Mr Keith John Betteley & Mrs Jennifer Ann Betteley

Fallowfields Residential Home

Inspection report

14 Great Preston Road
Ryde
Isle of Wight
PO33 1DR

Tel: 01983611531

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 25 August 2016 and was unannounced. The home provides accommodation for up to 22 people including people with dementia care needs. There were 18 people living at the home when we visited. The home is based on two floors, connected by a passenger lift, in addition to a basement where the kitchen and laundry are located. There was a choice of communal rooms where people were able to socialise and some bedrooms had en-suite facilities.

A registered manager was not in place at the time of the inspection, although the manager had applied to be registered with CQC and their application was being processed. 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.

This comprehensive inspection was carried out to check on the service's progress in meeting the requirements made as a result of the previous inspection in March 2016. Following that inspection, the service was rated inadequate and placed in Special Measures. This meant we started to use our enforcement powers to monitor and check the service. We had identified that staff did not always respond appropriately to allegations of abuse; risks to people were not managed effectively; safe recruitment practices were not followed; staff were not suitably trained and did not follow legislation designed to protect people's rights; staff did not always communicate effectively with people; action to address previous failures had not been completed; quality assurance systems were not effective; and the providers did not always notify CQC of significant events.

Following the inspection in March 2016, the providers sent us an action plan detailing how they would become compliant with the regulations. At this inspection, we found action had been taken, but further improvement was required.

The providers, the manager and staff demonstrated a shared commitment to making the necessary improvements. A new quality assurance system had been introduced, but this had not yet become embedded in practice and had not picked up the concerns we identified.

For example, whilst most individual risks to people were managed effectively, we found measures were not always taken to protect people from the risk of pressure injuries and a hoist used to support people to transfer between chairs was not fit for purpose. Also, some risk management processes were over-protective and did not support people's freedom or empower them to retain their independence.

Staff were not always aware of people's dietary needs and one person was not receiving a suitable diet. The amount people drank was not always recorded accurately and action was not always taken when people did not drink enough.

Staffing arrangements were not robust, especially during the mornings when people were being supported to get up and have breakfast. People's medicines were managed safely, although the recording of topical creams was not always accurate.

Entries in people's care plans showed they were not always treated in a considerate way and staffing shortages meant staff were sometimes task-orientated. However, at other times staff interacted positively with people and people said staff treated them in a caring way.

People were satisfied with the meals they received and were given help to eat when needed. However, menu choices were not offered in a way that was supportive of people living with dementia.

Improvements had been made to the environment, although further work was planned. The conservatory still became too hot in the summer; corridor lights were repeatedly turned off, meaning people would not be able to see where they were walking; handrails were not easily seen and people's access to the stairs was not controlled for their safety.

Staff had received additional training in legislation designed to protect people's rights. Decisions were made in the best interests of people and verbal consent was sought before staff provided care and support. However, legislation designed to protect people's freedom was not followed consistently.

The providers had become more involved in supporting some people to take part in activities outside the home and staff told us they ran activities in the evenings. However, activities for some people were not always meaningful and the frequency was variable. The provider's action plan said this would be addressed by the end of October 2016.

All but one staff member understood the action to take in the event of a fire. Fire safety systems were tested and maintained regularly. People felt safe at Fallowfields and staff knew how to identify, prevent and report abuse.

Clear recruitment processes were in place to help ensure only suitable staff were employed. Staff were suitably trained and were positive about the support they received from management.

Staff supported people to build and maintain relationships. They protected people's privacy and made sure confidential information was kept securely.

People were involved in planning and reviewing the care and support they received. Care plans were comprehensive and helped ensure people's individual needs were meet in a personalised way.

The provider sought and acted on feedback from people, relatives and professionals. People were happy living at Fallowfields and thought it was well-run. The manager was being supported to develop their skills and was responsive to feedback during the inspection.

There was an open and transparent culture where visitors were welcomed. CQC were notified of significant events and the ratings from our previous inspection were prominently displayed. People were supported to access healthcare services when needed and staff had a good working relationship with healthcare professionals.

We identified breaches of regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the 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.

People were not protected from the risk of pressure injuries and a hoist used to support people to move was not fit for purpose.

Other risks to people were managed effectively, but not always in a way that promoted their freedom or independence.

Staffing arrangements were not robust and one person was not attended to promptly.

Recruitment procedures were safe and suitable arrangements were in place to manage people's medicines.

Most staff knew what action to take in the event of a fire and staff had been trained in administering first aid.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff were not always aware of people's dietary needs and action was not always taken when people had not had enough to drink. People enjoyed the meals, but menus did not support people to make informed choices.

Enhancements had been made to the environment, although further work was needed to ensure it supported people's needs.

Staff sought verbal consent from people and decisions were made in people's best interests. However, legislation designed to protect people's freedom was not followed consistently.

Staff were suitably trained and supported in their role and people had access to healthcare services when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

Comments in care records showed people were not always

treated in a considerate way. At times, staff were task-orientated, although at other times, they interacted positively with people.

People felt staff treated them with kindness and compassion. Staff supported them to build and maintain relationships.

People's privacy was protected and they were involved in discussions about the care and support they received.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People had mixed views about the provision of activities, which were not always meaningful or relevant to people's individual preferences.

Most people received personalised care that met their needs. Care plans contained comprehensive information and were reviewed regularly.

The provider sought and acted on feedback from people.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Quality assurance processes had improved, but were not always effective and were not embedded in practice.

There was a clear management structure in place and the manager had applied to register with the CQC.

The providers, the manager and staff demonstrated a shared commitment to improving the service. External consultants had been engaged to assist them in this endeavour.

There was an open and transparent culture, where visitors were welcomed. Links with the wider community had been developed to the benefit of people.

Fallowfields Residential 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 25 August 2016 and was unannounced. It was conducted by two inspectors. Before the inspection we reviewed previous inspection reports and an action plan we had been sent by the providers. We also reviewed notifications we had been sent by the providers. A notification is information about important events which the service is required to send us by law.

We spoke with nine people living at the home, six relatives and a visiting friend. We also spoke with one of the providers, the manager, six care staff, the cook, the cleaner and a visiting healthcare professional. We spoke with an external contractor who was supporting the home with infection control training and guidance. We also spoke with a social care professional from the Clinical Commissioning Group who was supporting and advising the provider and the manager with their improvement programme.

We looked at care plans and associated records for seven people and records relating to the management of the service. These included staff duty records, staff training records, four staff recruitment files, records of complaints, accidents and incidents, and quality assurance records.

We observed care and support being delivered in communal areas. We also 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.

Requires Improvement

Is the service safe?

Our findings

At our last inspection, in March 2016, we identified that staff did not always respond appropriately to allegations of abuse; individual risks to people were not always managed effectively; and safe recruitment practices were not always followed. At this inspection we found action had been taken, but further improvement was needed.

People were not always protected from the risk of pressure injuries. Since the last inspection, a process had been put in place to check that special pressure-relieving mattresses remained set at the right level according to the weight of the person using them. However, other measures to protect the integrity of people's skin were not always taken. Staff used a nationally recognised tool to assess the likelihood of people developing pressure injuries. However, where these showed a high or very high level of risk, no action was specified to reduce the risk. The manager provided examples of action they would take to reduce the risk, but accepted these had not always been taken, or recorded, so there was a risk staff would not provide the necessary care and support in a consistent way.

We observed staff supporting people to move, including through the use of standing aids and walking frames. Staff told us they were confident using most of the equipment, although they found using the hoist difficult. A hoist supports a person's weight when moving to make manoeuvring safer for the person and for staff. We observed two members of staff having difficulty hoisting a person from a wheelchair to a chair as the hoist was manually operated and could not reach the required height level. The layout of furniture in the room also made it difficult to move the hoist close enough to the chair and for staff to position themselves on either side of the person. Staff were only able to position the person onto the chair by physically lifting them the last couple of inches. This risked harming the person and causing upper body injuries to the staff. One of the staff members said of the hoist, "It's not up to the job. It doesn't lift high enough and it's difficult to look after the person while having to pump [the hoist manually]."

The failure to ensure individual risks to people were managed effectively and that equipment was fit for its intended purpose was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other risks to people were managed effectively. Risk assessments were recorded in people's care plans and included action staff should take to reduce the risk. For example, one risk assessment detailed how staff were to prompt a person to put the brakes on their wheeled walking frame, if they were going to sit down, to steady themselves and we saw staff doing this. The manager told us, "Most of our clients are high risk [of falling] so we now have a plan in place." We looked at the plans for two people at risk of falling and saw suitable measures were in place to reduce the risk. Where a person had fallen, staff had reviewed their risk assessment and considered any additional action that could be taken. For example, installing monitoring devices to alert staff when someone moved to an unsafe position. Staff were aware of people who were at risk; a staff member told us, "One person falls sometimes. When we take him to [the bathroom], we tell him to use the bell when he's ready, but he always forgets, so we have to keep an eye out for him." When people sustained head injuries during falls, medical attention was sought promptly, followed by regular

observations for a period of 24 hours, where recommended by medical professionals.

Whilst people were protected from most risks, this was not always done in a way that supported their freedom and did not always empower them to make choices or promote their independence. One person had a monitoring device in place to alert staff when they moved from their chair. When they removed the device, in order to mobilise independently, they were chastised by staff for doing so, rather than supported to achieve their objective. The person's care records also included the comment: "Yesterday he was found in the kitchen with hot water in a cup; he told staff he was making a cup of tea, staff told him that they would make him a cup of tea as he could well have fallen and scalded himself." Staff had not explored ways they could enable the person to make a cup of tea for themselves in a safe way. We discussed this with the manager, who agreed to address the issue.

Staffing arrangements were not robust, although most people and relatives felt there were sufficient staff to meet their needs. One person said, "There's always staff nearby." However, another person told us, "If I press my bell, it depends how busy [staff] are. Sometimes I have to wait. It's just a bit frustrating." The manager told us they used a dependency tool to work out how many staff were needed for each shift. Staffing levels had been reduced two weeks previously, after one person moved from the service, and the 8:00am to 11:00am shift had been discontinued. This left three care staff to support 18 people at these times. A staff member told us, "It leaves people vulnerable. A lot of people wander and are at risk of falling. Some people are already in the lounge when we arrive [for work]. When we're getting others up and doing breakfasts, people are left unsupervised."

Whilst we observed most people being attended to promptly, one person waited 10 minutes during the morning to be transferred from a wheelchair to a lounge chair, as a second staff member was not available to use the hoist. Once the person had been transferred they were offered a drink, but this took 23 minutes to arrive as staff were busy supporting other people to transfer from their bedrooms into the lounge.

When we arrived at the home, we found the cleaner was helping prepare and serve people's breakfasts as care staff were busy helping people to get up and the cook did not start work until 9:30am. Although the cleaner was happy to support care staff colleagues by helping people with their breakfasts, this took them away from their own work. An external consultant, who had reviewed the cleaning arrangements at Fallowfields told us there were "not enough cleaning hours" provided to be able to clean the home effectively and had raised this with the provider.

The manager told us they were having to cover far fewer shifts than at the time of our last inspection, so were able to spend more of their time on managerial duties. However, they had had to cover two night shifts after a night staff member had left, including the night before our inspection. They said they were in the process of recruiting a replacement to avoid the need to do this in the future. They also agreed to review the staffing levels in the morning.

People's medicines were managed safely. Suitable arrangements were in place for obtaining, administering, storing and disposing of medicines. However, staff did not record the use of topical creams in a consistent way. For example, one person was prescribed topical creams twice a day but there was only one recorded entry on the medication administration record (MAR). We discussed this with the manager, who agreed to put a clearer recording system in place for the use of creams. Guidance had been developed to help staff know when to administer 'as required' (PRN) medicines, such as for pain relief. This included individual signs people may show when they were in pain. Staff told us this was important when supporting a person who is not able to verbalise that they were in pain. There were systems in place to monitor the temperatures at which medicines were stored. Some medicines need to be stored at low temperatures to ensure their

effectiveness when used and records confirmed a suitable temperature was maintained. Checks of the MAR charts showed that people had received their medicines as prescribed. Staff were knowledgeable about people's medicinal needs, had received appropriate training and had their competency assessed. One member of staff told us that they had requested, and received, additional training which had improved their knowledge.

At the last inspection, we found not all staff were aware of how external fire doors could be opened in the event of a fire. At this inspection, most staff knew how to open the fire doors. However, we found one staff member was not aware of the two methods that could be used to open the doors in an emergency. This could compromise people's safety in the event of a fire. We brought this to the attention of the manager who agreed to take action. Fire alarm tests and drills were conducted and fire safety systems were maintained regularly. People had personal emergency evacuation plans in place detailing the support they would need in an emergency. Staff were trained in administering first aid and first aid equipment was readily available.

Clear recruitment procedures were in place to help ensure staff were suitable to work at the home. These included reference checks from previous employers and a criminal record check with the Disclosure and Barring Service (DBS). The DBS helps employers to make safer recruitment decisions. Staff confirmed this process was followed before they started working at the home. One staff member, who was not a UK national, said they had also been required to produce evidence of their entitlement to work in the UK.

People told us they felt safe at the home and they appeared relaxed and comfortable when interacting with staff. One person said, "I feel safe here in my room." A family member described Fallowfields as "a safe and comfortable place for my [relative]". Staff had the knowledge and confidence to identify safeguarding concerns and acted on these to keep people safe. They had received appropriate training and were aware of people who were at particular risk of abuse.

Requires Improvement

Is the service effective?

Our findings

At our last inspection, in March 2016, we identified that staff were not following legislation designed to protect people's rights and freedom; staff were not adequately trained; the environment did not support the needs of people living with dementia; and the amount people ate and drank was not recorded accurately. At this inspection we found action had been taken, but further improvement was needed.

Staff were not always aware of people's dietary needs. For example, one person had diabetes, which their care plan said was controlled through their diet and by taking tablets. The care plan specified the need for them to receive a 'low sugar' diet, but three staff members were not aware of this and did not know the person was diabetic. When we discussed the person's diet with staff, they told us, "[The person] loves puddings and often has two." Records confirmed that the person regularly received desserts with a high sugar content and staff had not offered them more healthy alternatives. When we spoke with the person, they could not remember whether they needed a special diet or not. Another person needed their meals to be pureed, due to swallowing difficulties, and they told us this was always done.

Some people needed their fluid intake to be monitored due to health conditions. However, this was not done consistently. For example, one person's care plan stated they needed to drink 1786mls of fluid each day. Some days the amount of fluid offered and taken was not added up and on other days there were gaps in the person's records. This meant that it was difficult for staff to monitor how much fluid the person had consumed. For this person, and other people, where fluid totals showed they had drunk less that the recommended amount, staff were unable to tell us whether any action had been taken. We discussed this with the manager, who agreed it was an area for improvement.

Most people told us they were given a choice about what they ate and said staff came round with a menu board so they could pick their meal. However, when asked before lunch, many people did not know what they were having for their meal and some people said they could not read the menus displayed in the home. There were three menu boards, two in the dining room and one by the main entrance of the home. They were not supportive of people living with dementia or visual impairment as the writing was small and there were no supporting pictures. This made it difficult for people to understand the options and make informed choices. A staff member told us, "We were going to do meal pictures, but we haven't yet." During lunch, a musician arrived and started carrying their equipment, including a keyboard, through the dining room to set up in the adjacent lounge. This caused people to become distracted from their meals; one person stopped eating altogether and did not finish their meal.

People said they liked the food at Fallowfields. Comments included: "The food is good"; "It's excellent" and "You get mostly what you want''. A family member told us their family member's diet and nutrition had improved since moving to Fallowfields. They said, "[My relative] never used to eat, but since moving here it's got a lot better".

Staff monitored people's weight and took action when people experienced unplanned weight loss, for example by contacting the person's GP. The provider had purchased a weighing chair since the last

inspection, which could be used for people who were unable to stand unsupported on weighing scales. The manager told us they had an assessment tool to calculate people's risk of malnutrition, but had not started using this yet.

Most people chose to eat in the dining room. Staff were attentive to people's needs by offering drinks and additional portions. One person required additional support during mealtimes by having their food cut up into small pieces and using a spoon to eat. We observed staff gave the person time to eat independently but offered assistance when it became clear they were not eating well. They sat quietly with the person, described the food to them and encouraged them to eat it. Another person needed to have pureed food, due to swallowing difficulties, and we saw this was provided. The inspection took place on a hot summer's day and staff offered people ice lollies to help keep them cool.

Some improvements to the environment had been made since the last inspection and the providers had met with people in small groups to discuss the decor. An air conditioning unit had been installed in the conservatory; this had helped keep the temperature comfortable, although the manager told us, "Yesterday, the temperature got to 48 degrees, so we had to move people out." One of the providers said, "The aircon has improved things, but it's not perfect." Pictures or symbols that were relevant to people had been attached to their bedroom doors, to help them identify their rooms more easily; and additional pictures, at appropriate heights, had been hung in communal areas and corridors. Lighting levels had been improved, although we found corridor lights were repeatedly turned off during the inspection. The lights did not operate on movement sensors, so when people came out of their rooms, for example to visit the bathroom, they found the area was poorly lit. This could increase the risk of them falling. We brought this to the attention of the manager who agreed to raise the issue with the provider.

The manager acknowledged that further improvement still needed to be made to the environment. For example, handrails were a similar colour to the surrounding walls, which meant they were difficult for people with impaired eyesight to spot and use. One of the providers told us of plans to reduce people's access to the stairs through the use of a door in the hallway; once implemented, this would mitigate the risk.

People's freedom was not always protected. 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 Mental Capacity Act, 2005 (MCA). The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). At our last inspection we found the providers had appropriate policies and procedures in place in relation to DoLS, although staff were not aware of conditions that had been applied to an authorisation for one person. At this inspection, we found staff knew about the relevant conditions and how to keep the person safe in an appropriate way. For example, a staff member told us, "If [the person] tries to use the front door, we use distraction techniques." Two additional DoLS applications had been made and the manager was waiting for the local authority to undertake the assessments. However, the legislation was not being applied consistently. The manager told us they were still reviewing the need to submit further DoLS applications, including for one person who told us they were not able to leave the home unaccompanied. In addition, an application had been made for a person who had been assessed as having capacity to make all decisions. This was not appropriate as people who are able to make decisions cannot be made subject to DoLS. The manager agreed that this application should not have been made and said they would withdraw it.

In respect of other decisions, staff protected people's rights by following the MCA. The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Since the last inspection, the manager and staff had received training in the MCA. Where people lacked capacity to make decisions, families were consulted and decisions made in the best interests of the person. For example, decisions had been made about the delivery of personal care, the administration of medicines and the use of equipment to monitor people's movements.

People told us that staff asked for their verbal consent before supporting them. This was confirmed by the care records where people's decisions to decline care were clearly recorded. We also heard staff seeking people's verbal consent before providing them with care or support, such as offering to help them mobilise or to have an assisted wash. However, where people had capacity to make decisions, there was no record to show that the person had agreed to the care and support that was being delivered by staff. We discussed this with the manager, who told us they would consider using consent forms to capture this information.

People's needs were met by staff who were suitably trained. One person told us staff were "very good and look after us well". A relative said, "The staff's priority is people's care." Staff were positive about the training they received and said they had completed a lot of training since the last inspection. Most staff were now up to date with the provider's mandatory training, which included moving and positioning, safeguarding, infection control and dementia awareness. Where some staff members still needed to complete some training, we saw dates had been set with an external training provider to deliver this.

New staff completed a comprehensive induction programme before they were permitted to work unsupervised. Arrangements were also in place for staff who had not worked in care before to undertake training that followed the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people. In addition, some staff had completed, or were undertaking, vocational qualifications in health and social care.

Staff demonstrated an understanding of their training and how to support people living with dementia. For example, a staff member told us that it was important to "let the person take the lead, obtain people's consent to care, be patient and know about people's life history to engage them if they become confused or disorientated".

People were cared for by staff who were appropriately supported in their role. All staff received one-to-one sessions of supervision. These provided an opportunity for a supervisor to meet with staff, discuss their training needs, identify any concerns, and offer support. Staff who had worked at the home for over a year had also received an annual appraisal to assess their performance. Staff told us that they found supervisions useful as they provided a chance to discuss any issues with the manager. They also spoke positively about the support they received from the manager on a day to day basis. One staff member said, "I've had supervision. It was really good. I had to evaluate myself on 50 questions; I got top marks on everything."

People were supported to access healthcare services when needed. Records showed people were seen regularly by doctors, specialist nurses and chiropodists. They also had access to dental care and eyesight tests when needed. One person told us, "I see the district nurse twice a week for my bandages." A family member said, "Doctors come in when needed; [the staff] are very good at [arranging] that." A community nurse told us staff were "very helpful and accommodating and follow our advice".

Requires Improvement

Is the service caring?

Our findings

At our last inspection, in March 2016, we identified that staff were not always discreet when discussing people's needs and were not always able to communicate effectively with people. At this inspection we found action had been taken, but further improvement was needed.

In their efforts to protect people from the risk of harm, staff did not always treat people in a considerate way. For example, an entry in the care record of a person who was at risk of falls included the comment: "It has been explained to him that we could be closed down if he was seriously hurt and that a lot of our clients would be going to new homes, which would mean him also." This comment sought to put an unreasonable responsibility on the person for the future of the home and the welfare of others. Entries in the care plan of another person, who was living with a form of dementia that caused them to hallucinate, included: "[The person] sits on the bed and jibber jabbers", and "can be grumpy at times". This showed a lack of respect and understanding of the person's condition. We discussed the comments with the manager, who agreed to address the issue with staff.

Staff shortages in the morning meant staff were not always able to be attentive to people's needs and we observed that interactions were task orientated; for example, offering drinks and supporting people to move. However, at other times, interactions between people and staff were more positive, showing that staff understood people's needs and knew them well. Staff spoke fondly of the people they cared for and described them as "lovely" and "like a family". Regardless of their role, they expressed a shared view that they were responsible for meeting people's needs and making life as pleasant and comfortable for people as possible.

People felt staff treated them with kindness and compassion. One person, and a community nurse, described the atmosphere at the home as "calm". Another person told us, "What is there not to like? The staff are lovely. I get on with them all very well." A further person said they liked their own space and staff respected this; they added: "It's a nice place to come because you are left alone in peace." A family member told us, "Staff are brilliant; even when they answer the phone they are polite." A response to a survey conducted by the provider included the comment: "I have always found the staff and management warm and caring with a wonderful sense of humour."

Staff supported people to build friendships and maintain relationships. Friends and family members were made welcome at any time and people were encouraged to keep in touch with people who were important to them. When family members visited, staff took time to answer any questions they had. A family member described a close relationship their relative had formed with another person living at Fallowfields. Staff encouraged this by supporting them to sit together and eat their meals together. Another family member told us the providers had offered to bring their relative round to the family home for a visit, in the event that they were not able to visit Fallowfields.

People's privacy was protected by staff knocking and waiting for a response before entering people's rooms. When personal care was provided they ensured doors were closed and curtains pulled. People had been

asked whether they had a preference for male or female care staff; their preferences were recorded, known to staff and respected. A community nurse told us staff always took people to their rooms so they could be examined in private. When staff asked people if they wished to use the bathroom, they did so quietly and tactfully, so as not to cause any embarrassment to the person. Confidential information was kept securely and only accessed by those authorised to view it.

When people moved to the home, they (and their families where appropriate) were involved in assessing and planning the care and support they received. One person said, "They do ask me what I want, but not too much, otherwise it would get annoying." Comments in care plans showed this process was on-going. Family members told us they were kept up to date with any changes to the health of their relatives.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection, in March 2016, we identified that activity provision was not always tailored to people's interests. At this inspection we found some action had been taken, but further improvement was needed, which the provider's action plan stated would be completed by the end of October 2016.

People had mixed views about activity provision. One person said, "We get very very little activities. We used to have them, but I don't go now. They're all a bit corny." Another person told us there were "not all that many activities". However, other people were more positive. One person said, "You can go out if you want, it's no problem; the staff will arrange it for me." Other people and their relatives spoke positively about evening "sing-songs", describing them as "a good way of people joining in and having fun". One person told us, "Some of the sing-songs in the evening are fantastic." In response to a survey conducted by the provider, most people said they were satisfied with the activity provision and particularly enjoyed board games and quizzes, although one person said they would like more choice.

The providers had become more involved in organising trips for some people to local attractions. For example, one of the providers took a person bowling from time to time and the other provider took people out for coffee. A person told us, "[One of the providers] visits and is seeing me tomorrow with her mother. I look forward to that. And she is taking me out on Saturday. I didn't ask; she just offered." Staff told us one of them was deployed to run activities in the evenings and these included "board games, card games, quizzes, dominoes and music."

An activity planner was used to advertise activities; it was displayed prominently in the dining room and was supported by pictures of each activity to help people understand them. People's interests and activity preferences had been recorded in their care plans and records were kept of activities people had engaged in. However, we found activities were not always meaningful and the frequency was variable. For example, records of the activities a person had engaged in during August 2016 were given as 'watching TV, sleeping, listening to a keyboard player and reading the paper'. Activities for other people included: 'sat in lounge; 'in room; and 'reading'.

On the day of our inspection, a 'musical instruments' activity was advertised for the morning, followed by a 'reminiscence' activity in the afternoon. However, neither of these activities took place. In the afternoon, a volunteer played a keyboard in the lounge, which six people listened to. They were smiling and tapping their fingers indicating that they were enjoying it. However, staff were not present for the activity, it was not interactive and people were not able to request particular songs or tunes. One person enjoyed interacting with a board containing locks and bolts and we saw them using this.

We discussed activity provision with the manager, who told us of plans to use a company funded by a national charity who had agreed to undertake one to one activities with people who preferred to stay in their rooms. For example, one person had asked to do some cooking, and the charity was trying to source a volunteer to do this with the person.

Most people received personalised care from staff who understood and met their needs well. People had been asked how often they wished to receive a bath or a shower and these were provided according to people's preferences. Some people chose to have one bath a week, while other people had up to three showers a week. One person told us, "I prefer to have showers, three a week. I always have to be attended to and staff know how I like it done." They then described how staff supported them in a personalised way.

Staff demonstrated a good awareness of the individual support needs of most people living at the home, including those with dementia care needs. They knew how people preferred to receive care and support. For example, they knew the support people needed with their continence; and when they liked to get up and go to bed. They recognised that some people's abilities varied considerably from day to day and were able to assess and accommodate the level of support they needed at a particular time. A staff member told us, "[One person] has good days and bad days. On a bad day we have to keep prompting them to drink; but on a good day they drink loads." Care plans provided sufficient information to enable staff to provide appropriate care in a consistent way and were reviewed regularly. Family members told us they were involved in updating their relative's care plan to reflect their preferences and changing needs.

The provider sought and acted on feedback from people through the use of survey questionnaires. These showed people and their relatives were satisfied with the care provided. The manager also held 'residents meetings' to discuss menus, activities and to seek feedback about the service. Where feedback indicated improvements could be made, these were acted on. For example, a relative commented that they were not always offered refreshment when they visited, so the manager sent a communication to staff reminding them to offer refreshments to all visitors. Following suggestions from people at the residents meeting, the menu was changed recently. In response to comments from relatives that they did not know what the menu of the day was, an extra menu board was displayed in the entrance hall where relatives would see it when they signed in.

People knew how to complain and there was a suitable complaints procedure in place, which was included in the 'residents' handbook' which was given to people and their families when they moved to the home. The manager was familiar with the provider's complaints policy; however, no complaints had been recorded.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection, in March 2016, we identified that the previous manager had not completed an action plan to address the concerns we had identified; and the provider's quality assurance system was not effective. Following that inspection, the provider sent us a comprehensive action plan detailing how they would become compliant with the fundamental standards of quality and safety. The timescale accompanying the plan stated that some of the actions would not be completed until October 2016, for example improvements in the provision of activities. At this inspection we confirmed that the action plan had not been completed fully and further improvement was still needed to meet all fundamental standards. This included areas where the actions identified by the provider had reportedly been completed.

The provider and manager were working closely with a social care professional from the Clinical Commissioning Group (CCG) to develop an appropriate quality assurance system; we saw a framework had been developed and a range of audits had been conducted. However, the system had not become embedded in practice and was not yet fully effective. For example, although the manager had spent time reviewing people's care plans and told us they felt they were "up together now", we found this was not the case. There were inconsistencies with DoLS applications and a person had not been receiving an appropriate diet, which had not been picked up by the reviews. Measures to reduce the risk of people sustaining pressure injuries had not been recorded in people's care plans; and some entries showed people were not always treated with consideration. When we discussed this with the manager, they told us they had been sent a new tool to use for reviewing care plans, which they intended to implement.

The continuing failure to operate effective systems to assess, monitor and improve the service was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager conducted weekly checks of the home, to assess the cleanliness of the environment and the completion of medicine records. Where these showed improvement was needed, action was taken promptly. For example, gaps in the cleaning records had been identified in the most recent check and staff had been reminded of the need to complete these fully. In addition, a medicines audit had been conducted by a community pharmacist and an infection control audit by an external contractor. Actions had been identified from these audits, including the need to review the cleaning arrangements for the home, which was being done.

The manager had reviewed all staff files and we saw these were up to date with accurate records of employment, training and supervision. They had also updated the provider's 'Statement of Purpose'. This is a document that sets out the objectives of the service, the management structure and details how they will meet legal requirements and the needs of people living at the home. In addition, a new set of policies and procedures had been purchased and tailored to meet the needs of the home.

People were happy living at Fallowfields and felt it was run well. They said they often saw "the owners" and the manager. One person told us, "[The manager] has exceeded expectations. She is committed to the position and has put in 100%." Another person said, "No place is perfect, but this one is managed well."

Responses to a recent survey conducted by the provider included the comment: "The manager and provider always work well together and interact very well, both with staff and service users."

A clear management structure was in place. This consisted of the providers, the manager, the deputy manager and senior care staff. Specific responsibilities were being assigned to senior staff, such as for medicines management and infection control, and as dementia champions and dignity champions, although work on some of these roles had yet to be started.

The manager was new to the role and was going through the process of registering with CQC. They had been supported by the providers to complete a management course with a local training company and an MCA course for managers. They were also planning to complete other relevant management courses to develop their skills. A staff member told us, "[The manager] is really good and is turning the place around."

The providers, the manager and staff were responsive to feedback during the inspection and demonstrated a shared commitment to improving the service. The manager demonstrated their enthusiasm by remaining at the home throughout the inspection, despite having just completed a night shift. The providers had shown their commitment by engaging the services of social care professionals and consultants to provide advice to them and additional training to staff. One of the providers acknowledged the concerns raised during previous inspections and said, "It was naivety on our part. We should have monitored better. It won't happen again. There's a massive amount of work going on to put it right."

There was an open and transparent culture at the home. Communication between management and staff was relaxed; the manager had an open door policy and encouraged people and staff to discuss concerns. The previous CQC report and rating were displayed in the entrance hall of the home. This, together with action the provider was taking, had been discussed with people and their relatives. There was a duty of candour policy in place which required staff to act in an open way when accidents or incidents occurred. The manager had followed this by writing a letter to the family of a person who had sustained an injury. Notifications about significant events were reported to CQC as required. Visitors were welcomed at any time and could stay as long as they wished and there were good working relationships with external professionals. Links had been developed with the community through families, friends and volunteers, which helped keep people in touch with life outside the home.

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 12 HSCA RA Regulations 2014 Safe care and treatment The providers had failed to ensure that they had done all that was practicable to mitigate individual risks to service users and to ensure that equipment used to support people to move was fit for it's intended purpose. Regulation 12(1) & 12(2)(b)&(e).

The enforcement action we took:

We followed our enforcement pathway and continued to monitor the service closely.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers had failed to establish and operate effective systems or processes to assess, monitor and improve the quality and safety of the service provided. Regulation 17(1) & 17(2)(a)

The enforcement action we took:

We followed our enforcement pathway and continued to monitor the service closely.