Michael Goss

The Friendly Inn

Inspection report

Gloucester Way
Chelmsley Wood
Birmingham
West Midlands
B37 5PE

Website: www.friendlycare.co.uk

Date of inspection visit:
04 April 2019
08 April 2019

Date of publication:
10 June 2019

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

About the service: The Friendly Inn provides accommodation and personal care for up to 30 people, some who are living with dementia. There were 29 people living in the home on the first day of our inspection visit on 4 April 2019. On 8 April 2019 when we returned for our second visit 30 people lived at the home.

People's experiences of using this service:
• Risks to people's health, wellbeing, safety and the environment were inadequately managed.
• Governance systems to monitor the quality and safety of the service were inadequate.
• Some staff lacked confidence in the provider to support the home and demonstrate good leadership.
• People's independence was not always respected and promoted.
• Improvements were required in promoting person-centred care. Some care records lacked important information.
• Staff had not completed the training they needed to provide high quality, safe care.
• Accurate analysis of accidents and incidents to identify patterns and trends to prevent reoccurrence did not take place. That meant lessons were not always learnt when things went wrong.
• Staff did not always follow good infection control practice to prevent infection.
•People received their medicines when they needed them but checks of people's medicines were not always effective.
• People felt they received effective care and treatment from health professionals. However, support was not always sought in a timely way.
•Staff were not always available at the times people needed them to keep them safe.
• Despite our findings people and relatives felt the home was well run and they felt safe.
• Staff were recruited safely.
• Staff were caring in their approach and showed people kindness.
• Care was provided in a dignified way and people's right to privacy was respected.
• The home was clean, and the environment supported people living with dementia.
• People spoke positively about the food provided.
• Overall, people enjoyed the activities available to them.
• Some people's end of life wishes had been recorded.
• People and their relatives knew how to make a complaint.

Following our inspection, we notified the Local Authority commissioners about the areas of concern we identified.

We reported that the registered provider was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were:
Regulation 11 Regulated Activities Regulations 2014 – Need for consent
Regulation 12 Regulated Activities Regulations 2014 - Safe care and treatment
Regulation 17 Regulated Activities Regulations 2014 - Good governance
Regulation 18 Regulated Activities Regulations 2014 – Staffing

Regulation 18 of the Care Quality Commission Registration Regulations 2009. Notifications of other incidents.

Rating at last inspection: Good. The last report for The Friendly Inn was published on November 2017.

Why we inspected – The inspection was prompted by a notification of a potential serious incident. At the time of our inspection, we were aware of an ongoing police investigation. Whilst this inspection did not examine the circumstances of the incident, we considered the provider's management of risks.

The overall rating for this service is inadequate and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe and a rating of inadequate remains 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 if they do not improve.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions, it will no longer be in special measures.

Follow up: We will continue to monitor the service to ensure that people receive safe, compassionate, high quality care.

Enforcement: Full information about CQC's regulatory response to the more serious concerns found in inspections is added to reports after any representations and appeals have been concluded.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe

Details are in our findings below.

Is the service effective?

Inadequate

The service was not effective

Details are in our findings below.

Is the service caring?

Requires Improvement

The service was not always caring

Details are in our findings below.

Is the service responsive?

Requires Improvement

The service was not always responsive

Details are in our findings below.

Is the service well-led?

Inadequate

The service was not well led

Details are in our findings below.

The Friendly Inn

Detailed findings

Background to this inspection

The inspection: We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team: Two adult social care inspectors undertook this inspection.

Service and service type: The Friendly Inn is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. The previous registered manager had left their employment and deregistered with us in February 2019. 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.

Notice of inspection: Unannounced inspection visits took place on 4 April and 8 April 2019. Due to concerns identified on 4 April 2019 we formally wrote to the provider to ask them to address our concerns. We returned unannounced on 8 April 2019 to check whether the provider had taken any action to mitigate the risks identified. We found action had been taken.

What we did: We reviewed information we had received about the service since the last inspection. This included details about incidents the provider must notify us about, such as serious injuries. We sought feedback from the local authority who worked with the service. We used all this information to plan our inspection.

During the inspection visit: We reviewed six people's care records, to ensure they were reflective of their needs, and other documents such as medicines records for seven people. We reviewed two staff files to check staff were recruited safely and were trained to deliver the care and support people required. We also

looked at records of the checks the provider and deputy manager made to assure themselves people received a safe and good quality service.

We spoke with nine people who lived at The Friendly Inn and one person's relative. We also spoke with six care staff, the deputy manager, the administrator, a senior care worker, the maintenance worker, the cook, a domestic assistant and the director. We also spoke with one visiting health professional.

Due to their needs, some people could not provide us with information about the care they received, or quality of the service provided. Therefore, we used different methods to gather experiences of what it was like to live there. For example, we saw how staff supported people throughout the inspection to help us understand people's experiences of living at the home. As part of our observations we also used the Short Observational Framework for Inspection tool (SOFI) in a communal area. SOFI is a way of observing care to help us understand the needs of people who could not talk with us.

Inadequate

Is the service safe?

Our findings

Inadequate: People were not always safe and at risk of avoidable harm. Some regulations were not met.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong.
• Risks to people's safety, health and wellbeing were inadequately managed. One person had damaged skin and a risk management plan was not in place to inform and guide staff on how to manage the risk. Some staff told us the person's skin had healed. This contradicted what we were told by a health professional caring for the person.
• Staff were applying a cream to another person's skin which contained highly flammable ingredients. The fire risk posed by using this cream was increased because the person smoked. A risk management plan was not in place and staff were unaware of the fire risk associated with the unsafe use of emollient creams.
• In the designated smoking area, we saw a plastic dustbin which could have been used by people to extinguish cigarette ends. The dustbin lid stated, 'no hot ashes'. The potential fire risk had not been identified until we brought it to the attention of the deputy manager who then took action to mitigate the risk.
• One person's behaviours were not managed safely. Risk management plans lacked important information to support staff to provide safe care. Discussions with staff did not assure us they knew how to confidently manage the person's behaviours. Action taken to manage behaviours was ineffective and had not taken place in a timely way. For example, support from health professionals had not been sought until five days after a serious incident, linked to the person's behaviours had occurred.
• Risk management plans were not always reviewed following incidents to ensure people were kept as safe as possible. One person had fallen on 16 March 2019, but their falls management plan had not been reviewed since January 2019. Another person had choked on a sandwich in January 2019. No action had been taken to reduce risks.
• Staff failed to follow instructions to mitigate risk. We saw one person was seated on a pressure cushion to reduce the risk of their skin becoming sore. However, the cushion was deflated. A staff member confirmed that they had forgotten to inflate the cushion which posed a risk to the person's health.
• Environmental risks were not always managed safely. On day one of our inspection we identified some first-floor windows did not have restrictors fitted. This created a risk of people of falling from height. The provider had not identified or assessed this risk in line with health and safety requirements. During our second visit suitable window restrictors had been fitted.
• Accidents and incidents had not always been recorded. This meant accurate analysis of accidents and incidents to identify patterns and trends to prevent reoccurrence did not take place. Action was being taken following our visits to address this.

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

• We received information from the deputy manager immediately after our inspection visits which assured us action was being taken to start improving risk management. We also received an improvement action plan from the provider in May 2019 to demonstrate how the issues we identified were being addressed.

Staffing and recruitment
•During our first visit we identified there were not enough staff on duty at night time to keep people safe and meet their needs. In response immediate action was taken by the deputy manager to increase the number of staff members on duty at night time from two to three.
• People provided mixed feedback about the availability of staff. One person described having to wait for two hours to go to bed because staff said they were busy. The person told us they had also had to wait the day before when they needed to use the toilet. However, another person told us, "I use the bell to call for help. They (staff) come quickly."
• The provider's recruitment procedures minimised, as far as possible, the risks to people's safety. Staff confirmed they had not started work until the required checks had been completed to ensure they were suitable to work with people who lived at the home.

Preventing and controlling infection
• The home was clean and tidy.
• Some staff had not received infection prevention training and staff did not always follow good practice guidelines to prevent infection. For example, we saw a staff member emptied a person's leg catheter bag and then wash their leg bag in the sink in their bedroom.

Systems and processes to safeguard people from the risk of abuse
• Despite our findings people felt safe. One person said, "Staff supervise me in the shower. It makes me feel safe just knowing they are there." A relative commented, "(Person) is safe. I have peace of mind knowing she is here."
• Procedures were in place to protect people from harm. However, not all staff had completed safeguarding training to ensure they knew how and when to report any concerns. Action was taken to address this following our visits.
• Safeguarding concerns had been reported to the local authority when people had been placed at risk.
• Information was available to people, staff, relatives and visitors on how to report any concerns if people might be at risk of harm or abuse.

Using medicines safely
• People received their medicines when they needed them.
• Medicine administration records (MARs) gave an accurate account of the medicines administered and the amount in stock.
• Medicines including controlled drugs were stored in line with best practice guidance.
• Protocols for medicines given 'when required,' detailed information as to how to determine when a person might need their 'when required' medicine.
• Checks of people's prescribed creams were not always effective. For example, some prescribed creams in use did not a have an open or discard date recorded in line with best practice guidance.

Inadequate

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Inadequate: There were widespread and significant shortfalls in people's care, support and outcomes. Some regulations were not met.

Ensuring consent to care and treatment in line with law and guidance:
The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA applications procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether any restrictions on people's liberty had been authorised and whether any conditions on such authorisations were being met.

• They provider had failed to meet their responsibilities in relation to MCA and had not ensured staff understood how to protect people's rights.
• Records showed on six occasions during March 2019 one person, who staff told us had capacity to make their own decisions, had their movement around the home restricted by staff. There was no evidence to demonstrate this action was the least restrictive option. This meant the person was being deprived of their liberty. The provider had no legal authorisation to do this.
• Staff confirmed they were restricting another person's movement within the home to keep them safe. The person did not have capacity to make decisions and the provider had not sought the required authorisation to impose the restriction which meant the person's liberty was being unlawfully restricted.
• The provider had not ensured people had mental capacity assessments, best interest's decisions, and evidence of people's legal representatives recorded where appropriate.
• Despite some staff not completing MCA training we saw, for other people, they worked within the principles of the act. For example, they gained people's consent before they provided assistance.

The above concerns demonstrated a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff support: induction, training, skills and experience
• Not all people thought staff had good knowledge and skills. One person described how staff had 'panicked' and did not know what to do when a hoist they were using to assist them to move stopped working. The

person told us, "I was in the air. I had to let go and fell back into the chair. I told (staff) the battery was going as it was bleeping."
• Staff had not completed the training they needed to develop their skills and knowledge to provide high quality, safe care. This included safeguarding adults, dementia awareness and moving and handling. Discussions with staff confirmed this. One said, "I haven't had moving and handling training, but I use the equipment. Experienced girls [staff] show me."
• The director was aware staff training was not up to date. They explained this was because staff had not logged in to the electronic system to complete their training. Sufficient action had not been taken to address this the time of our first visit. Following our first visit action was taken by the deputy manager to begin to address this shortfall.

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

• Staff received individual support through regular one to one meetings with the deputy manager.

Staff working with other agencies to provide consistent, effective, timely care: Supporting people to live healthier lives, access healthcare services and support:
• Support from health professionals was not always sought in a timely way. For example, a delay of five days had occurred before advice was sought following a serious incident, linked to a person's behaviours.
• We found action had not been taken to follow up a referral made, for another person, in March 2019 to Speech and Language Therapists. This was actioned during our second visit at our request.
• Despite our findings people felt they received effective care and treatment from health professionals including opticians and chiropodists.

Assessing people's needs and choices
•Before people moved to The Friendly Inn an assessment of their needs was completed.
•People's needs were documented in their care records. However, care records had not always been updated when there was a change in a person's health or wellbeing to ensure their needs continued to be met.

Supporting people to eat and drink enough to maintain a balanced diet
• People spoke positively about the food provided and their dietary needs, and preferences had been recorded. However, dietary recommendations made by health care professionals were not always followed. One person had been assessed as requiring a 'fork mashable' diet to reduce the risk of them choking. Staff knew this, but we saw the person had been offered unsuitable foods including biscuits which presented a risk.
• During mealtimes staff were attentive. However, staff placed meals in front of people without explaining what their meal was. This was not supportive of people living with dementia.

Adapting service, design, decoration to meet people's needs
• The environment supported people living with dementia. For example, signage was provided to help people locate their way around their home. Also, garden and courtyard areas were accessible to all people.
• The facilities were under constant review. A kitchenette in the home had recently been refurbished and some sink taps had also been replaced.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Requires Improvement: People were not always well-supported, cared for or treated with dignity and respect. Regulations were met.

Respecting and promoting people's privacy, dignity and independence
• People's personal information was not managed in line with data protection law. Videos of people unable to consent for their information to be shared were available on the home's social media page. The information was removed on our request.
• Some people's independence was not respected and promoted which impacted on people's wellbeing. One staff member described the effect of restricting a person's freedom they said, "It's not fair on (person) being cooped down here. It's too enclosed and [person] is getting more frustrated than usual."
• People felt staff provided care in a dignified way. One person explained how staff maintained their dignity whilst they assisted them with personal care routines.
• Staff knocked people's bedroom doors before they entered which respected their right to privacy.

Ensuring people are well supported
• The provider's aim to 'put residents at the heart of everything and provide a safe and homely environment' had not been achieved.
• We found multiple breaches of the regulations related to the safety and quality of people's care demonstrating the provider's approach to people and staff was not caring.
• The provider had not ensured all people received their care and support in line with legislation and best practice guidance and had not supported staff to develop knowledge and skills to meet people's needs
• Where people needed assistance to take part in discussions, some easy read and large print documents were available to help people feel involved. This was in line with the accessible information standard.
• During our SOFI staff were caring in their approach and showed people kindness.
• People and their relatives described care staff as ' kind' and 'caring' and people's visitors were welcomed at any time.

Supporting people to express their views and be involved in making decisions about their care
• Where possible people felt involved in decisions about their care. One person said, "Me and my son had a meeting about my care. It was a good meeting." However, the involvement of people or those closest to them was not always clearly reflected in care records.
• Some people were unable to verbally communicate well and make complex decisions. Information about people's mental capacity, and details about who their legal appointees were not always in place. Therefore, we could not be sure decisions were being made in conjunction with people's representatives.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Requires Improvement: People's needs were not always met. Regulations were met.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control:
• An initial assessment of people's needs was completed before they moved into the home. Information gathered was used to complete care plans.
• Some care plans lacked the detail staff needed to provide personalised care and manage risk.
• Most care records had been recently reviewed but some important information had not been updated to reflect when people's behaviours and needs had changed. Despite omissions in records staff knew people well.
• A variety of social activities were provided. Most people enjoyed the activities. However, one person commented, "If I could pick one thing to improve it would be the activities as there isn't much to do. So, I read a lot."
• Activities were not always planned in line with people's interests. One person told us they liked going to the pub and out for a walk but had not had the opportunity to do so. We shared this with the director and action was taken to address this.
• Staff attended a 'handover' meeting at the start of their shift where they shared information including how people were feeling. One staff member told us, "We have a communication book, so we can pass on information."
• People were supported to practice their religions. This included opportunities to take part in visits from faith groups to the home.

End of life care and support:
• A health professional told us they were supporting one person living at the home who was nearing the end stage of their life. However, discussions with some staff did not assure us they knew this.
• Some people's end of life wishes had been recorded.
• Some staff had not received training to support people as they neared the end of their lives.

Improving care quality in response to complaints or concerns:
• People and their relatives knew how to make a complaint.
• A copy of the provider's complaints procedure was displayed within the home.
• Complaints were not always managed in line with the providers procedure. One person told us they had been unhappy with the way a care worker had spoken to them, the person had raised their complaint with the deputy manager. The complaint had not been recorded. That meant opportunities to make required improvements and learn lessons could have be missed.

Inadequate

Is the service well-led?

Our findings

Well Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

Inadequate: There were widespread and significant shortfalls in service leadership. The provider and the culture they created did not assure the delivery of high-quality care. Some regulations were not met.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility:

• Governance systems to monitor the quality and safety of the service were inadequate. For example, risk management plans lacked important information to support staff to provide safe care. Also, checks had not identified people were at risk because accurate records of the care they required were not maintained.
• Health and safety checks of the building did not always take place. For example, checks did not take place to ensure falls from height were mitigated. Action was taken to address this on our request.
• The director was present during both of our visits and we shared our inspection findings with them. They were unable to explain why their governance systems had failed to identify the significant short falls we had found. Following our visits, we requested and received information which assured us action was being taken to start improving risk management.
• Some staff expressed lack of confidence in the provider to support the home and demonstrate good leadership. One said, "(Deputy manager) has just been left to cope. She is brilliant, but she can't do everything. She is on call 24/7."
• The director visited the home weekly and care staff felt supported by their peers and the deputy manager. However, four staff could not remember the last time the provider had visited the home. One said, "I think he came for the summer fayre last year but not since then."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.
• The provider had not met their regulatory responsibility to inform us about significant events that happened at the service. For example, a Deprivation of Liberty Safeguard (DoLS) was authorised by the supervisory body in respect of a person who lived at the home in November 2018. On 2 January 2019 a person fell and cut her head. Their injury required emergency medical treatment. CQC were not notified of these incidents.

This was a breach of Regulation 18 of the Care Quality Commission Registration Regulations 2009. Notifications of other incidents.

• A registered manager was not in post. The previous registered manager had left their employment in February 2019. Since then the deputy manager had been in an 'acting manager' position. However, they had resigned from their post and were due to leave the home at the end of May 2019. The director told us a new manager would start work at the home by the end of April 2019.

• The deputy manager told us they did not want to be the home manager. They said, "I try my best, but I can't do everything I really do try. There is only one of me. Keeping up with paperwork has been difficult."
• People liked the deputy manager. One said, "She's lovely." Staff shared this viewpoint. One described them as 'approachable' and 'the best.'
• Staff had not completed the training they needed to carry out their roles effectively. We were made aware some staff training sessions such as, safeguarding adults had been booked to take place following our visit.
• People's personal information was not managed in line with data protection law.
The provider failed to meet their responsibilities in relation to MCA. For example, some people were being unlawfully deprived of their liberty.
• Improvements were required in promoting person-centred care. Care staff had not queried why people were being unlawfully deprived of their liberty which showed us they accepted this was normal practice.

Continuous learning and improving care; Working in partnership with others
• Where quality assurance processes had identified shortfalls in safety and quality, action had not always been taken to address them. For example, a medication audit completed on 15 March 2019 by the deputy manager had identified one person's prescribed topical cream did not have the date of opening recorded in line with best practice. During out visits we found two people's topical creams did not have the date of opening recorded. Therefore, the opportunity to drive forward improvement had been missed.
• Accidents and incidents that happened in the home had not always been recorded. Therefore, accurate analysis to identify patterns and trends to prevent reoccurrence did not take place. This meant lessons were not always learnt when things went wrong.

The above concerns demonstrated a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014. Good governance.

Engaging and involving people using the service, the public and staff, fully considering their equality Characteristics
• Despite our findings most people and relatives felt the home was well run. One person said, "Everything is okay."
• Newsletters were sent to people which informed them what was happening in their home. For example, a newsletter dated February 2019 informed people the registered manager was leaving.
• People had opportunities to attend meetings to share their views on the service they received. Minutes from recent meetings showed us people were happy.
• Staff had opportunities to attend meetings with the deputy manager to discuss the service and raise any issues.
• It is a legal requirement for the provider to display their ratings, so the public can see these. The latest CQC rating was displayed within the home and on the provider's website.

Working in partnership with others
• Staff at the home had worked hard to develop links with the local community and some people had recently attended a coffee morning at a local community centre. One person told us, "It was great."

After our inspection we shared our findings with the local authority. They informed us they were continuing to closely monitor the quality and safety of the service provided to people. Also, they would not admit any new people into the home until improvements were made.