manager will be referred to as 'manager' throughout the report.

The service was last inspected on 14 and 15 November 2016, when we found people who used the service were not protected against the risks associated with receiving care and treatment they had not consented to or which had not been agreed in a best interest forum. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 11: Need for consent. The provider submitted an action plan with information on how they intended to meet with the breach we identified, by 30 April 2017.

During this inspection we checked and found that the action had not been completed or reviewed. The provider was not always compliant with the Mental Capacity Act 2005. People were not supported to have maximum choice and control of their lives and people were not supported in the least restrictive way possible; the policies and systems in the service did not support this practice. People were still not protected against the risks associated with receiving care and treatment they had not consented to or which had not been agreed in a best interest forum. This was a continued breach of Regulation 11.

At the previous inspection in November 2016 we found the provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service provided in the carrying out of the regulated activity. The provider failed to maintain accurate up to date records to mitigate associated risks for people. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 17: Good governance. The provider submitted an action plan with information on how they intended to meet with the breach we had identified, by 30 April 2017.

During this inspection we saw the provider had failed to meet all the actions they told us they were implementing to meet the breaches of this regulation identified in the previous inspection in November 2016. We found the provider did not have effective systems in place to assess, monitor and improve the quality and safety of the service provided in the carrying out of the regulated activity. The provider failed to maintain accurate up to date records to mitigate associated risks for people. This was a continued breach of

Regulation 17.

At the previous inspection we found the provider failed to protect people against the risks associated with the unsafe use and management of medicines by the inappropriate arrangements for recording and handling of medicines used for the purposes of the regulated activity. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12: Safe care and treatment. The provider submitted an action plan with information on how they intended to meet with the breach we had identified, by 26 January 2017.

During this inspection we checked and found that the action had been completed. However, we found manufacturer's instructions had not been followed in line with the provider's policy for medication where people received their medicines from a patch. Records failed to record where a patch had been applied and the provider was unable to evidence safe practice. Body maps were not always used to record the application of creams prescribed for use, 'as and when required'. We recommended the provider researched and implemented best practice in line with NICE guidelines.

During this inspection we found that the service was not always safe. Risks to the health and safety of people using the service were not always thoroughly assessed and effectively managed and this placed people at risk of otherwise avoidable harm. Risks associated with the system and process in place to assess, manage, prevent, detect and control the spread of, infections; including those that are health care associated, were not robustly followed or reviewed for their effectiveness. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 12: Safe care and treatment.

The provider did not have a systematic approach to determine sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed to keep people safe and meet all their needs at all times or to meet other regulatory requirements. There was no system in place to ensure staffing levels and skill mix were continuously reviewed and adapted to respond to the changing needs and circumstances of people using the service. Our observations confirmed that at times staffing numbers were insufficient to fully address people's care needs. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 18: Staffing.

People received additional support from dietary and nutritional specialists where this was required. However, we found inconsistent records and information available for staff to ensure people were always supported to eat and drink which was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 14: Meeting nutritional and hydration needs.

At the previous inspection in November 2016, we found a review of each care plan was scheduled each month. However, these were not always completed, nor did it guarantee that care plans were fully reflective of people's current needs. We recommended that the register manager sought advice and guidance on the accurate maintenance of care files.

During this inspection we found care records included pre-admission assessments that had been completed before people were accepted into the home. We found this information was included in live records, but had not always been updated. Care records were inconsistent and we were concerned that information was not always current or up to date. This meant people were at risk as the information used by staff to provide care and support was not reflective of people's current needs.

Systems and processes were not followed and it was unclear from reviews of care plans where information had been updated.

Care was not always observed to be person centred due to insufficient staffing levels to meet people's individual needs all of the time. Care and support was observed to be task orientated and an activities programme could not be provided due to insufficient staff.

The above concerns were a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 9: Person-centred care.

At the previous inspection we found the manager had failed to notify the CQC of all significant events. This meant we could not check that appropriate action had been taken. This was a breach of the Care Quality Commission (Registration) Regulations 2009: Regulation 18: Notifications of other incidents. We wrote to the provider to advise them of the information they should submit.

During this inspection we found the manager had notified the CQC of some events but continued to fail to submit notifications for all notifiable events. This meant the provider was in continued breach of Regulation 18.

The provider had failed to display the previous inspection ratings in the home and on the provider's website. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 20A: Requirement as to display of performance assessments.

The provider completed appropriate checks to determine whether staff were suitable to work with vulnerable people.

Relatives told us there were no restrictions on the times they could visit people living at the home and that they were always welcomed by staff on arrival.

The provider had a policy and procedure in place to manage any complaints, concerns or compliments that they received.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures 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. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action.

Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

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.

Staff had received training and understood how to raise concerns. However, accidents and incidents had not always been evaluated or referred for further investigation by the local safeguarding team in line with policy and procedures.

Risks were not always effectively managed and this impacted on the safety of people using the service.

Improvements were needed to the number of staff on duty to meet the needs of people who used the service.

Staff received appropriate checks to ensure they were of suitable character to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not effective.

People's best interest decisions were not always completed according to the Mental Capacity Act requirements and nor were they reviewed.

We found evidence that the provider had failed to implement effective systems and processes to comply with the Mental Capacity Act 2005.

People's nutrition and hydration needs were inadequately recorded to ensure their needs were met.

Staff received an induction and support with training and supervisions to ensure they had the appropriate skills to meet people's individual needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Care records contained information to record consent but documents had not always been signed.

There was insufficient evidence to demonstrate where people had been involved in their own care planning and making decisions.

We received a mixed response from individuals who we spoke with regarding the care and support people received and our observation confirmed care and support was not always centred on the individual.

Is the service responsive?

Inadequate

The service was not always responsive.

Care records were ineffective and did not reduce the risk to people because they were not up-to-date.

There was no evidence to show that people were involved in reviews of their care or if the changes had formally been discussed with the person, family or legal representative.

There was insufficient staff to meet people's individual needs and people showed signs of distress whilst waiting for staff to attend to them.

The provider had a policy and procedure in place to manage any complaints, concerns or compliments that they received.

Is the service well-led?

Inadequate

The service was not Well-Led.

The provider had not submitted the required notifications to the CQC.

The quality assurance system failed to identify that care plans were insufficiently robust to meet people's needs and were out of date.

Audits were ineffective and had failed to identify the associated risks we evidenced during our inspection.

The provider had failed to display the ratings of the previous inspection in the home or on their web site.

Eastfield Farm Residential Home Limited

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 was carried out on 7, 9 and 16 June 2017 and was unannounced. This meant the provider and staff did not know we would be attending.

The inspection team consisted of two adult social care inspectors and one expert by experience. Experts have experience of using these types of service. On this occasion the expert had experience of older people and dementia care.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the provider and information we had received from the local authorities that commissioned services with them. Notifications are when registered providers send us information about certain changes, events or incidents that occur.

We also contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they had with the service.

The provider was not asked to submit a Provider Information Return (PIR) prior to the inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with five members of staff, the manager, the provider's nominated individual, five people who used the service and four people's relatives. We spent time observing the

interaction between people who lived at the service, the staff and visitors.

We looked around the home, which included people's bedrooms where they provided us with permission to do so.

We also spent time looking at records, which included the care records for seven people, their medication records, handover sheets, and supervision and training records for four members of staff.

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 communicate directly with us.

Inadequate

Is the service safe?

Our findings

At the previous inspection on 14 and 15 November 2016 we found the provider failed to protect people against the risks associated with the unsafe use and management of medicines by the inappropriate arrangements for recording and handling of medicines used for the purposes of the regulated activity. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment.

During this inspection we checked the policies and procedures in place for medicines management and we observed people receiving their medicines over the lunch time period. We found that improvements had been implemented since our previous inspection. There was a designated team leader who had responsibility for medicines, and we observed they wore a red tabard whilst dispensing the medication to avoid being disturbed. Where staff were involved with medicines they had received up to date training. A medicine trolley was taken to the communal area and individual medicines were taken to people in their bedrooms. The team leader checked the Medication Administration Record (MAR), administered the medication and waited until the person had taken the medicine and assisted where necessary before completing the MAR.

There was a system and process in place for the ordering, storage, handling and disposal of medicines and this was in line with best practice. Records were up to date and audits were completed to maintain safe practice. However, where a person received medicines from a transdermal patch applied to their shoulder we saw this was recorded on the MAR but that staff failed to follow the providers Medication Management Policy. Checks on the manufacturer's guidance and instructions for application of patches had not been completed. Manufacturer's guidance states when replacing a patch, the new patch should be applied to a different skin site. Patches should not be applied to the same area of skin for three to four weeks. The provider had failed to record where patches had been positioned. We spoke to the staff member regarding our concerns. They were unaware of the guidance. They told us, "There are two people with responsibility for the administration of medicines and we know where we have administered the person's patch." They recorded the letters 'L' and 'R' on the MAR to reflect the shoulder where the patch had been applied during our inspection. We made a recommendation for the provider to review their practice to record the application of patches.

Records for one person recorded they required the application of creams to dry areas of skin. Areas of documented risk that recorded signs of associated 'redness' had not been included in the review of the risk assessment. There was no oversight of this area of care for staff and no body maps in place for application of creams by staff.

People told us they felt safe living at the home. One person said, "There is always someone about; if I didn't like it or I didn't feel safe then I would leave." Staff had received training in safeguarding and understood the types and signs of abuse to look out for and how to record their concerns. Staff members told us, "If I had any concerns I would speak with the manager or I would speak directly with the safeguarding team at the council." and "I would whistle blow any concerns regarding bad practice to the CQC; it's important people

are protected."

The service had policies and procedures in place to guide staff in safeguarding people from abuse. The manager told us they used the local authorities safeguarding tool to decide when they needed to inform the safeguarding team of an incident, accident or an allegation of abuse. We viewed safeguarding records and saw two safeguarding concerns were recorded on a 'Safeguarding Consideration Log'. However, after reviewing the monthly overview of accidents and incidents for the month of May 2017, we identified some additional concerns where the provider had made the decision not to refer to the local authority. These were not included on the 'Safeguarding Consideration Log'. An incident recorded a person had stood up to help another resident and had fallen, resulting in a fractured hip. The provider had submitted a notification for this incident to the Care Quality Commission (CQC) as part of their requirements of registration. The notification recorded the registered provider had contacted the local authority regarding the fall. However, there was no evidence to show that this, and other accidents and incidents had been considered for escalation to the local authority as they were not recorded on the 'Safeguarding Consideration Log'. This meant we were unable to evidence how these accidents and incidents were evaluated for further investigation, or what actions had been implemented to mitigate further occurrence.

We looked at records for malnutrition, eating and drinking, turn charts, behaviour and daily record sheets that were used to record and evaluate the care and support provided, and mitigate associated risks. However, these were not always complete, up to date or reviewed. This meant people were at risk from receiving care and support from staff that was not appropriate for their needs.

Where bed rails were used to keep people safe from falls, risk assessments had not always been fully completed to assess they were suitable for the person and reviews were not always completed monthly in line with procedure. We looked at 'Risk Assessment Forms' for the use of Bed Rails'. We found one form to be incomplete and despite provision on the form to record information about the 'Resident', 'Type of bed', 'Type of mattress' and appropriate 'Fitting' these had not been completed. The form had only been signed by the assessor and not the person it related to or their representative. The form was dated March 2017. Provision was available to record further monthly reviews but this had not been completed. There was no evidence to show where staff had received training on the risks and safe use of bed rails and this information was not included in individual staff training records. This meant people were at risk of unnecessary restrictions from equipment that was not robustly assessed for safe use.

We checked and found the provider did not have systems or processes in place to adequately manage the risk of falls from windows, including any assessments to the premises and people who lived there. We saw an alert providing guidance on window restrictors dated January 2013 and this had been filed in the health and safety file. This guidance included advice for the provider to put in place a program for inspecting, repairing and replacing window restrictors but this had not been implemented. We discussed our concerns regarding the fitment of window restrictors to some windows upstairs but not others despite the window openings being of the same size. The registered manager confirmed they were not responsible for this process which was part of the checks carried out by the provider. We found up to date guidance had not been sought with regards to the correct implementation of window restrictors, the health and safety implications, and staff training in the safe usage and awareness of window restrictors or maintenance programs to ensure window restrictors remain safe and operational to prevent people falling and injuring themselves.

We saw documentation and certificates to show that relevant checks had been carried out on the electrical circuits, gas supplies, water temperatures, electrical items and all lifting equipment including hoists and the stair lift. We saw that a suitable fire risk assessment was in place and regular checks of the fire alarm system,

fire extinguishers and emergency lighting were carried out to ensure they were in safe working order. We also saw that regular fire drills took place to ensure that staff knew how to respond in the event of an emergency.

However, the provider had failed to ensure the premises and equipment was always used in a safe way. We observed access into and out of the kitchen crossed a step. There was no warning in place to highlight the risks associated with the step. Staff were observed lifting a trolley down the step and out of kitchen with hot tea and coffee on it. When asked about the process and safety implications, the manager told us, "Staff do not have to do it that way; it's the way they choose to do it." No risk assessments had been completed to ensure people and staff remained safe from avoidable harm.

Despite an infection control policy and procedure, and a cleaning rota in place we observed areas of concern regarding the cleanliness of the home. Risks associated with the system and process in place to assess, manage, prevent, detect and control the spread of infections, including those that were health care associated were not robustly followed or reviewed for their effectiveness. The laundry room contained items of rusty furniture and non-laundry items that posed a risk of cross infection. These items also prevented access to the sink area. The shelves and storage area for people's clean clothing were dirty and both old and new files with paperwork in them were stored on top of the shelves.

During a walk around the home on the first day of our inspection, we observed laundry hanging over radiators in the corridors approaching the laundry room and outside the bedrooms where people lived which posed a risk to infection control. This was removed during our inspection. In the kitchen, dining room and in the toilets, waste bins had no lids. We observed dried brown deposits that appeared to be faeces on the wooden bed rail in one person's room, a commode had been used but was not cleaned or emptied and a urinal bottle was observed to be stained and not clean. The carpet in the communal area was stained. We discussed these concerns with the manager. Because of our feedback the laundry area was tidied and rusty furniture removed. However, the commode remained unclean.

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

During our inspection we were concerned about the number of staff on duty. The provider did not have a staff dependency tool in use to ensure sufficient numbers of suitably qualified, competent, skilled and experienced staff were deployed to keep people safe and meet their needs at all times or to meet regulatory requirements. There was no system in place to ensure staffing levels and skill mix were continuously reviewed and adapted to respond to the changing needs and circumstances of people using the service. At the time of the inspection there were six out of 23 people who required support from a minimum of two staff. This included three people who required two staff for transferring and one person who required the support of two staff in their own bedroom at all times. A further three people choose to spend most of their time in their own bedrooms, and required assistance of one staff member at all times.

We observed staff rushing to complete tasks with very little time to provide one to one care and support to people. During lunch time and during the administration of people's medicines, we observed people in communal areas without assistance from staff to meet their basic needs, such as visiting the bathroom. People showed signs of distress and were agitated whilst waiting to be attended to. Four staff we spoke with told us, "90 % of people now require two staff to one person support, we work 12 hour shifts and staffing is a problem. People's needs have deteriorated with different stages of dementia, yet staff numbers haven't increased." "Generally there is not enough staff; people have complex needs, no increase in staff numbers."

The above concerns were a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 18: Staffing.

We found that application forms were completed, references obtained and checks made with the disclosure and barring service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and ensured that people who used the service were not exposed to staff that were barred from working with vulnerable adults.

Requires Improvement

Is the service effective?

Our findings

At the previous inspection on 14 and 15 November 2016 we found people who used the service were not protected against the risks associated with receiving care and treatment that they had not consented to or which had not been agreed in a best interest forum. This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 11: Need for consent.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

During this inspection, we checked and found the provider was not always working within the principles of the MCA. At the time of this inspection, records confirmed where people had been assessed by the provider as having a lack of capacity. Some applications had been made to the local authority for further assessment and approval for DoLS.

We saw a best interest meeting had been held regarding a DoLS application for the provision of 24 hour care for one person. We saw this had been submitted for approval on 24 February 2016 and approved on the 20 January 2017. No further reviews had been completed or were scheduled to continually assess the decision or the person's continuing capacity to make their own daily decisions. Where the person was determined to have capacity to make small decisions there was no evidence in their care records to demonstrate where they had been involved with or consented with those decisions.

Care plans we looked at did not always demonstrate where people had been involved in their care and support despite provision to record this. Best interest meetings were not always evident and where they had been completed, reviews had not been carried out or scheduled to ensure any restrictive practices were still appropriate and the least restrictive option. This meant people may be restrained without their consent or legal approval to do so.

We saw where one person had been identified as having a lack of capacity and had restrictions in place with regard to bed safety rails. The provider had failed to submit an application to the local authority in respect of the deprivation of their liberty. A relative raised concerns regarding the decisions made about the care and support of the person. The relative told us they had power of attorney (POA) for finance and care and support. A POA is a legally appointed responsibility that can enable decisions on behalf of a person in respect of their finances and care. A 'Risk Assessment Form' for the use of bed rails was available in the person's file but this was incomplete and signed only by the manager despite provision for the person or their legal representative to record their consent. We asked the manager about the application for a DoLS and they told us this had been an oversight.

Care records for one person included an internal capacity assessment record which determined they had capacity to make day to day decisions but did not have full capacity for medical intervention or financial discussions with an overall outcome recorded as not having capacity. It was unclear from the form who had been involved in the decision making. The form included provision to record if a best interest assessment had been completed but this was left blank. A second stage 'MCA Capacity Test', confirmed the person had an overall lack of capacity but this was only signed by the team leader. There was no evidence of a best interest meeting to determine the outcomes. A 'Consent to care and treatment' form was available as part of the care records but this was not completed. A 'personal finance assessment', was completed and documented that the person's relative had POA. At the time of the inspection the manager was unable to evidence any checks they had made regarding this and it was unclear if the relative had POA or what legal decision the relative was authorised to make. A copy was sent to the Commission following the inspection and this confirmed the relative had POA for the person's property and financial affairs. However, we saw care plans had been signed by the relative, agreeing to the person's care and support. When questioned by the inspector, the manager was unsure if the signature constituted consent or if the signature constituted a review by the relative without consenting. There was no evidence that any additional consent had been sought.

Care records for one person evidenced the person had full capacity. However, there was no evidence of the person's involvement in the care plan and they had not signed their agreement or consent. A respite care plan was evidenced and this had been signed by the manager. There was no provision for the person to agree and sign their consent to the care plan being implemented.

Do not attempt cardio-pulmonary resuscitation (DNACPR) documents were in most people's files we looked at. These recorded decisions regarding the agreement to provide resuscitation to a person at times of medical emergency. Where these had accompanied the person on a hospital discharge the provider had not arranged for them to be reviewed as part of the handover of medical responsibility as advised as best practice on the form. We found the forms we looked at were incomplete and they had not been checked for accuracy. We discussed these concerns with the manager who was unaware of the checks required to ensure DNACPR forms were robustly completed and agreed by the relevant individuals and professionals involved with their care and support.

Care records did not show evidence that people were involved with the planning or implementation of their care and support. People with capacity had not always been consulted or signed documents to agree to their care. Those without capacity had not always been appropriately represented, as checks on the legal status of relatives had not been completed.

Care records included some background information on people but this was often not very detailed. The manager told us, "We add more information into people's backgrounds as part of people's reviews, as we get to know them better." One person with capacity had an end of life plan but this was signed by the manager and not the person. There was no other evidence available to demonstrate how the person had been involved in their own care planning and making decisions and so they were not supported to be autonomous.

These examples showed us that consent to care and treatment was not consistently sought in line with relevant legislation and guidance on best practice. This was a continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 11: Need for consent.

At the previous inspection in November 2016, we saw that people's weights were monitored and recorded in their individual care files. We found there were a number of gaps in people's individual weight records. The

Malnutrition Universal Screening Tool (MUST) had not been calculated and there had been no entries for several people. We saw that food and fluid charts were in place for people who were deemed at risk of weight loss. However, we found that the recording of food and fluid was not always accurately completed and the fluid intake for people was not always tallied.

During this inspection, we checked records used to record and review how people were supported to maintain good health including measures in place to ensure they were assessed and received appropriate food and hydration. We found that accurate records were not maintained which meant people could be at risk of weight loss and from developing a pressure ulcer. We found that the recording of food and fluid was not always accurately completed and the fluid intake for people was not always added up each day.

A Care record we looked at included, 'The Dependency Scale – assessment of need' and this was dated 28 February 2017. The record assessed the person as 'Requires total assistance with eating & drinking', 'No speech', 'Requires full assistance and monitoring' 'Incontinent' and 'Chair Bound'. Despite the record of high needs, observations and records were all documented on a single 'Food/fluid intake, 2 hourly Movements & skin inspection / hygiene care' sheet. This information was limited in content, only acknowledging the task completed. For example, 'Turned and checked', 'Assisted with breakfast' was recorded, without additional narrative in the comments section. The records were not complete and contemporaneous so they could be used to plan and review the care and support provided or its effectiveness in minimizing the associated risks. We were unable to see at a glance exactly what area of care or support required further monitoring due to any identified risks or what was working well as these were not recorded.

An associated care plan recorded 'has been known to cough when taking fluids and 'needs food cutting up.' However, we observed staff served the person a meal containing whole pieces of braising steak in gravy. We observed no further assistance was provided to cut up the person's food and no drink was provided for approximately 5-10 minutes after the person's food was presented. We asked a member of staff who was busy bringing in people's food if the person normally had their food cut up. The staff member told us they were not sure. The manager advised the person was more at risk of choking with liquids. This was not clear in the care plan. However, it was clear from our observations that staff were unsure how to support the person. We found these care plans did not contain suitable and sufficient risk assessments to effectively manage this risk or information for staff to support the person in a safe way.

People received additional support from dietary and nutritional specialists where this was required. A care record included information regarding diet and input from a Speech and Language Therapist, (SALT). However the information was confusing as there were two records on file; one document was dated 28 October 2014 and the other had no date. Due to incomplete records the person could be at risk from staff following out of date guidance when providing assistance with their diet.

We saw people had to wait to be provided with a drink to accompany their meals. One staff member asked a person if they had enjoyed their meal; however the person had not received their food. This was remedied and the person was then seen to enjoy their meal. Where other people had chosen to eat in communal areas we saw they were left without assistance during their meal as staff were busy supporting other people.

We found inconsistent records and information available for staff to ensure people were always supported to eat and drink which was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 14: Meeting nutritional and hydration needs.

Staff we spoke with told us and records we looked at confirmed they had completed an induction to the home and received ongoing support with training. A staff member said, "We have a lot of training and a lot

of it is done on the computer; it is managed electronically so I think I am pretty up to date with everything." Another told us, "I completed the care certificate; it took about three months." The manager told us, "New staff complete the care certificate, and we support staff with NVQ's at level two and above." The care certificate is an identified set of standards that health and social care workers adhere to in their daily working lives.

Training included areas the provider considered essential for all staff for example; safeguarding, managing challenging behaviour, health and safety and infection control and other areas applicable to people's individual needs. We saw this included pressure care, first aid, end of life care and diabetes. We checked training records and competency checks for the safe use of bed rails by staff. This training was not evident. The manager told us they were implementing checks to ensure staff had the required competencies and skills learnt via online learning. We saw these checks had been implemented and completed where staff were involved in the management of medicines. One staff member told us, "We are observed administering medications, which is important to ensure we are doing it right and people receive their medications as prescribed."

Staff confirmed they were supported and received supervisions every three months. A staff member said, "I have a meeting with my team leader; we can discuss any concerns and along with our team meetings I can discuss people's individual needs and any concerns we have." Supervision records included a summary of agenda items discussed, key outcomes or actions and personnel objectives, targets and timescales.

We observed two members of staff use a belt to transfer a person from their chair to a wheel chair. This was done very effectively and the staff member spoke with and reassured the person throughout.

Requires Improvement

Is the service caring?

Our findings

People told us that staff were kind and we observed friendly and warm interactions between staff and people at the home. Staff knocked on the door to people's private rooms and asked if it was ok for them to come in before entering. However, we received a mixed response regarding the care and support people received. A relative told us, "The staff are always very helpful and friendly. They have supported me through a rough time and I don't know what I would have done without them." People in the home told us, "This is the best place they could have sent me." And, "All staff are nice here. They are always feeding you. They don't bother you. You can do what you want." However, one relative told us, "They [staff] are quite caring but they are always busy, there could do with being more on duty." Another relative told us, "[Name] needs the bathroom; it's ok though; we can see they [staff] are busy with other people."

One staff member said, "We are like a family, we help each other out and are supportive of each other." However, one member of staff raised concerns regarding the approach of a team member. They told us, "One member of staff does not address or communicate with people appropriately; people get upset as they raise their voice." They continued, "I have informed the manager but I am not sure what has been done about it." We discussed this with the manager who told us, "I have spoken with the staff member; they were not aware of their actions and the impact they had on people." We saw a record of how the concerns had been addressed informally with the staff member.

We used the Short Observational Framework for Inspection (SOFI). The SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We found that the SOFI confirmed the findings from our other observations. It demonstrated that there were inconsistencies in how the care and support was provided. During the SOFI, we observed some positive, caring and kind interactions where staff provided proactive care and support. However, we also saw examples where the care and support was task orientated and required improvement. Throughout our inspection we observed people waiting to be attended to. Call bells were heard throughout the inspection and these were responded to, but we were concerned that people in their rooms had to wait to be supported with their needs. At times we observed no staff were available in communal areas to support people with their basic needs as the staff member in the room was busy administering people's medicines. We observed people had to wait at meal times to be served and where people stated they did not want to eat, little encouragement was provided.

We observed some good interaction between staff and people as they then left the dining room but once everybody was seated in the communal area interactions reduced and people were seen to be staring into space, fidgeting with sweet wrappers, rubbing hands together, rolling up sleeves or staring at the television and into space.

A relative of a person who was cared for in their own room, raised concerns with us that the person was not mobilised as assessed and was often found facing a wall for several hours after being turned by staff. This was despite the bed having wheels. A member of staff confirmed the person liked to look at pictures and the television. We observed, during our morning walk around the home on 7 June 2017 that the person responded with a smile when asked about the pictures. It was clear they were important part of their well-

being and enjoyment. A member of staff confirmed some staff failed to rotate the bed when turning the person to face the wall and that they told us they found this upsetting.

We found limited evidence to demonstrate that people had been involved in discussions or decisions regarding their care and limited evidence to demonstrate that people were encouraged to be autonomous. Care records included some background information on people but this was often not very detailed. The manager told us, "We add more information into people's backgrounds as part of people's reviews, as we get to know them better." Including information about people's life histories supports and enables staff to deliver person centred care as they then have person centred information which can be used as topics for discussion. This was unavailable.
One person with capacity had an end of life plan but this was signed by the manager and not the person. People's wishes in regards to end of life should always be discussed and if they are unable to sign their care records the care plan should reflect this. There was no other evidence available to demonstrate how the person had been involved in their own care planning and making decisions and so they were not supported to be autonomous.

The above concerns were a continued breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 11: Need for consent.

The manager was aware of when to involve the use of advocacy support. At the time of our inspection nobody had an advocate involved. An advocate can be used to help people to have information in a way they understand to help them with choice independence and control over their lives and associated decisions.

Relatives told us there were no restrictions on the times they could visit people living at the home and that they were always welcomed by staff on arrival.

Staff confirmed they understood how to respect people's confidentiality. One staff member said, "Whatever we hear from people remains confidential; we don't discuss things out of the home or with anybody who doesn't need to know. We hear all sorts of things, if anything were of concern I would speak with the manager."

Inadequate

Is the service responsive?

Our findings

At the previous inspection in November 2016, we found a monthly review of each care plan was scheduled. However, these were not always completed and did not guarantee that care plans were fully reflective of people's current needs. We recommended the registered manager sought advice and guidance on the accurate maintenance of care files.

During this inspection we found care records included pre-admission assessments that had been completed before people were accepted into the home. A health worker confirmed this and told us, "The provider is responsive when assessing people prior to admission; it's reassuring for us to know they will have things in place to meet people's needs when they arrive at the home." This ensured that the service was able to meet the person's individual needs and formed a basis of the ongoing records of care.

We found that pre-admission information was included in live records but had not always been updated to reflect the changes in people's needs. We reviewed Care records for seven people and we were concerned that information was not always current or up to date. This meant people were at risk from staff using the assessment records to provide care and support that was not reflective of people's current needs.

There was no evidence to show that people were involved in reviews of their care or if the changes had formally been discussed with the person, family or legal representative.
Everybody had a file which contained records of their care and support. A front page recorded a checklist for completion by the member of staff responsible for the person's monthly reviews. The checklist included provision for the reviewer to record if an update to the care plan was or was not required. We saw these check lists were initialled but the updated information had not been completed on them. Dates within the care records had not been amended and we were unable to conclude where a person's records had been updated, for example, after a hospital admission or a change in their medical needs.

One care file we reviewed included a care plan that recorded information on care and support for 'eating and drinking'; dated 14 April 2016, 'emotional wellbeing and reassurance'; dated 24 November 2016, 'night care'; dated 24 November 2016 and 'defusing behaviour technique'; dated 5 December 2016. The manager told us the person had previously posed challenging behaviour, but as a result of changes to their medication their behaviour had improved and was no longer deemed to be challenging. An audit check list had been initialled to confirm the documents had been checked but provision on the form to record where any updates in the care plan had not been completed. It was not clear where records of the person's needs had been updated or where care plans had been updated to reflect any changes that staff needed to be aware of.

The manager confirmed that staff responsible for the reviews of people's care records should indicate where changes are made in line with the guidance on the form. However, they advised that despite the omissions that we identified, we should assume the information was up to date. The manager re-printed a form with a revised date and advised us this showed the records were up to date.

Care records included a 'Daily Check List'. This form was meant to be completed daily by staff to record daily activities of care and support for bath, shower, bowels, nail care, hairdressing, catheter care, chiropodist and bed change. These records were not completed regularly in any of the care records we looked at. We saw records for one person from March to May 2017, recorded one full body wash on 13 May 2017. All other dates were not completed. In addition we found that only 19 days of bowel movements were recorded, two days of nail care, one day for hairdressing and one day for a bed change were recorded. The manager told us staff were not necessarily recording everything on the daily records but did record in daily notes. We checked the daily notes and saw additional dates when a full body wash had been given. These were recorded on 13, 17 and 19 March. This meant the systems and processes in place to record and evaluate daily activities of care and support were insufficiently robust, inconsistent and failed to identify areas of risk.

Care records for another person included a patient summary from a GP surgery and this was dated 31 October 2016. This included a printed list of all medications. There was no evidence this information had been reviewed, updated or checked with GP. It was not clear if this information was up to date as a correct reference for staff to follow.

Care was not always observed to be person-centred due to insufficient staff to meet people's individual needs all of the time.

During our inspection visit on 7 June 2017, we observed a very chaotic lunch time period. There was one team leader on duty and three care staff. We observed one person was in the manager's office confused and upset, one person in the communal area was trying to ask for help as they could not locate their glasses. One person, with visiting relatives required the toilet. One person was sitting in the dining room on their own waiting for food. One person was asleep at a table in the communal area on their own as lunch was served in the dining room. Staff were busy supporting people in other areas of the home and were therefore unable to attend to these people who required support.

We observed one person to be upset when they left the dining room. They complained about the noise at lunch time to the manager, in particular about the television and the music. We observed the television was left on quite loud with nobody in the vicinity. The radio was on in the conservatory and loud music played in the dining room. Despite the person's anguish with the noise no attempt was made to change the environment or to find a quiet place for the person to sit and eat as staff were too busy. The manager did not respond well to this person's needs.

During our inspection visit on 16 June 2017, we observed one person who made several attempts to mobilise on their own and asked for somebody to help them. There were no staff in the communal area to support them. Other people were asleep or watching television. The person showed signs of agitation. We observed two staff walked past the person but the staff did not recognise that the person required assistance. We asked a member of staff if they could assist the person. The staff said they would respond and take the person to the toilet but then walked past the person to let a visitor out of the home. The person was left unattended and was not supported.

Care and support was observed to be task orientated and an activities program could not be provided due to insufficient staff. We observed a documented activities program but the manager told us this was on hold and people were not robustly supported with activities of their choosing or group activities. We observed minimal one to one interactions between staff and people. The manager told us the team leader had been given responsibility for the activities program. However, it was not clear how they would fit this into their working day as other responsibilities already took up the majority of their time. These included being part of a team of four to provide task orientated care and support and to manage and administer medicines.

People did not complain. However, some people and their relatives told us they had chosen to live at the home because they liked the rural environment, but we did not observe people being assisted to go into the garden areas. We observed that some people remained in the communal lounge in the same positions throughout the day, moving only for meal times or to visit the bathroom before returning to their chair with very little one to one support from staff.

Other people were observed to be in and out of sleep and lacked any motivation. During this period we observed staff walking through the communal areas, rushing to other areas of the home. We observed staff were not taking note of residents in the communal area who were trying to communicate their needs. One person spoke quietly in their attempt to try and get help as they were slipping further down in their chair.

The above concerns were a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 9: Person-centred care.

The provider had a policy and procedure in place to manage any complaints, concerns or compliments that they received. This included guidance on dealing with complaints and complaint forms. The forms had provision to record the type of complaint, details of the complaint and any actions required as a result.

At the time of our inspection no complaints had been received. One person told us, "I can talk to the manager if I have anything I am worried about, but I haven't got any worries." A relative told us, "I am not happy with the care and support [Name] receives but I don't know who to talk to, I don't want to upset anybody." We discussed the concerns with the manager after seeking the permission of the relative, who immediately arranged a meeting with them.

Inadequate

Is the service well-led?

Our findings

At the previous inspection in November 2016, we found the provider had failed to notify the Care Quality Commission (CQC) of all incidents that affected the health, safety and welfare of people who used the service. This was a breach of Regulation 18 (4) of the Care Quality Commission (Registration) Regulations 2009.

During this inspection we checked and found evidence of accidents incidents that had affected the health, safety and welfare of people who used the service. These were recorded by the provider but had not been evaluated under the safeguarding policy and procedure for further investigation. Where applications for DoLS had been submitted by the provider they had failed to notify the CQC of the outcome of the applications. This meant the provider was in continued breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

At the previous inspection in November 2016, we saw that when audits identified any areas for improvement, actions plans were put in place to rectify the problem. However, these were not always completed. We found that the quality assurance system in place had failed to identify that care plans were not always reflective of people's current needs. Food and fluid charts were not adequately maintained and the weight records were missing. Audits failed to identify that the service was not following the principles of the Mental Capacity Act 2005. This meant that people could have decisions made about the care they received, without their consent. These concerns were a breach of Regulation 17 Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Despite submission of an action plan by the provider to meet the breaches of regulations identified at our previous inspection in November 2016, we found that all the actions had not been completed or updated and reviewed in a timely way. We found improvements to the management and administration of medicines had been implemented and these improvements were effective in addressing the breaches we previously found in medicines. However, audits for medicine management and administration had failed to highlight the concerns we found regarding the application and recording of medicines administered by way of a transdermal patch and the failure to implement body maps to record where creams were applied to prevent dry skin.

The manager showed us audits they completed to check people's care records were up to date. The audits consisted of a spreadsheet with a room number and the persons initial. Dates were added to the spreadsheet when the care plan was audited. This process was completed by the manager. The manager told us the audit process involved the checking of the persons 'Checklist' that we saw was included at the front of people's care plans. We found this document was initialled monthly by staff with responsibility for the person's monthly review. However, we found the checklist process included the requirement for the staff member responsible to highlight if the care plan had been updated or not. This was not completed for the records we looked at. Despite the checklist being initialled as reviewed by staff, we found care plans contained information that we were advised was out of date by the manager. We concluded the checks were ineffective and had failed to identify the associated risks we evidenced during our inspection.

Despite monthly reviews and oversight checks by the manager care plans were disorganised and were inconsistently maintained. Information and other records for people were not always complete, legible or accurate and up to date to reflect people's current needs.

The provider had an infection control policy and procedure and completed health and safety checks around the home. Despite these checks we found breaches of health and safety and areas of the home where we found risks from associated cross contamination and poor infection control. This meant the systems and processes in place were ineffective and not fit for purpose.

We found evidence that the provider had failed to implement effective systems and processes to comply with the Mental Capacity Act 2005. Decisions made on behalf of people who were assessed as having a lack of capacity were not robustly recorded we were unable to evidence that where those decisions had been made they were taken in line with the requirements of the Mental Capacity Act 2005. Care records we looked at failed to include an accurate record of all decisions taken in relation to the care people received and where best interest meetings were required we found reference to discussions with people who used the service, staff and those lawfully acting on their behalf had not always been recorded. This included consent records and advance decisions to refuse treatment.

There was no system in place to ensure staffing levels and skill mix were continuously reviewed and adapted to respond to the changing needs and circumstances of people using the service. The manager told us they had a staff dependency tool. However, they confirmed this was not in use at the time of our inspection. This meant sufficient staff could not be guaranteed to ensure people were always supported with their needs and preferences.

The manager showed us a 'service user questionnaire for 2017 that included an evaluation of an anonymous survey received from 17 people. The evaluation included responses to questions that had been scored as 'not very satisfied' and 'quite satisfied'. Other areas were rated as very satisfied. The manager had not completed an action plan to address those areas for improvement and advised us they were trying to find out who the respondents were so they could address those concerns individually. After the inspection the provider showed us minutes of a staff meeting where some areas for improvement as a result of the questionnaire had been discussed.

As a result of the above concerns we found the provider was in continued breach of Regulation 17: Good Governance of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Before this inspection we checked the provider's web site on 01 June 2017 and found the web site did not include the previous inspection rating. We checked the home on the 07 June 2017 and found the provider had failed to display the previous inspection ratings in the home. The manager told us the ratings had not been published as they needed to prepare and print out a response to provide people with further narrative regarding the rating. The ratings were then displayed in the home by the end of our first day of inspection with additional narrative and published on the web site. This was a breach of Regulation 20A: Requirement as to display of performance assessments of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us they were supported in their role and knew what was expected of them. However, we were concerned regarding the limited resources available to manage and drive the required improvements forward. A member of staff told us how they were responsible for day to day care and support but also had responsibility for other staff, medicine management and administration and had also agreed to implement and run an activities programme. We saw all staff were continuously moving around the building but care

and support was task led. The manager discussed how actions regarding the breaches at the last inspection had focused on the highest areas of risk; medication and care plans. They told us the team leader responsible for the care plan improvement process was away from work and that this had impacted on implementation of the improvements.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered provider had failed to submit notifications for the outcome of applications to the local authority for DoLS for people.

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care and support was not always centred on the person or appropriate to the current needs. There was little evidence to suggest people were not always involved in their care and support. Where people lacked capacity care and support was not always provide with regards to the Mental Capacity Act. Reviews of people's care records were not robust.

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Consent was not always obtained from the relevant person with regards to their care and support. Decisions were not always made and recorded in the persons best interest.

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered provider failed to ensure systems and process were in place to mitigate the risks associated with peoples care and support and equipment used in the home. This included the use of bed rails and window restrictors. The home and environment was not always clean and the registered provider had not done all it could to prevent, detect and control the spread of infections, including those that are health care associated.

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Information and records for people's nutritional needs was not robustly maintained. People were not always supported to eat and drink in line with guidance in their care records.

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not effective in identifying and responding to the concerns we found and to drive forward improvements required to ensure the service was compliant. The registered provider had failed to maintain securely, an accurate and complete record of each service user.

The enforcement action we took:

NOP to cancel registration

Regulated activity	Regulation

Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The registered provider had failed to ensure the previous ratings had been displayed on the provider web site and in the home.

The enforcement action we took:

Fixed penalty notices

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to implement systems and processes to ensure sufficient staff were on duty with the required skills and experience to meet with people's holistic needs all of the time and to review staffing for it's effectiveness.

The enforcement action we took:

NOP to cancel registration