Mosaic Community Care Limited

Fresh Fields Nursing Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

We carried out an inspection of this service on 19 and 20 April 2016. The inspection was unannounced. This meant the provider did not know we were coming.

The home was last inspected in July and August 2015 where we found breaches of the regulations in relation to person centred care, consent, premises and equipment, good governance, staffing, notifications and medicine management. Notifications are things providers must tell us about which affect people using the service. We checked at this inspection to see that action had been taken to meet these regulations.

Fresh Fields Nursing Home is a purpose built home set in the grounds of Wythenshawe Hospital. The home provides nursing and residential care for up to 41 people. At the time of the inspection there were 32 people living in the home. The home is spacious with a large communal area on the ground floor with an open plan dining area attached. There are separate lounges throughout the home which have their own small kitchen area for residents and their visitors to use. The main kitchen and laundry facilities are on the ground floor of the building and there is also a hairdressing salon. All floors are accessible by a lift and stairs.

The home did not have a registered manager in post. The service is required to do so and was therefore in breach of this regulation. 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 persons'. Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. We found the lack of a registered manager over the last twelve months had significantly impacted on the quality of the service provided at Fresh Fields Nursing Home. Details can be found in the main body of the report.

After the last inspection in 2015, the provider sent CQC an action plan to show how they would meet the regulations. We found some areas of the action plan had been completed but others had not.

At the last inspection in 2015 we found there were not enough staff to meet the needs of the people using the service. Since then, the staffing levels had been increased and over the two days of the inspection we saw there were enough staff to meet people's immediate needs in relation to personal care and medicine administration. However, we found the home was still in breach of the regulation relating to staffing because staff had not been appropriately trained and this impacted on the quality of care some people received.

We reviewed people's care files and found improvements had been made since the last inspection. We looked at risk assessments and saw there was comprehensive information to identify what the risks were to people, and staff we spoke with knew how to keep people safe.

We saw individual plans were available to support people in an emergency. They contained enough information about how to mobilise people if they needed to be evacuated from the building.

At the last inspection we found there was a breach in relation to person-centred care. This was because people were not always involved with planning their care. At this inspection we found improvements had been made which meant some people had had more involvement in care plans relating to their clinical needs, but we did not see any person-centred care plans for people who were living with dementia or who did not communicate in conventional ways. This constituted a continued breach of this regulation.

We found staff were recruited safely. Suitable checks were made to ensure people recruited to posts were of good character and had appropriate experience and qualifications.

Whilst reviewing how the home managed and administered medicines, we found improvements had been made since the last inspection; for example the introduction of a more robust system of recording on Medicine Administration Records (MAR). However we still had a number of concerns. These included people running out of medicines and staff not keeping a record of when, where or why they were administering creams. We found some people were not receiving their topical medicines and some other medicines as prescribed. The home was therefore still in breach of the regulation about how they managed and administered medicines.

When walking around the building we noted whilst people's bedrooms and communal areas were mostly clean and tidy, bathrooms and bath chairs were not and the home was in need of new carpets and redecoration in some areas. At the last inspection in 2015 we found breaches in relation to the safety of premises due to issues with infection control and unsafe flooring which presented a trip hazard. At this inspection we found improvements had been made and were shown plans the provider had to improve things further, including plans to fit a new carpet within the two weeks following our inspection. We considered the provider had done enough to comply with the regulations but that improvement was still needed in this area.

We reviewed the information and support available to ensure people received enough nutrition and hydration. Records kept to monitor people's intake of food and fluids were poorly completed, inaccurate and did not outline why people were being monitored. Whilst we did not see that anybody at was at risk, we asked the provider to review their current system of recording and monitoring the food and fluid intake to ensure it was done correctly for those people who needed it.

There was no system in place to assess people's capacity to consent to care and consideration was not given to the principles of the Mental Capacity Act 2005. We found this at the last inspection in 2015. This meant the provider was still in breach of this regulation.

The people who lived in the home and their visitors and relatives were positive about the staff. We saw examples of staff interacting with people in positive and caring ways but it was clear that at times they were simply too busy and some interactions were rushed or missed. We therefore found improvement was needed in relation to how some staff carried out interventions.

We noted that information regarding people's use of glasses, hearing aids and dentures was prominent in their files and staff were prompted to ensure people had these items at all times.

We saw a complaints procedure was available within the home and on notice boards, however people we spoke with were not happy with how complaints they had made had been managed.

We were told and it was clear that staff morale at the home was low.

At the last inspection in 2015 we found breaches in relation to good governance. This was because there was a lack of leadership and management within the home which meant quality audits were not being completed and the quality of care being delivered was compromised as a result. We found little or no improvement at this inspection and so this was a continued breach of the regulation.

The kitchen and laundry were organised with appropriate risk assessment and cleaning schedules in place in the kitchen. The provider had recently purchased new equipment for the kitchen and they had scored a hygiene rating of five out of five at the last local authority inspection. We found improvements had been made since our last inspection.

Although improvements had been made since our last inspection, we found a number of areas where improvement was still needed. We therefore placed the service into 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.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see the action we have asked the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were not managed safely.

Improvements had been made in relation to infection control and safety of the premises although more work was needed.

There were suitable plans in place to support people in the event of an emergency.

Is the service effective?

Inadequate

The service was not effective.

The service did not support people in line with the principles of the Mental Capacity Act 2005.

Staff's skills and knowledge were not up to date as they had not received appropriate training.

The service worked well with other health care professionals and made referrals as required to meet people's holistic health needs.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider did not provide people with explanations or involve them in things which may affect their health and well-being.

People we spoke with told us the staff were very nice and considered trustworthy by them.

We observed that staff were very busy but when opportunities arose, they spoke with people in a respectful and caring way.

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive person-centred care.

People felt their concerns and complaints were not actioned appropriately.

People had access to activities within the home which they said they enjoyed.

Is the service well-led?

Inadequate

The service was not well-led

There had been no registered manager in place for over 12 months. Leadership was lacking which impacted on the quality of service delivered.

The provider did not monitor the quality of the service and had not adhered to their registration requirements,

There was mistrust between the people who used the service, their families and the provider. There was not a culture promoting openness and transparency and staff morale was low.

Fresh Fields 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 functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 19 and 20 April 2016 and was unannounced. On the first day the inspection team included two adult social care inspectors, a pharmacy inspector and a specialist advisor. The specialist advisor was a registered general nurse. On the second day the inspection team included two adult social care inspectors, a specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of older people's services. The specialist advisor was a registered mental health nurse with specialist knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

Before our inspection, we reviewed the information we held about the home, requested information from Manchester City Council and sourced information from other professionals who worked with the home. We looked at notifications we had received from the service and reviewed action plans sent to us by the provider after the last inspection with the improvements they said they were going to make.

During the inspection we spoke with 10 staff including the provider, nurses and carers. In addition we spoke with the chef, assistant chef, kitchen assistant, administrator, finance manager and the laundry and domestic staff. We also spoke with three visiting healthcare professionals including district nurses, plus nine people who lived in the home and nine visitors.

We observed how staff and people living in the home interacted and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We observed support provided to people in the communal areas, including the dining room and lounges during lunch, during the medication round and when people were in their own rooms. We looked in the kitchen, laundry and staff office and in all other areas of the home.

We reviewed 8 people's care files, including medicine records and looked at care monitoring records for personal and nursing care. We also looked at five staff personnel files.

Requires Improvement

Is the service safe?

Our findings

Before the inspection we had been made aware of a number of concerns people had about the quality of care people were receiving at Fresh Fields. We had also received feedback from Manchester City Council (MCC) and the Clinical Care Commissioning Group (CCG) about their concerns. At the inspection in July/August 2015 the service had been rated as Inadequate in this domain and we needed to check whether sufficient improvement had been made.

To do this we spent time over the two days obtaining feedback from the people who lived at the home, their families and the staff team to ascertain if people were safe.

All the relatives we spoke with told us they had no immediate concerns for their relative's safety but did worry about the pressure staff were under and how this may impact on their family member's care. One person told us, "The morale of the staff is poor, I don't understand why as they are absolutely fantastic. They are just rushed off their feet", and a second person said, "Weekend staffing is sparse, [my relative] tells me sometimes they don't come."

Another person said, "They are terribly short staffed; they are run off their feet. I've been quite happy with the care but the atmosphere at the home is a bit down, there is no continuity of staff. There is poor communication between staff and management. I was told by a staff member at the beginning of the year they wanted to call in bank staff but had been told they couldn't."

We were aware of a recent crisis at the home. Staff told us they were unable to source agency staff as invoices had not been paid. They said this had put them under pressure as they did not want to leave people living at the home because they were vulnerable. The Local Authority and the CCG had attended the home during this time to ensure people were safe and had then shared their concerns with us.

During the inspection we were made aware that some of the nurses and staff had worked excessive hours to ensure people were safe. We spoke with the provider who acknowledged this situation was not acceptable and had started to put things in place to ensure it did not happen again. The newly appointed finance manager confirmed invoices had now been paid and agency staff could again be used. On the second day of our inspection there was an agency staff member present within the home; they had worked at the home previously and knew the people well.

One staff member told us, "Yes, staffing levels are just about okay now. We don't have much time to spend talking to people. That could be better." We spoke with the two registered nurses on duty who informed us that they were the only registered nurses employed substantively by the care home. They also told us that they did a great deal of overtime to provide cover and that other shifts were covered by agency nurses. We found that although there was sufficient nursing cover on both days of inspection, this was mainly due to the fact the home had 10 empty rooms. If the number of residents increased then there would not be enough staff. We therefore asked the home to enter into a voluntary undertaking not to admit any more people until the appropriate arrangements had been made. We also spoke with the local authorities and

clinical commissioning groups to ensure the home is closely monitored so that people are kept safe.

We reviewed the dependency assessment completed by a previous manager. This was used to determine the support needs of the people who lived in the home. We found a number of inconsistencies within the assessment as levels of assessed need differed to what was recorded in people's care plans. We also found the assessment had not been used to identify an overall risk score, making it difficult to identify correct staffing levels.

We carried out observations throughout the two days and saw there were enough staff to meet the basic care needs of the people using the service. Staff were kept busy throughout the day but spent a disproportionate amount of time writing in care plans. The provider showed us the new electronic 'CareDocs' system they had introduced to ensure care and support needs were recorded more effectively. Whilst we saw this was a good system, its effectiveness was compromised as staff were not using it properly. The provider explained this was because staff needed more training and some were apprehensive about using an electronic system.

We were told by the provider that they were currently recruiting for a registered manager and a clinical lead. We saw the home was using a recruitment agency to select candidates for these positions and to help them through the selection process to recruit the right candidates. This meant the provider had started to make improvements to ensure the staff were appropriately supported within the home. We will closely monitor this and check progress at the next inspection.

We looked at medicines management, as this was an area the home were breaching regulation at the inspection in 2015. At that inspection we found medicine was out of stock and proper records were not kept of medicines administered. At this inspection on 19 April 2016 we found sufficient improvements had not been made and medicine was not always administered correctly.

For example, one person had been prescribed Solaraze gel. This was labelled, 'emergency supply to be used twice a day for 3 months'. Instructions on the printed Medicine Administration Record (MAR) read, "To be applied daily" and we saw that according to the MAR the gel was only being applied at breakfast time. The discrepancy in dose frequency had not been queried to determine what was correct.

When asked if they believed their relative was safe at the home, one family member told us that in general they felt the person was safe but had concerns about the management of agency staff and their competence. They told us, "[My relative] was handed some liquid medication by the agency nurse. I was aware that [they] had been taken off that particular medication. The nurse just said "Oh this must be yours then" and handed it to [name]. [Name] cannot speak but [they] refused it. I reported it to [manager] and was told she would deal with it and ensure that the agency did not send that nurse again. She has left now and I don't know what has happened."

We reviewed the medicine receipt, storage and administration systems in place. We saw most people's medicines were administered from dosette boxes provided by the pharmacy with other medicines supplied in boxes or bottles. Dosette boxes are blister packs individual to each person. They contain tablets for each day of the week and time of the day according to how they are prescribed. This is a system designed to reduce the risk of administration errors. We also found a large quality of fortified juices and thickeners stored in the communal kitchen areas throughout the home. This meant there was a risk that people could access products prescribed to others and demonstrated a lack of understanding of the importance of safe storage of medicine. We also noted that one person had half a cup of fortified shake on the table in front of them all day. Before we left we checked the MAR and saw that the MAR had been signed by the nurse in the morning

to say that the person had drunk the shake.

MARs were not up to date and there were gaps in recording. We saw that one MAR had been altered with dates crossed out as the GP had recommended the medicine stop although there was no information or record to support the change. We could not track this to ensure the person was receiving the correct medication.

We noted medicines prescribed 'as required' had no medicine care plans to inform staff when they should be administered. Medicine care plans identify signs and prompts for when the 'as required' medicines would be needed. Not having medicine care plans in place for 'as required' medication could mean that people were not receiving medicines when they needed them.

Topical creams and lotions were kept in people's rooms and in bathrooms. None of the creams had an administration record or corresponding body map to show where the cream should be applied. Some creams were prescribed 'as required' but there were no details of to explain when they would be required. We saw creams and lotions were not being signed as administered according to the instructions. For example, one person's cream should have been applied twice daily, but the person told us it was applied once a day. We asked staff how they knew how often to apply a particular cream. One staff member told us, "I look at the person's skin and decide." Whilst staff thought they were doing the right thing, we found people were not protected from the risk of unsafe care or treatment as they were not always receiving topical medicines as they were prescribed.

We found one person had run out of their medicine yet the nurse had written "W" for withheld on their MAR. This was not an accurate record of the administration of this medicine. We spoke to the nurse on duty who told us they were not aware this medicine had run out. Another person was prescribed pain relief once a week. The pain relief patch they were prescribed was classified as a controlled drug (CD). We saw CDs and other medicines were stored securely, however the room temperature was consistently high which would compromise the integrity of some of the medicines. Due to the nature of controlled drugs extra vigilance is needed for their storage and administration. According to the person's MAR and the record in the CD register, the patch due on 12 April 2016 had been applied a day late, on 13 April. No reason for this was recorded on the MAR, in the CD register or in the records on the computer. This meant that the person could have been in pain unnecessarily.

We looked at the topical medicines and found two which were prescribed more than four weeks before the inspection. These had not been labelled on the date they were opened. Both medicines had a 'use by' date of four weeks from being opened. This meant that it was impossible to tell if they were out of date. When medicines are not dated at the time of opening there is a risk that people will receive medicines after their use by date and this might cause them harm. We were told the home had stickers with dates on for this purpose but they were not in use at the time of the inspection.

We found that people who lived in the home were not receiving all of their medication as prescribed by their doctor. We saw records were not kept accurately and basic procedures were not followed. These Included procedures for ensuring medicines did not run out or were still within their use by date.

We spoke with staff about how the risks to people who lived in the home were handled on a day to day basis. Staff told us they attended handover meetings where information was exchanged about each person who lived in the home. We observed a handover between nurses in the morning and although rushed we saw important information was shared between staff.

We reviewed records to ascertain how the home managed accidents and incidents. We saw these had been completed sporadically and only when there had been a manager in post. This meant there were gaps in the recording of accidents. Therefore the provider could not identify trends and patterns to prevent accidents and incidents reoccurring so preventative measures could not be planned.

We found breaches of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Each person who lived in the home had a Personal Emergency Evacuation Plans or PEEP. They were kept in people's files and also in a folder behind the door in the manager's office. This meant they were easily accessible in the event of a fire and would help frontline staff to support people safely.

Inadequate

Is the service effective?

Our findings

We asked people and their relatives what they thought of the food at the home and how it was served. The general feedback was that the food was poor and there was not enough of it. Comments included, "The food is not very good and it can be cold," and, "Food is diabolical. Not enough fresh fruit."

We saw one person had a sign above their bed reminding staff to ensure the person had enough to drink. A visiting relative told us, "I don't think [my relative's] getting enough fluids; the sign was put up by [previous manager] to make sure [they] always has a drink." Another person told us, "I like the food and if I don't then I can have something else, I just ask."

Walking round the home we noticed people had snacks and drinks in their rooms. These had been brought in by family members and visitors. One visiting relative told us they would often bring food in themselves so they could be sure their relative had enough to eat. They told us that they visited every day and had never seen people being offered food or drinks after the kitchen closed. The relative described how they had to bring their own bread to make toast and drinks for people at the home as there was none at the home. We checked the kitchen downstairs and saw there were stocks of bread but none in the satellite kitchens upstairs.

We spoke with the kitchen staff who told us they used to make a tray of sandwiches for people to access if they got hungry after 6pm when the kitchen closed. They told us they no longer did this as there was too much wastage, but staff could access the kitchen if people wanted something to eat.

We spoke to staff and asked them whether people received any snacks or were offered any supper. One care worker told us, "If people are hungry, they will ask and we will always make them something." As some of the people using the service were living with dementia we did not consider this an appropriate response as these people may not be able to express their wishes.

During both days of inspection we saw tea and coffee was offered throughout the day and juice was available in a dispenser in the downstairs dining area. This meant people sitting downstairs had access to a drink whilst those being nursed in bed and those who sat upstairs did not.

We therefore found improvements were needed to ensure people had access to, and were offered snacks and drinks throughout the day and night if required.

The home had recently introduced an online system for recording and monitoring people's care needs. The system was called CareDocs. We checked the online care plans of five people who were at risk of malnourishment and found electronic records were incomplete. People's weight was not always recorded weekly as required by their care plans and food and fluid records were not maintained on a regular basis. However, a few of the family members we spoke with told us that their relatives who lived in the home had gained weight since moving there. We checked the care plan for these people and could see that there was a nutritional plan in place to support them with their weight gain. We also found some of the information

missing from the CareDocs system was handwritten in people's care plans. We spoke with the provider who told us further training was required to ensure all staff were confident using the online system.

We spoke with staff who were able to tell us about the people who were at risk of malnourishment and saw them completing food monitoring charts at lunch time. We noticed that charts were being completed for everyone who lived at the home. We asked the staff member why they completed charts for people who were not identified as being at risk of weight loss. They told us that this is what the nurses had said they must do. We noticed that a large proportion of time was spent filling in these charts by the staff during the lunch time period which meant less time was being spent in meaningful activities, conversation and interaction with the people living at the home.

We spoke with the nursing home team from the hospital and nurses from the clinical care commissioning group who were also present on the second day of inspection. They said they believed that people were being nursed appropriately but confirmed that significant improvement was needed in the leadership and management of the home to ensure nurses and care staff had the time to properly record and monitor the care they were delivering. We also found nursing staff needed more time to ensure care records were completed properly and people received the correct level of support to meet their nutritional needs. We found the lack of effective monitoring, and the gaps in the records were part of the wider problem resulting from inadequate leadership and management and were a breach of Regulation 17 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found there was a breach of regulation relating to the skills and knowledge of some of the staff. We checked to see if improvements had been made.

We reviewed five personnel files. We found staff had not completed training for the 12 months prior to our inspection. We requested the training matrix from the provider which they sent to us after the inspection. Staff we spoke with told us they had not had a team meeting for "some time" and no one we asked had received an appraisal in the last 12 months.

Some of the staff told us they had not received supervision in the last 12 months but we did see evidence of supervisions in the personnel files we looked at. Staff told us they had received supervision from a senior carer and that different staff groups got together to discuss concerns and issues. However there were no minutes of these discussions to ensure staff unable to attend were made aware of the issues.

We wanted to check how well the staff knew about the care needs of the people they were supporting. We looked in one person's file and saw they needed to be encouraged to use the toilet every two hours. We spoke to two staff about this person and asked how much support they needed with their personal care. One staff member told us, "Getting up, after lunch, and after dinner." We asked if they knew what the care plan said about toilet frequency and they told us they did not. They then went onto say this person did not use the toilet and used a continence pad instead." This did not show respect for the person being supported nor did it help promote their well- being or independence.

Relatives we spoke with told us staff needed more training specifically in how to support people living with dementia. We spoke to the provider about available training and they acknowledged there was a need for more specialised training. We spoke with staff who said they would like more training to better understand the people they supported who were living with dementia. Two of the staff told us they had received training but this had been in a home they had previously worked in.

We found the on-going lack of training and support and the lack of insight by staff of the impact their lack of

knowledge may have on the individuals they support was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 to 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).

At this inspection we found that staff working at the home, including nurses, had no understanding of the Mental Capacity Act 2005 or the process which should be followed if someone needed to be deprived of their liberty.

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. At the inspection in 2015 we found there was a breach of regulation in relation to the lack of consent people had in relation to their care at the home.

The MCA clearly states that all people should be assumed to have mental capacity until all the proper tests and assessments have been done in accordance with the Act. We found there were no formal capacity assessment tools used and no mental capacity assessment documentation in people's care files. Staff we spoke with made an assumption that people did not have capacity.

There were no assessments of whether people lacked capacity to decide whether or not to accept care or treatment in line with the Mental Capacity Act 2005 or whether the person's needs could be met in a least restrictive way. Although family were consulted there was an obvious lack of involvement of advocacy services. All the care files we that were reviewed contained a standard assessment page; each person had the same information with the name changed stating that they lacked capacity.

Staff we spoke with were not aware of the importance of a formal Mental Capacity Assessment and the requirement to gather evidence to support the final best interest decision to deprive a person of their liberty.

We spoke with the staff member we were told was responsible for mental capacity assessments and DoLS applications and asked them how people's capacity was determined. They told us, "If they [the person] are confused, and this is often the case, they will be seen as unable to make decisions for themselves." We found the staff member was unable to explain the basic five principles of MCA or how they would achieve an informed outcome.

We checked care records for four people for whom applications for a DoLS had been submitted. We found some information in people's care files was confusing. For example in two people's file it stated they did not have capacity to make decisions but on a best interests form it stated that they had consented to having bed rails fitted. We found that decisions made to deprive someone of their liberty were not carried out in line with the MCA which meant people's rights were not protected.

We spoke to one of the two nurses who worked at the home full time about their understanding of DoLS and whether they had any involvement in capacity assessments. They told us they completed a risk assessment if bed rails were deemed to be needed and that, "They don't have anybody on DoLS". We asked again about bed rails and whether capacity assessments were done to gain people's consent for using them. They confirmed they did not carry out capacity assessments. This again meant people's rights were not protected in line with the Mental Capacity Act 2005.

The lack of capacity assessments and poor compliance with the process for DoLS was a breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the agency nurse on duty and found they had a good understanding of the Mental Capacity Act, assessment of capacity and its importance. However their experience did not come from working at Fresh Fields Nursing Home.

Requires Improvement

Is the service caring?

Our findings

We asked people who lived in the home and their relatives about the relationships they had with staff. Most of the comments from family members were positive about the caring attitude of the staff but all felt lack of leadership and management in the home had significantly impacted on the morale of the staff.

We received a number of comments from both people using the service and their families about the staffing levels within the home which they felt impacted on the quality of care they received.

Comments included, "We all get on well, most staff are kind and when they have the time they talk to me", and, "I've been quiet happy with the care but the atmosphere at the home is a bit down, there is no continuity of staff. There is poor communication between staff and management."

Another person told us, "Weekend staff don't have the time to treat people as individuals, they just move them around, it needs someone to organise staff, they should have team leaders, [manager's name] used to challenge other staff actions but there is no one doing it now."

Over the course of the inspection we observed how staff and people who lived in the home interacted. We saw staff were caring and respectful in how they spoke with people. We saw when people made requests wherever possible staff did what they could. However, we also saw that some staff appeared stressed and rushed.

During the inspection we heard one person shouting and in apparent distress behind a closed door. We approached the door and it became apparent two staff members were providing personal care to this person. We heard staff speaking to the person in a kind and reassuring way, agreeing that they would get a nurse to look at something they were unhappy about in relation to this person's physical health. We observed the staff member leave the room and saw they knocked before re-entering when they returned a short time later. We later spoke with this person who told us, "They are very kind to me, I'm quite happy here."

We saw the CareDocs system enabled the home to plan end of life care and we spoke to one person's relative in relation to this. They told us, "We discussed a care plan and that [my relative] wants to die here and not in hospital. We discussed an end of life care plan at the end of last year." This relative went onto tell us that the home involved them in decisions about their family member who lived there and they had no concerns with the quality of care being offered to their relative. This meant appropriate support was being planned to ensure appropriate care was given to people at the end of their life and in line with their wishes.

The same relative also told us they had no concerns about privacy and confirmed staff always knocked before entering their relative's room. We observed staff doing this throughout both days of the inspection.

We spoke with staff and the people who lived in the home about how the care plans were written and reviewed. The people we spoke with who lived in the home had not seen their care plans. Staff we spoke

with told us they updated and reviewed plans without involving the people but that family members were often consulted when plans were reviewed. We found improvement was needed to ensure people who use the service are more involved in the planning of their care.

We completed two SOFIs (Short Observational Framework for Inspection) during the inspection. We use SOFI's to help us ascertain the quality of interaction between people who required support and the staff supporting them. We saw a mixture of good practice and some where improvement was needed. One SOFI was completed early in the morning as people were being assisted through to the lounge. We noted one person was already seated in the lounge area when we arrived at 7am. We saw this person had been given a cup of tea and looked relaxed and comfortable. We then observed people being brought through to the lounge at their leisure. We noted that throughout the morning staff would ask people if they wanted to get up or stay in bed and asked them where they would prefer to have their breakfast. We saw that people's morning routine was relaxed and unhurried. This was a good example of how the staff promoted and respected the independence of each person by respecting their choices.

However on the second day of inspection we found the atmosphere in the home was not as relaxed as it had been on the first day. We were informed one of the nurses was off sick that morning which we were told had then impacted on the morning routine. During the day we observed some of the interactions between the staff and the people they were supporting were not as positive as they could have been. For example, we saw some staff talked over the heads of people including making comments as to how they were that day in comparison to other days. Staff spoke about people's conditions and care interventions openly in front of other people. Staff also did not respect people's personal information as they should. We saw people's care files open on tables in the dining areas where visitors and other people could access them. We found this compromised people's right to confidentiality and improvement was needed to ensure care plans were not left visible to people who were not privy to the information.

At mealtimes, we saw some staff sitting with the person they were supporting, making eye contact and conversation throughout the intervention, whereas others stood up to support a person to eat and appeared rushed and flustered. Mealtimes offer an opportunity for people to sit together with staff and interact in a positive and meaningful way. We discussed with the provider the importance of ensuring the mealtime experience was a positive one for everybody. We found that improvements were needed at mealtimes to ensure staff were given enough time to support and interact with people so that they could enjoy their dining experience.

Inadequate

Is the service responsive?

Our findings

Before the inspection we had received a number of concerns in relation to how the provider responded to complaints and concerns raised by people who use services, their families and stakeholders.

Due to the lack of consistent leadership and management at the home we were unable to find a comprehensive log of complaints which had been made. We therefore spent time during the inspection listening to families experience and speaking with visiting healthcare professionals to obtain feedback about their experience.

Comments included, "Three weeks ago I noticed bruising on my [my relative's] hands. [My relative] said it was the night time care staff. I reported it to [manager at the time] as I'd not seen anything before." They told us they had not been informed of the result of their complaint as this manager had since left.

Another family member told us, "I came about three weeks ago [my relative] had not been shaved, I complained to [manager at the time] and she said I'd get a response within 28 days. I've heard nothing", and, a third family member said, "Three weeks ago there was excrement on the wall and [my relative's] teeth had not been cleaned. I've had meetings with the new owners. It's a lack of staff, more so at weekends. I shouldn't be worrying about [my relative's] care."

We spoke with nine relatives and all of them told us they had raised concerns or made complaints and were unhappy with the response from the provider. They told us they were mainly satisfied with the way the staff supported their loved ones but were extremely concerned about the lack of leadership and management within the home. One said, "The new owners simply don't care."

We spoke with the provider about these issues and they acknowledged more should have been done to alleviate people's concerns and anxieties. We found the lack of robust systems to record, respond to and monitor complaints was a breach of Regulation 16 (1, 2, 3a, b, c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with people and carried out observations about how they spent their days. Some people told us there was not much to do. On the first day of inspection we saw the activities co-ordinator facilitating a game of bingo which people were seen to enjoy. On the second day there was a game of giant dominoes , which did not appear to be met with as much enthusiasm. We spoke with the activities co-ordinator and it was clear they were passionate about their role and were highly thought of by the relatives we spoke with. We were shown an activities file which the co-ordinator had devised with a record of which activities people enjoyed and which they did not.

Whilst we saw activities taking place in the downstairs lounge the people upstairs were not seen to be encouraged to participate. Although we were told there was no difference between the floors, we found there was a difference in the level of engagement people experienced. People in the upstairs lounge sat with the TV on all day and there was limited conversation or interaction with staff. In addition, we did not see

people who were being nursed in bed participate in any activity or one to one conversation other than at medicine rounds and mealtimes.

We spoke with people about what they would like to do. One person said, "Going out in the garden would be lovely, it's beautiful day." A family member we spoke with said, "Facilities like the garden are not used, nothing is proactive, we have to ask for anything ourselves. It's a beautiful warm day. This garden should be full of residents getting a bit of fresh air." We mentioned this to staff who then assisted people sit outside if they wanted to, which several people did.

At the last inspection in 2015 we found breaches in relation to the provision of person-centred care, so we looked to see if improvements had been made. Person-centred care planning is particularly important when supporting people who are living with dementia or do not communicate verbally. This is because people who live with dementia can sometimes feel they are living in a time and place from their past. They may behave in a way they did at that time of their life and recognise faces and people from that time and place but not those from the present. Understanding about people's lives and histories can help staff understand about why people behave in a particular way. Staff can then provide appropriate support and assurances to people who may be distressed, confused or afraid.

We spent time during the day interacting with people in the downstairs dining area and observing how they were supported. We noted one person was unable to communicate with us in a way we could understand although they clearly understood what we were saying to them. We asked this person to respond to our questions by pointing to 'yes' or 'no' which we had written on our notepad. This person was able to tell us they were safe and happy but became increasingly frustrated as they clearly wanted to expand on their answers beyond a simple yes and no.

We spoke with the activities co-ordinator about how they communicated with this person and if they used any techniques, such as word or picture books to assist. The activities co-ordinator advised us they knew the person well and could tell from their expressions what they required. We asked some other staff how they communicated with this individual and they told us they relied on the activities co-ordinator as a 'translator.'

With the permission of the individual we looked in their room and found a communication book which contained some information about how they communicated. It was in a poor state of repair and pages had been left blank. It was therefore not clear to us how this person would indicate to agency staff or staff who did not know them well what they wanted or needed or if they were in pain. This meant the home did not work to ensure people's mental health and wellbeing was protected by ensuring care and support was person centred and responsive to their needs.

Care plans we looked at addressed people's clinical needs but there was nothing to tell staff about the person before they came to live at the home. Staff confirmed most of the people living at the home were living with dementia. There were also no dementia care plans to guide and inform staff about the individualised emotional care and support needs of the people at the home.

We found the CareDocs system, if used correctly, a good tool to use to plan care and support in a person centred way. However the care plans we reviewed on line were filled in generically and the information had been cut and pasted from one plan to the next. They were not individualised and not person centred.

We therefore found there was a continued breach of Regulation 9 (1a, b, c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at whether assessments for people living at the home were regularly reviewed and updated. We saw they were but found gaps in the recording on the CareDocs system. We spoke with the nursing home team who were visiting and asked their views on how the home assessed and monitored people's care needs. They told us, "It's been impossible as they [the nurses] have not had management supervision or clinical supervision. If they were given time and training and support they could do it. The nurses feel panic-stricken if they have a day off."

We found the failure to ensure records were up to date and accurate was as a result of the lack of leadership and management within the home. This was a breach of Regulation 17 (c) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service well-led?

Our findings

We had received a number of notifications sent to us to tell us about concerns people had about the lack of leadership and management in the home. All of the complaints we had received related to the fact that the home had had six managers over the last twelve months.

After the last inspection in 2015 we had met with Manchester City Council, the Clinical Commissioning Group and the provider of the home to seek assurances that the provider would address the issues we had raised. As part of this inspection we checked to see if improvements had been made.

At this inspection we found the provider had started to address some of the issues which staff were unhappy about. This included unpaid wages and invoices and new equipment which was needed. The provider had recruited a finance manager who confirmed they were in negotiation with contractors for the provision of services within the home such as clinical waste removal and food supplies. A new payroll system was being introduced which meant staff would get the correct wages at the correct time. Kitchen staff confirmed new equipment had been purchased and the provider had ordered a new carpet for the downstairs corridor which had been an on-going concern.

We saw some safety checks had been done and that all the equipment had had the correct safety checks in place in line with manufacturer's specifications.

In relation to the management of the home, comments from people who used the service and their relatives included, "Nobody is managing the staff, they clearly don't understand [my relative's] issues", "I raised these issues with [the provider] about nine months ago, nothing has changed. She takes the problems on board but doesn't know how to cope with them" and, "There's no direct leadership, they need to spend some money." One person who used the service told us, "The problem here is that the owner doesn't want to spend money. That affects everything really doesn't it?"

We spoke with people who used the service and asked them who the manager was. None of them knew but most thought it was one of the nurses. Staff we spoke with also said they thought the nurse was their immediate line manager. This lack of structure and leadership within the home over a twelve month period had resulted in a deterioration of staff morale and trust in the provider. We spoke to the provider about this and they acknowledged they had a lot of work to do to gain the trust of the staff, people who used the service and their families, as well as other healthcare professionals.

We were told staff were proud of the relationships they had built with the people who lived in the home. Every staff member we spoke with told us they felt the home had done well in very difficult circumstances. Visitors we talked with spoke kindly of the staff and were very clear the issues at the home stemmed from a lack of leadership and management and not the staff themselves.

At the last inspection we found the provider was in breach the regulation relating to good governance. This was because they had not ensured appropriate checks were done to monitor and improve the quality of the

service. We checked the audits which had been carried out. We found despite some good systems for recording and monitoring the quality of the service these had not been used consistently or at all. This meant the provider had no oversight of the issues within the home and had not taken responsibility for ensuring this was managed. This had resulted in a breakdown of trust between the staff, families of people who use services and the provider.

We spoke with a visiting healthcare professional about how the home had responded to any issues they had raised with either previous managers or the provider. They told us, "They talk the talk. Two members of my team are not welcome here." They explained that this happened after the staff members had raised concerns with the Local Authority; as a result they were told by the manager at the time that, they were no longer welcome. They also said "If [the manager] doesn't like what you're saying, that's it"

We found the provider had not ensured that effective systems for monitoring the safety and quality of service provision were implemented. This was continued breach of Regulation 17 (e, f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Family members told us a relatives' meeting had been arranged by the previous manager which they had found useful. We did not see a record of this meeting however so were unable to ascertain what was discussed or any required actions.

We spoke to the provider about their vision and values for the future of the home. They told us that they were committed to ensuring things improved. Before the inspection they had commissioned an agency to help them recruit a new manager and a clinical lead and had also hired a consultant to help them create action plans to help the service move forward. The consultant was present on the first day of the inspection. The recruitment agency contacted the provider during the inspection to advise that people had been shortlisted for the roles. This was evidence that the provider had started to make some positive changes. We will closely monitor their progress.

The provider had not met the requirements of their registration with CQC and forwarded notifications as required. Under the regulations, providers and registered managers have a statutory duty to inform CQC about a range of occurrences, including deaths and serious injuries. This again was because there was no consistent leadership or management within the home. We were made aware of a number of expected deaths that had happened at the home. Part of a provider's responsibility is to ensure the relevant bodies are informed when a death occurs so that checks can be made if necessary. We had not received notification of five deaths which had occurred since January 2016. This was a breach of regulation 16 (3) Care Quality Commission (Registration) Regulations 2009.

It is a statutory requirement that providers display their most current CQC inspection ratings. The ratings awarded at the last inspection were not on display at the home. We spoke with the provider who told us they thought they were on the wall in the reception area. They were not. Failure to display ratings is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Overall, we found the lack of a registered manager within the home and the lack of leadership, management and governance from the nominated individual had compromised the quality of care in all aspects of service delivery. Improvement was needed in all areas to ensure people received safe, effective, responsive and well led care. We met with the provider after the inspection in 2015 and had received assurances that improvements would be made. The regulations are clear in relation to the action a provider must take to ensure people are protected in the absence of a registered manager. We found the provider did not make sufficient arrangements to ensure the staff at the home were supported, trained or supervised. We also

found that the provider did not consider the impact this lack of leadership may have had on the people who used the service.

All the families we spoke with told us they did not trust the current provider as they were never at the home and did not know what was going on. They said because managers did not stay they worried about their relatives that lived at the home. Relatives also told us they felt staff did what they could and kept them informed of any problems, but they did not feel confident staff received the correct level of training. We asked the staff how much involvement the provider had at the home. They all told us the providers never came, and one staff member said, Except in the last few weeks when there have been issues."

We spoke with the provider who was also the nominated individual at the home. They acknowledged they had not done enough and said they were committed to improving things. However, we found the provider had not fulfilled their statutory responsibilities and did not demonstrate they had the qualifications, competence, skills and experience which were necessary for their position. This was a breach of Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.