Lilian Faithfull Homes

Faithfull House

Inspection report

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Date of inspection visit:
20 July 2017
21 July 2017

Date of publication:
07 September 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

We carried out this unannounced focussed inspection on 20 and 21 July 2017.

This inspection was prompted in part by concerns we received in relation to the care of people who lived with dementia. These included the lack of availability of appropriately and suitably trained staff and inappropriate and unsafe delivery of care. As a result we undertook a focused inspection to look at these concerns.

This report only covers our findings in relation to these topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Faithfull House' on our website at 'www.cqc.org.uk'. The previous inspection was carried out 5 and 6 January 2017. At that inspection the service was rated as "good" and was meeting all of the relevant regulations. There was some area for improvement identified regarding the personalisation of people's care plans. As a result of this inspection we found three breaches of regulations. These relate to the assessment, planning and delivery of safe care and treatment, the reporting of incidents and the governance and monitoring of the service. Our findings at this inspection have changed the current rating of 'Good' for the key questions Safe and Well-led to 'Requires Improvement' and the overall rating of this service has changed from 'Good' to 'Requires Improvement'. The provider has subsequently given us an update on the actions taken to improve the practices and processes involved in keeping people safe and in ensuring that improvements to these are sustained. We will inspect these actions at the next inspection of the service.

Faithfull House is registered to care for a maximum of 72 people. The service provides care for older adults, some of whom also live with dementia. At the time of the inspection there were 65 people living there. Accommodation is provided across three floors and on different levels. These can be accessed by stairs and passenger lifts. Outside there is parking to the front of the building and at the rear a large, adapted garden with summerhouse. There is a ramp at the front and rear of the building for easy access by wheelchair.

The service is required to have a registered manager. At the time of the inspection there was not a registered manager in position. 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. A new manager had been appointed in November 2016. They had submitted their application to become the registered manager for the service to CQC to ensure the provider would meet their registration requirements.

During the inspection we observed people receiving support from staff in a caring way, but at other times, people who lived with dementia, did not receive the support they needed to stay safe. We observed delays in people receiving support when they became anxious and agitated placing them at risk of their behaviour escalating which could harm them or others. For those people who required support with their behaviour, detailed positive behaviour plans were not in place that addressed all the risks associated with their

behaviour. For example although their care plans informed staff that they needed to monitor or assure people; their care plans did not inform staff of what might trigger their behaviour, strategies to prevent their behaviour from escalating and how to keep them and other's safe if their behaviour was to escalate. Without clear risk management strategies in place new staff who did not know people well and people newly admitted to the service, whose needs might not be known to all staff, might therefore not always receive consistent and appropriate support from all staff to ensure they were always supported to manage their behaviour safely.

Management systems put in place to ensure shortfalls in quality of care and risks in the home would be identified and rectified were not always operated effectively. For example, the provider's monitoring systems failed to identify that not all incidents which had an effect on people's safety and welfare, had been appropriately reported to the manager or relevant agencies. This meant the actions taken to keep people safe had not always been evaluated to ensure they would be effective and were in accordance with good practice. The provider's monitoring processes had identified the need for some changes and improvements to the service however, they failed to identify the poor care practice we identified at the inspection when supporting people to manage their behaviours and to mitigate the risks to them and others.

You can see what action we told the provider to take 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 always adequately protected against risks that affected their safety and welfare.

Detailed positive behaviour support plans were not in place for people living with dementia who required consistent support from staff to identify and manage their anxiety and associated behaviour so they could remain safe.

We observed people living with dementia not always receiving the support they needed promptly to prevent their anxiety and behaviour from escalating which could place them and others at risk of harm.

Is the service well-led?

Requires Improvement

The service was not sufficiently well-led.

People were not adequately protected by the provider's processes and procedures as these had not always been operated effectively to identify and manage risks and quality concerns in the service.

People were not protected by the arrangements and agreements in place for reporting incidents which have an impact on people's safety and welfare.

The provider's monitoring systems did not always identify shortfalls in people's care so that action could be taken to make the required improvements.

Faithfull House

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.

We undertook this unannounced focused inspection of Faithfull House on 20 and 21 July 2017. The inspection was in response to us receiving concerns which indicated people may not be in receipt of safe care. The service was inspected using two of the five questions we ask about services. In this case, 'Is the service safe?' and 'Is the service well-led?'

Prior to the inspection we reviewed the information we held about the service and this included statutory notifications. Statutory notifications are information the provider is legally required to send to us about significant events.

This inspection was carried out by one inspector. During the inspection, although we spoke with people who lived with dementia, we also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not tell us about this. We spoke with the Chief Executive Officer of the provider, the Director of Care and Development, the service's manager and four care staff.

We reviewed records which related to people's care. These included the care records of two people, which contained care plans and risk assessments, the recorded daily care sheet for one other person and an observation record for another person. We also reviewed the electronic records relating to two call bells which were rung and responded to during the inspection. We requested a print out of all call bells rung and responded to between 1 May 2017 and 21 July 2017. We reviewed the records of an internal investigation, carried out by the provider, which followed one statutory notification sent to us.

We requested and were provided with copies of the minutes of a staff handover meeting, the provider's whistleblowing policy, the staff training record and the service's complaints summary record.

We were offered and accepted copies of the job description and responsibilities of a dementia team leader, the service's 2017 business plan, the service's business continuity plan, a summary of the provision of care at Faithfull House, information pertaining to the service's occupancy and paid staff hours, a report about visits carried out by a representative of the provider and a report by trustees following their visit to the care home.

Requires Improvement

Is the service safe?

Our findings

During our inspection we observed some staff using good practice when supporting people living with dementia to manage their anxiety and agitation. However, we also found people living with dementia were not always receiving care that protected them from risks which may have an impact on their safety and welfare.

Some people living with dementia relied on staff to both identify and manage risks relating to their anxiety and associated behaviours. We found they had not always received the support they needed to stay safe. One person's behaviour could at times put themselves or others at risk of harm. Care records showed that following an incident an initial risk relating to this person's behaviour had been identified nine months prior to this inspection. Although some monitoring arrangements had been implemented these had not been effective and had not mitigated the risk and further safety incidents had taken place. It was after the most recent incident, which was reported to the inspector during this inspection, a care plan was written with regard to the need to monitor and support this person. However, we found that a detailed positive behaviour plan was not in place for this person that addressed all the risks associated with their behaviour. For example although their care plan informed staff that they needed to be monitored throughout the day, their care plan did not inform staff of what might trigger their behaviour, strategies to prevent their behaviour from escalating and how to keep them and other's safe if their behaviour was to escalate so that they would always receive the support they needed. During the inspection we saw a record which showed that the staff were closely supervising this person so that support could be provided as soon as required to keep them and others safe. However, when the person left the communal areas these arrangements were not sufficiently robust as staff observing them were not always able to leave the communal area to continue their observation. Although staff told us the observation would be carried out by another member of staff all other staff at the time of the inspection were equally busy supporting people.

Another person lived with dementia and at times became distressed and confused when receiving personal care. Their care plans stated, "Finding it hard to follow instructions when being prompted due to dementia" and their dementia was, "...impacting on their behaviour during personal care." A care plan review also noted, "Anxious and agitated, not understanding what is happening." Although their care plan instructed staff to "Give reassurance to avoid [name] being frightened"; we found this care plan did not go on to give staff detailed guidance on how to support the behaviours the person exhibited when they were anxious and distressed. Although staff had received training in dementia care and associated behaviours they had not always supported this person to manage their anxiety effectively. This person's care records showed their behaviour had at times escalated and resulted in them becoming increasingly distressed and agitated. Without positive behaviour plans in place to support staff to manage the risks associated with people's behaviour, people were at risk of not receiving consistent emotional and behaviour support from staff.

During our inspection another person became distressed and wanted to leave the building. Staff told us they lived with dementia and their desire to leave the building intensified in the late afternoon and they could not safely go outside without staff support. Although staff knew this person was at risk of becoming anxious at this time, we observed them becoming increasingly distressed without prior intervention from staff to

distract them or de-escalate their anxiety. Staff at this time were observed to be busy attending to other people who required support. After observing this person for several minutes pacing up and down the dining area and eventually walking to the front door, the manager who joined us in the same vicinity as the person addressed this person's request to leave the building. After some negotiation it was agreed that they would take a walk in the garden with one member of staff. This however, required this member of staff to leave their allocated area to provide this necessary one to one support. At the same time another person became distressed about property they had mislaid. This person was supported initially by us and then by the Director of Care. During the inspection another person had become distressed when they had been supported to join several others in a communal room. This person had needed support to leave the area and to became calmer once out of the room. As the member of staff present in this area had needed to leave to support another person, we remained with this person whilst the manager found a member of staff to provide support for the person. These examples showed that the care staff were not always able to respond promptly when people became anxious and unable to always take prompt action to stop people's behaviour from escalating, thereby placing them and others at risk of harm.

At lunchtime we observed one member of staff supporting two people to eat their food and supervising another person to eat independently, on one dining table. Behind them were two further people, one had become agitated with another. The member of staff supporting people with their meals needed to interrupt their support several times to try and diffuse this situation. Eventually they helped the person who was being challenged onto their table. A senior member of staff was monitoring the dining room at this time and was nearby but did not recognise this as a situation that required their support. Some staff missed opportunities to support people promptly to manage their anxiety and behaviour so that it would not impact on other people needing to be supported at the same time.

People were not always supported to manage their behaviour safely. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We shared our concerns with the manager and the Director of Care and Development as we observed the above situations taking place during the inspection and they intervened and helped to support people. Following the inspection they assured us that these concerns would be addressed promptly; this included reviewing how staff were used and guided by senior staff to support people living with dementia throughout the home. Other, potentially longer-term plans were to be brought forward. For example, alterations to the environment were planned so that the service could better meet the needs of those living with dementia.

The provider has subsequently given us an update on the actions taken to improve people's safety. These actions will be inspected during the next inspection of the service.

Requires Improvement

Is the service well-led?

Our findings

There had been a change in manager following our previous inspection in January 2017. The registered manager had stopped managing the service in November 2016. The deputy manager had subsequently been promoted to manager of the care home. At the time of the inspection they had submitted their application to CQC to become the registered manager of the service and were awaiting the outcome of their application.

There was evidence to show that the support needing to be provided to people in the home had changed in a relatively short period of time. This was in terms of people's needs and a change in the type of admission the service accepted. For example, more people who lived with dementia required short stays in the care home before returning again to their own homes. We found there was a faster turnover of people staying at Faithfull House. There was also an increased turnover of staff and some new staff still had to be fully trained and supported to adequately perform their respective roles. At the time of the inspection, some of these new staff had started and others were yet to complete the recruitment process. The new manager had submitted a business plan to representatives of the provider and an action plan was in place on how and when these staffing skill issues would be addressed. Some actions had already started for example, the recruitment of new staff with the appropriate skills and experience to support people living with dementia.

The provider had introduced a new structure of senior care staff to provide staff with the supervision and support they required. However we found improvements were needed to ensure senior staff would always effectively identify and manage risks to people on each shift. For example, one person had been seen by staff and provided with their breakfast at 8:30am. This person required support to get washed, dressed and to get out of bed. We observed them at 11:05am lying slightly across their bed. Although we were informed at the time this person sometimes liked to get up later, we found them without any means of calling for help if they needed to. We were told the person wore a pendent call bell. This was not on the person and no other call bell device was available. A drink was on a bedside cabinet but both were well out of the person's reach. A member of staff was called to assist this person once we had raised our concern. Earlier in the inspection it had been explained to us that senior care staff had recently been allocated areas of the care home to monitor. This was so they could supervise care staffs' work and ensure people received safe and effective care. We spoke with the senior member of staff allocated to this person's floor. They told us they had been providing care and administering medicines elsewhere in the care home. They had not been available to check their allocated floor. Management systems put in place to ensure staff would be supervised and directed on each shift, so that people would receive their support when they needed it, were not always effective and people were at risk of not receiving their required support.

The provider's safety incident procedures were not always implemented effectively. For example, we found one incident had not been reported to the manager so that they could ensure staff had taken appropriate action to keep the person safe. In this case, as the manager had remained unaware of this incident, relevant agencies including CQC, which also have a responsibility to protect people and to ensure they receive safe and appropriate care, had not been notified. The provider's quality assurance checks had failed to identify that all safety incidents had not been reported appropriately prior to the inspection so that action could be

taken to manage risks to people.

We also found that where a concern had been reported about inappropriate practice the initial action taken had not protected the person from further potential inappropriate care. A subsequent investigation by the provider had taken place and this had failed to identify poor and inappropriate care practices and did not result in action which would address this. For example, during the inspection there remained a lack of appropriate assessment and planning in relation to this person's needs and behaviours. It would have been reasonable to expect these shortfalls to have been identified from the information available during this incident investigation. The provider's monitoring processes did not identify the shortfalls in the incident investigation and had not challenged the findings. When we pointed these issues out to the Director of Care and Development during the inspection they recognised these and understood our feedback. They told us action would be taken to improve the effectiveness of the incident reporting and investigation procedures.

Systems and processes in place to assess, monitor and improve the quality and safety of the service provided had not been operated effectively. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider has legal obligations to submit statutory notifications when certain events, such as a death, serious injury or any abuse or allegation of abuse concerning a person using the service occurred. We identified the provider had not notified the CQC as required on two occasions since our last inspection.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 (part 4).

The provider has subsequently given us an update on the actions taken to improve the practices and processes, which ensure people are kept safe, are monitored and sustained. These actions will be inspected at the next inspection of the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents Incidents which affect people's safety and welfare had not been appropriately reported to relevant agencies who also have responsibility to ensure people remain safe and are appropriately cared for. (Registration) Regulations Part 4 Regulation 18 (1) (2)(e)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's care and treatment was not assessed and planned in such a way which ensured they were provided with care and treatment which met their needs, and, any changing needs. All that was practicably reasonable had not been completed in order to reduce risks which impacted on people's safety and welfare. Regulation 12 (1) (2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not operated effectively to ensure risks relating to people's safety and welfare were mitigated. Opportunities to improve the quality of people's care and treatment were not always recognised and acted on. Regulation 17 (1) (2)(a)(b)