WCS Care Group Limited

Fourways

Inspection report

Mason Avenue
Lillington
Leamington Spa
Warwickshire
CV32 7PE

Tel: 01926421309
Website: www.wcs-care.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 6 and 11 June 2018. The first day of our inspection was unannounced.

Fourways is a care home registered to provide personal care and accommodation for a maximum of 47 people. People in care homes receive accommodation and 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 home is located in a residential part of Lillington with access to shops and local amenities. There were 45 people living at the home at the time of our visit, some of who were living with dementia.

The service had a registered manager. This is a requirement of the provider's registration. 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. However, the registered manager was no longer working at the service, and a new manager had been appointed. The provider told us the registered manager was still providing support to the new manager, but acknowledged they needed to notify us of the changes in the day to day management of the home.

We last inspected Fourways in September 2015 when we rated the service as 'Good' overall. However, the key question of safe was rated 'Requires Improvement' because people did not always receive their medicines as prescribed.

At this inspection we found further improvements were required because staff were not consistently demonstrating the provider's values and ethos of care in their everyday practice. Improvements were required in staff's understanding of people's individual needs for support. People did not always receive support that was responsive to their social and emotional needs.

There were enough staff to keep people safe and people told us they felt confident with the staff who supported them. However, the deployment of staff meant they were not always responsive to people's needs.

People's individual risks were assessed and their care plans explained the actions staff should take to support people safely. However, staff did not always act consistently to mitigate people's assessed risks or follow the provider's guidance for managing medicines safely.

Staff went through a series of recruitment checks to ensure their suitability to work at Fourways. The induction, training and support given to staff ensured they had the skills, knowledge and confidence to carry out their duties and responsibilities effectively and understand their responsibilities to report any abuse or discrimination.

People were encouraged and supported to eat and drink enough to maintain their health. People told us they received good healthcare and were supported to access healthcare services when needed. The provider encouraged good working relationships between their own staff and community health professionals so information could be shared effectively.

The provider had made appropriate applications to the local authority in accordance with the Deprivation of Liberty Safeguards and ensured staff worked within the principles of the Mental Capacity Act 2005.

People felt cared for by staff who were kind and respectful of their wishes. Staff had training in equality and diversity and understood people were entitled to privacy and to express their views and opinions. Staff were respectful of people's relationships with their family and friends.

The provider used a recognised activity programme to ensure people received mental and physical stimulation every day of the week. However, people who were less able to express themselves verbally, or who did not want to join in the group activities, did not experience the same quality of engagement or interaction with staff.

People and relatives were encouraged to provide feedback and make suggestions to improve the quality of care provided. Complaints raised were responded to in line with the provider's policy and procedures.

There was an open culture in the home where learning from mistakes and incidents was encouraged. Where issues were identified, the provider learnt from experience and took action to improve. The provider had links with other organisations and agencies to share learning and good practice and improve outcomes for people within a care environment.

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 consistently safe.

There were enough staff to keep people safe, but their deployment meant staff could not always be responsive to requests for assistance. People's risks to their health and wellbeing were assessed and planned for, but staff did not always act consistently to mitigate those risks. Systems to ensure safe management of medicines were not always followed. People felt safe with staff who understood their safeguarding responsibilities. Accidents and incidents were recorded by staff and there was an open culture where learning from such incidents was encouraged.

Is the service effective?

Good

The service was effective.

People received support from a staff team who were trained to meet their needs. Staff supported people to eat and drink enough to maintain a balanced diet. People's health needs were monitored and appropriate referrals were made to other healthcare professionals where required. The provider acted in accordance with the Mental Capacity Act 2005 and assessed people's understanding to make their own decisions.

Is the service caring?

Good

The service was caring.

People told us staff were caring and kind and respectful of their wishes. Staff understood people were entitled to privacy and supported them to express their opinions. Staff were supportive of people's relationships with their friends and family who could visit when they wished to.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Improvements were required in staff's understanding of people's individual needs for support. Staff were not always responsive to

people's social and emotional needs. People were encouraged to share their views about how they would like to be cared for at the end of their life. People could be confident any complaints would be dealt with in line with the complaints policy.

Is the service well-led?

Requires Improvement 

The service was not consistently well-led.

The provider used a range of detailed audits and checks to monitor the quality of the service.The actions taken as a result of the provider's audits were not effective, because the provider had not checked or ensured their action was effective at improving staff's practice. Despite receiving training in the provider's values, some staff still did not deliver a person centred service. People and relatives were encouraged to provide feedback and make suggestions to improve the quality of care provided.

Fourways

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 comprehensive inspection took place on 6 and 11 June 2018. The first day of our inspection was unannounced. As the home manager was on annual leave on that day, we told the provider we would return on the 11 June 2018. Two inspectors, an assistant inspector and an expert-by-experience undertook the inspection on the first day. One inspector returned for the second day. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection visit, the provider completed a Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We used information the provider sent us in the PIR in our inspection planning.

We also reviewed the information we held about the service. We looked at information received from the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

During the inspection visit we spoke with eight people who lived at the home and five relatives. We spoke with six care staff, a lifestyle coach and the deputy manager about what it was like to work in the home. We spoke with the provider's Director of Innovation and Delivery, Director of Delivery and a project consultant about their management of the service.

Many of the people who lived at the home were not able to tell us in detail about how they were cared for and supported because of their complex needs. However, we used the short observational framework tool (SOFI) to help us assess whether people's needs were appropriately met and to identify if people

experienced good standards of care. SOFI is a specific way of observing care to help us understand the experiences of people who could not talk with us.

We observed care and support being delivered in communal areas and we observed how people were supported to eat and drink at lunch time. We reviewed three people's care plans and daily records, staff training records and management records of the checks the manager and provider made to assure themselves people received a safe, effective quality service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection visit we found the safety of the service required improvement because people did not always receive their medicines as prescribed. At this inspection we found systems to ensure people received safe care were not always consistently effective. We have therefore rated the safety of the service as still requiring improvement.

Staff were confident there were enough of them to meet people's needs safely and effectively without rushing. One member of staff told us, "There are enough staff if everyone gets on with the job. It is a good team on this floor."

People thought there were enough staff. One person told us their call bell worked and staff came promptly when they rang it. Other comments included: "Staff are usually around. They are pretty good, I never wait a long time when I ring", "There are lots of carers here" and, "Any place could do with extra staff, but the staff are very good and they do manage."

However, during our visit we observed occasions when staff were not responsive to people's needs because they were not deployed effectively. For example, during handover only one member of staff was left on each floor for approximately 20 minutes while the other staff went to the manager's office on the ground floor. During handover on the first day of our visit, two alarm calls were activated on one floor, but the staff member was unable to respond quickly because there were no other staff available to support them. This was confirmed by a relative who felt there were enough staff, but was puzzled why so many needed to attend the shift handover which impacted on staff availability. Following our inspection visit, the provider confirmed they had changed their handover process. The duty manager now visited each floor individually, which enabled staff to remain on their floor to respond to care needs and answer call bells.

We also saw other occasions when staff were not available to respond to people's anxiety or their requests for support. On one occasion a person sitting in the lounge called out, "I need to go to the toilet badly. Please help me." Another person in the room responded, "There aren't any carers in here at the moment." On two occasions a person activated the sensor mat in their bedroom. Staff only responded when the tone of the alarm switched to an emergency call after five minutes. During these five minute periods staff carried on preparing the tables for tea and clearing up rather than respond to the alarm call. On the second occasion the provider's project consultant intervened and reminded staff of the importance of responding to call bells quickly. They later assured us this would be addressed with the wider staff team.

People's individual risks were assessed and their care plans explained the actions staff should take to support people safely, while maintaining as much independence as possible. People and relatives told us staff took the actions agreed in their care plans to minimise their personal risks and maintain a safe environment. One person told us they were always supported with their continence care when needed. They told us they had the type of pressure relieving mattress and cushion they had been assessed as requiring to minimise their risks of skin damage and described both as 'very comfortable'. A relative told us their family member's door was left ajar at night, to make sure they were comforted by the light from the hallway and

not afraid. They told us their family member's sensor mat worked to alert staff if the person tried to get out of bed independently without calling for the support of staff, which they needed to stay safe.

However, we found that staff did not always act consistently to mitigate people's assessed risks. A member of staff told us there was no set routine for testing call bells worked, but said staff would check when they were providing care in people's rooms. We found this was not the case. One person who had recently moved into the home from hospital needed support from staff to move around and was in bed at the start of our inspection visit. They told us they were very thirsty, but had not been able to summon staff to bring them a drink. Their call bell had been put in a drawer and was not plugged into the call bell system. The duty manager told us the person had a sensor mat by the side of their bed to warn staff if they tried to get out of bed unsupported. However, when we tested the sensor mat, it was not working. We saw another person's call bell was also not connected to the system because it was in a drawer in their bedroom. The deputy manager confirmed that staff should have ensured this person had access to their call bell to call for assistance. This meant the equipment required to keep these people safe was not always accessible or effective.

One person was sitting in the communal lounge in their wheelchair. The person told us they were uncomfortable sitting in the wheelchair and asked a staff member if they could have a cushion for comfort. When we returned two hours later the person still did not have a cushion in place and told us they were now in considerable pain. When we checked this person's care plan, it stated they were at risk of skin damage and had an airflow cushion and mattress to mitigate this risk. When we asked a staff member why no action had been taken to respond to the person's request, they told us two staff were required to transfer this person, and no other staff were available. They also told us they were waiting for an airflow cushion for the person to be delivered to the home. However, when we discussed this with members of the management team, they told us the staff member should have rung for assistance. They also confirmed there were other pressure relieving cushions in the home that could have been used to alleviate this person's discomfort and minimise the risks of skin damage until their own cushion had been delivered.

People at high risk of developing skin damage had pressure relieving mattresses on their beds. We observed that the settings of pressure relieving mattresses were not regulated dependent on people's weights as guidelines recommend. For example, one person's pressure relieving mattress was set at 120kg when their actual weight was 42.4kg. Another person's mattress was set at 30kg and their last recorded weight was 56.3kg. On the second day of our visit, the provider had ensured the mattresses were on the correct setting and implemented a system to regularly check the correct setting was maintained. Other equipment such as hoists and bath chairs had been checked by an external contractor to ensure their safety.

We looked at how medicines were managed at the home. Only trained staff who had been assessed as competent to manage medicines safely, gave people their medicines. However, we observed an occasion when a person was left with their medicines in a communal lounge, because the staff member had not ensured the person had taken them. Staff should observe people take their medicines before signing the medicines administration record (MAR) to confirm they have been taken. This not only ensures people have taken the medicines they need to maintain their health, but also protects against the risk of other people taking medicines that are not prescribed for them. On this occasion the risks were increased because people in the communal lounge were living with dementia and lacked understanding of the risks of taking other people's medicines. The person had been given the medicines 40 minutes before we became aware of the issue which meant other staff working in the lounge had not identified the risks and acted to mitigate them. We shared our observations with the duty manager who confirmed this practice was not in accordance with the provider's policy and procedures.

Other medicines were not always stored securely. For example, some medicines were stored in fridges in the care offices on each floor. The fridges had been left unlocked and on several occasions we saw the office doors were left open which meant they could be accessed by people living in the home. During the afternoon of our first inspection visit, two crates of newly delivered medicines were left unattended in the deputy manager's office with the door left open. This was a risk as the office was based on the same floor as people's bedrooms and the main entrance to the home.

People told us they were supported to take their medicines when they needed them. Where people had medicines on an 'as required' basis there were guidelines and processes in place to ensure they were given safely and consistently. The electronic medicines recording system only allowed staff to give people their medicines at the prescribed times and ensured the correct gap was maintained between doses. However, some people were prescribed medicines that needed to be given 30 to 60 minutes before other medicines. The electronic recording system showed that these people's medicines were all given at the same time.

Some people received their pain relieving medicines via a trans-dermal patch applied directly to their skin. It is important the patches are rotated around the body to avoid people experiencing unnecessary side effects. Staff had not completed records of where patches had been applied to ensure people were protected from these risks. There was no record of daily checks to ensure the patches were still in place. Daily checks are important as patches can fall off or be removed by people, which could result in them experiencing unnecessary pain. The provider's quality director assured us body maps and checks would be implemented immediately.

The general appearance of the home was clean and tidy. There were occasions when accidents occurred, but when these were identified, staff acted quickly to clear them up. The communal toilets and shower rooms were clean and contained toilet roll, soap and paper towels to promote good hand hygiene.

We were told that generally there was one member of domestic staff on each of the three floors in the home and one member of staff in the laundry. However, on the first day of our inspection visit, due to annual leave and sickness, there was only one member of domestic staff on duty to clean all 47 bedrooms as well as the communal areas. The rota indicated this was the situation for the whole week which meant the standard of cleaning in the home would be compromised. Cleaning schedules confirmed that whilst bedrooms had been cleaned, the weekly 'deep cleans' of mattresses, chairs, wheel chairs and beds which had been recommended by an external infection control nurse, had not been happening. We raised this with the provider's project consultant. They acknowledged there needed to be more robust cover for absent domestic staff to ensure the provider's standards of cleanliness were maintained in accordance with the external expert's recommendations.

Staff wore personal protective equipment (PPE) such as gloves and aprons when providing personal care or preparing and serving food. PPE was available throughout the home to encourage staff to follow good infection control and hygiene practice. One person told us, "The staff always wear gloves, and the cleaners are great."

People told us they felt safe and well supported by staff. One person explained, "I'm quite safe, it is something about the atmosphere. There are no worries." A relative told us they visited every day and were totally confident their family member received safe care.

Staff recruited to the home went through a series of recruitment checks which included a Disclosure and Barring (DBS) check and reference checks. The DBS is a national agency that keeps records of criminal convictions. Recruitment checks were made before staff started work in the home.

Staff told us they had training in safeguarding and would not hesitate to report any abuse or to use the whistleblowing procedure to report any concerns about other staff's practice. One member of staff told us, 'I would say to staff, how would you like it, if it was your Nan?"

We found that when concerns had been raised, the provider had followed their policies and procedures to mitigate risks and ensure people were protected from abuse and discrimination. We did identify one incident involving a missing medicine that had not been reported to the local authority safeguarding team in accordance with the provider's safeguarding responsibilities. However, we were assured this was a single omission as other safeguarding concerns had been promptly reported as required. The provider's Director of Innovation & Development ensured the notification was submitted retrospectively.

The provider's policies to keep people safe included regular risk assessments of the premises and testing and servicing of essential supplies and equipment. Staff received training in health and safety, first aid and fire safety, to ensure they knew what actions to take in an emergency. One person told us they felt protected by the provider's emergency procedures and said, "The fire alarms go off regularly and the doors close automatically. You can't wish for any more safety precautions." The 'fire folder' in reception listed everyone who lived in the home, and explained the assistance they needed to mobilise, to ensure people could be supported safely if they needed to evacuate the home in an emergency. However, the list had not been updated since the 26 April 2018 and did not contain information about four people who had moved into the home since that date. The provider's Director of Delivery immediately updated the records so the emergency services had accurate information about everyone who lived at the home.

Care staff recorded accidents and incidents in people's daily records and completed an accident and incident form. Overall, the records of accident and incidents were very detailed and the investigations included the location and time and identified the probable cause and the actions taken to mitigate any immediate risks. The provider monitored and analysed accidents, incidents and falls to identify any trends or patterns and ensure, where necessary, appropriate action had been taken to minimise the risks of a reoccurrence. We found there was an open culture in the home where learning from mistakes and incidents was encouraged. Where the provider was able to take action to address issues identified during our visit, this was done immediately. The provider's Director of Innovation & Development assured us other issues would be addressed through supervision and staff meetings and monitored to ensure any identified actions became embedded in staff practice.

Good

Is the service effective?

Our findings

At our last inspection we rated the effectiveness of the service as 'Good'. At this inspection, we found staff training continued to meet the needs of people who lived at the home. People continued to have freedom of choice and were supported with their dietary and health needs. We continue to rate 'Effective' as Good.

People told us they felt confident with staff because staff knew their needs and how to support them. One person told us, "I am very happy with their knowledge and skills, they are well trained." Another person said, "I'm very happy with staff, they know what to do."

Staff told us the training and support they received gave them the skills, knowledge and confidence they needed to carry out their duties and responsibilities effectively. Staff told us they had training in the subjects they needed, such as moving and handling, first aid and supporting people living with dementia. The provider's Director of Innovation & Development told us the provider continually reviewed the training courses available to staff to ensure they remained current and relevant to the needs of people living at Fourways. They acknowledged that some staff needed to complete 'refresher training' to ensure they retained and developed their knowledge and skills, and this had been identified as a priority within the home. Staff were also encouraged to work for nationally recognised qualifications in health and social care to support their practice.

New staff shadowed experienced staff to learn about people's individual needs and how they preferred to receive their care and support. Care staff told us they were supported to deliver effective care because they had regular opportunities to discuss their practice and any concerns at one-to-one and group supervision meetings.

People were encouraged and supported to eat and drink enough. At lunch time we saw most people ate in the dining room. There was a choice of main meals and puddings. When people said they did not want the hot pudding, staff went to fetch ice cream from the kitchen, which most people preferred because it was a hot day. On one unit we saw there were jugs of different cold drinks so people could see the choice of drinks available, but on two of the units, people were only given the option to have orange squash. However, glasses were regularly refreshed during the meal.

One person told us the staff were good at ensuring they always had a jug of cold drink available. They told us the food was very good. They said, "I always get a choice and the selection is good. I am satisfied with the food." Another person in their bedroom pointed to their jug and said, "This is filled up all the time. They do check on us with our intake of fluids." We saw people were able to have breakfast whatever time of day they got up and in the communal lounges there were snacks and fruit which people could help themselves to throughout the day.

People were regularly weighed to check they maintained their normal weight. Staff told us if people were at risk of not eating or drinking enough, they monitored and recorded what the person ate and drank and reported to a senior if the person did not eat enough. Staff knew which people needed their meals 'fortifying'

with additional full-fat milk or cream, to increase their calorific intake.

The provider set a standard that every person who lived at Fourways should be encouraged to drink a minimum of 1.5 litres of fluid per day. The electronic recording system enabled the manager and provider to remotely monitor each person's diet, and to prompt staff to encourage people to eat and drink more if they were at risk. A member of staff told us, "750mls of fluid per shift is the bottom line." The provider's project consultant told us the focus on encouraging fluids had a positive impact on people's health because they had noted a reduction in the level of falls and urinary tract infections within the home

People's needs were assessed by using nationally recognised risk assessment tools, such as the Abbey pain scale, the Cornell depression tool and the Waterlow assessment to identify those people who were at risk of skin damage. Care plans included the equipment needed and the actions staff needed to take, to minimise the identified risks. People's care plans included their individual risks and the planned outcome of mitigating their risks, if staff followed the guidance available to them.

Staff effectively communicated information about people because they recorded when and how they supported people on the electronic care records. They recorded information about changes in people's appetites, moods and health and shared the information verbally at handover meetings at the beginning of each shift. People's daily records were available on the hand-held devices staff used to make sure all staff knew of any changes in how people were supported or cared for.

People told us they received good healthcare and were supported to access healthcare services when needed. Comments included: "The GP comes when needed" and, "She has all kinds coming to see her, doctors, chiropodists, all of them." One person particularly spoke about the prompt referrals made by staff and said, "No sooner had I started to cough and the doctor was here." District nurses regularly visited two people who needed support with their medical needs, and visited other people when a need was identified. Records showed people were referred to their GP when their health changed.

The provider encouraged good working relationships between their own staff and community health professionals so information could be shared effectively. Each person had a 'hospital pack' which went with them if they were admitted to hospital. This informed other health professionals about the person's current care plan and any immediate risks to their health and wellbeing. It also detailed the care the person had received in the previous seven days, including their nutritional intake, so other health professionals had an accurate picture of how the person had been.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The provider understood their obligations and acted in accordance with the MCA. People's understanding and memory had been assessed to check whether they could make their own decisions, or decisions needed to be made in their best interests. The provider had applied to the supervisory body to restrict a person's liberty, when it was in their best interests to do so, because the person lacked the capacity to recognise risks for themselves. Best interest decision meeting notes recorded who was involved in the meeting and why the decision had been made. Where a court had awarded the person's representative the right to make decisions on the person's behalf, the provider had obtained a copy of the court order, to ensure the decision maker had the legal right to make decisions.

People who were able to express themselves told us they were able to choose what time they got up and went to bed, and how they spent their day. One person told us they had decided to have a 'lie-in' that day, and staff respected their decision. Another person told us staff always sought their consent before carrying out personal care tasks and said, "They always ask first, would you like a wash."

The ground floor of the home had been adapted and designed to suit the needs of people who lived there. However, the decoration of the home was inconsistent. The corridors on the ground floor were decorated with people's artwork which the lifestyle coaches had supported them to make, as well as black and white photos of the local town. People's bedroom doors had their names and a door knocker on them, with a memory box to put items that were important to them. However, the corridors on the first and second floor were painted in a pale colour and did not have any decoration or points of reference to assist people living with dementia to recognise where they were in the home. Following our visit, the provider sent us an action plan of a refurbishment that was planned of the upper floors. The action plan included replacing items of furniture and putting new pictures and photographs on the walls.

There was a welcoming café, where people and their visitors could help themselves to hot and cold drinks and snacks. The adjoining conservatory had comfortable sofas and led out onto a level terrace, which was easy for people to access. There was a hairdressing salon, where people could make appointments or use with their own hairdresser. There was also a spa room where people could enjoy relaxing in a spa bath with lights, aromatherapy scents and music to make it a full sensory experience. The garden was secure and encouraged people to spend time outdoors relaxing. There were tables, chairs and parasols and an aviary with birds for people to watch. We saw people using these facilities during our inspection.

Good

Is the service caring?

Our findings

At this inspection, we found people were as happy living at the home as they had been during our previous inspection in September 2015, because they felt staff cared about them. The rating continues to be Good.

All the people we spoke with told us staff were caring and kind when providing support and respectful of their wishes. One person told us, "The staff are thoughtful and they are always polite. All the staff are caring." Another told us, "You can't fault the staff because they are always nice to you. I think it is their attitude, they have all got a smile on their face." One person told us how they valued their relationship with staff and explained, "We laugh and joke all the time. The night staff are great too, they always check on you." Another person said they felt listened to because, "Anything you want, they help."

Relatives were equally positive about the staff who they described as 'fabulous' and 'marvellous'. One relative told us they had no concerns about staff's attitude, or behaviour. They said they had been involved in care planning discussions and were able to speak on behalf of their relative and their opinions and views were respected.

We spoke with staff about what caring meant to them. One staff member explained, "Somebody who has time to stop and listen to others and be patient and sympathetic, somebody who understands the resident and knows their history." Staff told us they had time to get to know people because they worked on the same unit most of the time. When we asked one person whether they felt staff knew about them as a person they responded, "I think they get to know you after a time, oh yes. I think they are very understanding." This was confirmed by a relative who told us, "Staff seem very consistent in their care." Staff told us they enjoyed working in the home because they liked supporting the people who lived there. A member of care staff told us, "The job can be demanding and difficult, but it is so rewarding."

Staff told us they had training in equality and diversity and in dignity and respect. They told us they understood people were entitled to privacy and to express their opinions. Staff told us people were supported to maintain their faith and cultural beliefs both inside and outside the home.

The provider was committed to promoting equality and diversity and particularly how they supported people living with dementia who identified themselves as being Lesbian, Gay, Bisexual, Transgender or (LGBTQ). They planned to identify a 'LGBTQ Champion' from within the staff team to lead on promoting a truly inclusive and diverse culture within the home.

Staff supported people to express themselves in their surroundings. Bedrooms has been personalised with people's belongings such as small pieces of furniture, photographs and ornaments to help people feel at home. Staff knocked on doors before entering people's rooms and closed them when providing personal care to maintain people's privacy.

Staff were respectful of people's relationships with their families and friends. The provider had an open house policy and visitors were welcome at any time of the day. Relatives were able to choose to visit their

family member in their bedroom or in communal areas of the home. Some relatives particularly enjoyed spending time with their family members in the 'cafe' area of the home where they could help themselves to hot drinks and cakes which made it more of a social occasion. One relative told us, "I always feel very welcome and always make myself at home." Another said, "We always help ourselves to tea and cakes whenever we want." We heard one person who lived at the home say to a visitor, "This is a lovely home."

At a recent quality assessment visit to the home by Age UK, assessors had particularly praised the 'homely feel' at Fourways and how content people were with the staff who worked there.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection visit we rated the responsiveness of the service as 'Good'. At this visit we found staff were not always responsive to people's social and emotional needs. The rating is now 'Requires Improvement'.

Improvements were required in staff's understanding of people's individual needs for support. When staff were asked to bring one person a drink, a staff member brought the drink in a mug and put it on the bedside table which was out of the person's reach. The person needed their drink in a beaker and needed the support of staff to sit up to drink it, but the staff member left the room without checking whether the person needed assistance to quench their thirst. The person had to wait for another member of staff to come and resolve the situation. Later in the day, the person told us they were uncomfortable sitting in a wheelchair. They asked for a cushion for comfort, but waited two hours for staff to respond to their request.

At lunch time, not everyone was able to understand staff's verbal description of their choices, but we only saw one person offered a visual choice. When one person was given the choice of roast pork or cauliflower cheese they responded, "What is cauliflower cheese?" The member of staff described what it was in words, but did not give the person a visual prompt.

On one floor a person sat at the table for around 20 minutes waiting for their lunch. Staff served everyone else in the room and then started to take meals to those people who had chosen to eat in their bedrooms. The person complained about their wait, and because of their dementia they demonstrated their frustration by becoming verbally aggressive. In response, staff moved the person in their wheelchair to a table at the other side of the lounge where they sat by themselves with their back to the room. Staff assisted this person with their lunch when they were calmer.

We looked at this person's care plan. It read, "[Name] enjoys company and socialising, but will not initiate this. Staff to ensure full support and encouragement is given to [name]." It also advised staff to use the person's memory album to prompt happy memories which gave them a 'sense of happiness and wellbeing'. On the first day of our inspection visit staff were not responsive to this person's emotional needs because they did not follow the care plan.The person remained sat in the same position looking out of the window with their back to the room throughout the afternoon. On several occasions we spoke with this person who told us, "I've got nothing left in my life" which demonstrated they were very low in mood. At no point did we observe staff take action to integrate this person back into the lounge to prevent them from being socially isolated from the others who were there. On the second day of our visit, this person was sitting talking with another person and their mood was much brighter.

When we checked this person's daily records we found staff had not recorded the person's agitation during lunch time to help understand what could cause them to become frustrated and anxious.

People and their relatives had been involved in the planning and review of their care. People's sensory needs were assessed and recorded in their care plans and what support or equipment they needed to

enhance their ability to communicate. For example, one person used picture books to help them make their wishes known.

When needed, people received end of life care at Fourways. Staff attended end-of life training to enable them to understand how to support people at the end of their life. They also worked with other healthcare professionals such as doctors and district nurses to ensure people remained pain free People's wishes for how they wished to spend their final days was recorded in their care plans.

The home had received a number of compliments, some of them particularly about the level of care people received at the end of their life. One compliment read, "Thank you from the bottom of our hearts for the love, care and kindness you showed not only to [name] over the last few months, but also to our family."

The provider used a recognised activity programme to ensure people received mental and physical stimulation every day of the week. There was also a minibus service which enabled people to go out twice a month on trips to local attractions and other places of interest. The activity programme was led by activity staff known as 'lifestyle coaches'.

In the morning of our first inspection visit, we saw nine people were sat in the sunshine in the garden for their mid-morning drink. Some people played skittles with the lifestyle coach and others enjoyed the opportunity to socialise. A photo album containing pictures of people engaged in meaningful occupation was in the reception area. People and relatives coming into the home were able to see photos of people taking part in activities with the lifestyle coach. There was a list of the week's activities in the corridors on each floor.

In the afternoon, some people went out for a walk with staff and one member of staff took a person in their wheelchair to enjoy some fresh air. However, people who were less able to express themselves verbally, or who did not want to join in the group activities, did not experience the same quality of engagement or interaction with staff. A lifestyle coach told us care staff engaged people in activities such as dominoes, ball games, quizzes and armchair exercises, but we did not see care staff engaging in such activities on the day. We were told each floor had 'rummage boxes' containing items relevant to people's interests and hobbies. We did not see staff encouraging people to use these items.

In the 'lifestyle' section of one person's care plan, we read they needed to be 'occupied' to distract them from shouting out in their anxiety. Their care plan suggested the person was invited to do painting for example, because they needed to do something of 'worth' to increase their contentment. We did not see the person being invited to do this during our inspection and they continued to shout out in their agitation.

When we asked staff whether there were enough staff to respond to people's individual needs, one staff member said, "No comment." They told us care staff were not 'allocated' to spend time with individual people, as it depended on the day. When we asked another staff member if they had time to sit and talk with people they responded, "We probably don't get as much time as we would like. Generally the best time is after lunch when they are sitting and relaxing." On several occasions during the day, we saw people who needed support to engage with other people and their surroundings were in the communal rooms without a member to staff to support them to engage. Staff were attending to the 'tasks' they needed to complete, such as making beds, taking washing to the laundry room and preparing and clearing up meals and drinks.

People and their families were given information about how to complain and details of the complaints procedure were displayed in the home. Relatives told us they knew how to raise a concern and they would be comfortable to do so. One person told us, "I would know how to complain, but I've not needed to." A

relative told us they had no complaints because if they raised any issues with staff, they were sorted out straight away. A member of staff told us they sorted complaints about 'small issues', such as laundry, straight away. Another staff member told us if there were concerns of a more serious nature, "I would let the care co-ordinator or [name of manager] know, and let them take it from there."

Nine complaints had been recorded in a complaints log in the five months prior to our inspection and dealt with in line with the provider's policies and procedures. Where necessary, actions had been put in place to make any necessary improvements. However, we saw that one complaint had been in relation to some staff not engaging with people to meet their social needs and another had been about a person not having access to their call bell. Actions put in place to manage these concerns were not consistently effective as we identified similar issues on the first day of our inspection visit.

Requires Improvement

Is the service well-led?

Our findings

At our last inspection in September 2015 we rated the leadership of the service as 'Good'. At this inspection we saw some detailed audits and checks to monitor the quality of the service. The actions taken as a result of the provider's audits were not effective, because the provider had not checked or ensured their action was effective at improving staff's practice. Despite receiving training in the provider's values, we saw some staff still did not deliver a person centred service. The rating is therefore 'Requires improvement'.

The provider had a strong track record of delivering high standards of care which provide very positive outcomes for people. However, since our last inspection at Fourways, several staff from the provider's management team had left the organisation, and from what we saw and heard, this had impacted on how the home was managed and run on a daily basis.

Providers must have effective governance systems to assess, monitor and drive improvement in the quality and safety of the service provided. This should include acting on feedback to improve outcomes for everyone using the service. Whilst the provider had governance systems in place, they were not being implemented consistently or effectively.

All staff had received training in the provider's values and the ethos of the service, which included, 'Play', 'Make their day', 'Be there' and, 'Choose your attitude (by parking the personal)'. These values were the benchmark of the care provided and put people at the heart of the service so that every day was a day well lived for them. We did not see all staff putting these values into practice during our inspection, particularly for those people less able to communicate their preferences. However, people and relatives who were able to tell us about their care told us they were very satisfied, because they liked the staff and they felt well-cared for.

One person who needed staff's support to sit up and move about, was in bed without a call bell to hand. They had been unable to tell staff they were thirsty because they had been unable to call for assistance. Later in the day, the person told us they were uncomfortable sitting in a wheelchair. They asked for a cushion for comfort, but waited two hours to be given one. Staff told us they were unable to respond because they had 'been busy'. Another person was socially isolated from other people because they were left sitting at a table with their back to the room for over four hours. This person was very low in mood and it was not 'a day well lived' for them.

Written documents did not always demonstrate the provider's values. In the care office on the middle floor there was a notice titled, 'Weekly bath list' with the days of the week and names of people who lived at the home. A member of staff agreed, it would be more respectful if this list was called, 'People's preferred days to bath or shower'. The door of the care office was unlocked and contained people's confidential information.

The provider had invested in an electronic care records system and staff had immediate access to people's records though hand held mobile devices. The manager was able to monitor the quality of care people

received on a daily basis through the system and prompt staff if any gaps were identified. However, the provider's observations and checks had not identified that staff were not always demonstrating the expected values in their every day practice and being responsive to people's needs. They had also not identified that policies and procedures relating to safety were not always implemented effectively. This was reflected by the fact the provider had received nine complaints about various aspects of care delivery in the five months prior to our inspection visit. Actions put in place to manage these concerns had not always been effective.

The provider understood their regulatory responsibilities. They had informed us about important incidents that occurred in the home and the ratings from our last inspection visit were prominently displayed. However, the registered manager was no longer working at the service, and the provider had not informed us, by way of a statutory notification, how the service would be managed in their absence.

This was a breach of Regulation 17 of the Health and Social Care Act 2008. Good governance.

Following our inspection visit the provider sent us an action plan stating they were going to revisit the values training with managers and staff. They wrote: 'We will engage with the total staff team to embrace that social interactions and activities are a WCS value and not just the responsibility of the lifestyle coach. This will be monitored to ensure that it is embedded [in staff practice].'

On the first day of our inspection, the new appointed manager was on leave, so we spoke with the duty manager and members of the provider's executive team. A duty manager was assigned each day to ensure there was always management support available to people and staff. The name of the duty manager was displayed in reception, which ensured people and visitors knew who to ask for.

We arranged to return to complete our inspection when the manager had returned from leave, but unfortunately on the second day of our visit, the manager was still unavailable. However, staff told us there had been some positive changes since the new manager had been appointed. Two staff told us the new manager was 'firm' about the provider's dress code, punctuality and about the process and expectations if staff needed to be away from work when they were sick. A member of staff told us the manager regularly 'walked around' the home to check people were being supported and cared for according to their needs. A relative told us they had seen some positive changes since the new manager had been appointed. They saw that everyone's names were now on their bedroom doors and staff with long hair now tied it back at mealtimes.

The manager carried out a variety of audit checks and delivered monthly reports to the provider so the provider could be assured that care was delivered and monitored consistently across the provider's homes. The provider produced monthly statistics for a range of indicators which enabled managers to compare their performance and learn from others. The manager attended meetings with other managers to reflect on their practice and share ideas.

Where issues were identified, the provider learnt from experience and took some action to improve. For example, people were now weighed at a minimum of monthly intervals following learning from an incident when a person had not been identified as being at risk of malnutrition. Analysis of the records demonstrated that all people in the home who were at risk of malnutrition had been reviewed by their GP and referred to a dietician if required.

People and relatives were encouraged to provide feedback and make suggestions to improve the quality of care provided. This was through regular questionnaires and meetings, comment cards and a 'residents

forum'. The electronic care system also provided a 'Gateway' where relatives could access their family member's care plans to ensure their needs were being me and raise any concerns or queries. One relative told us, "Whenever I comment on Gateway they always reply promptly."

Staff told us they attended regular one-to-one meetings about their practice and 'unit' meetings to discuss people's needs and dependencies. A member of staff told us they discussed changes in people's weights, moods, health and preferences. This enabled them to identify when people's needs and risks changed, and to review and update their care plans. The member of staff had identified that when new people moved into the home, there was an impact on staff and the people who lived at the home, while the person settled in to their new environment. There was no evidence that this was accounted for by varying the number of staff on duty when a new person moved in.

The provider had links with other organisations and agencies to improve outcomes for people and share information. At one of their homes the provider had introduced an Innovation Hub to share their approach with other providers and learn from their experiences as well. They were a member of the National Care Forum which enabled sharing of good practice and learning with other member organisations. The provider was also working with a local university who were investigating the impact of a range of approaches and innovations on the health and wellbeing of people living in a care environment.

The provider had received national recognition of their achievements in the care sector and despite the issues we identified, we could be assured they were working in an innovative way to improve people's lives. For example, the provider had set a target for each person to spend at least 90 minutes outside every week. The attainment of this target was a work in progress, but through monthly monitoring, an upward trend was being achieved with identified benefits for people.

People and relatives we spoke with were very positive about Fourways. One person told us, "I'm so happy I would give it 10 out of 10, the staff are brilliant." A relative told us they could not think of anything to improve about the service and felt well-informed about the home.

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 17 HSCA RA Regulations 2014 Good governance The provider's governance systems to assess, monitor and drive improvement in the quality and safety of the service provided were not consistently effective.