Mrs C Duffin

Freegrove Care Home

Inspection report

60 Milford Road, Lymington.
SO41 8DU
Tel: 01590 673168
Website: www.freegrovecare.co.uk

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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Inadequate
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Inadequate

Overall summary

At an inspection on 29 July 2014, we asked the provider to take action to make improvements to how they managed the care and welfare of people, the cleanliness and infection control measures used within the home, staff recruitment, quality assurance processes and records. The provider sent us an action plan which said that they would ensure mental capacity assessments were completed when necessary and that staff would receive mental capacity training. They said that each care plan would be reviewed monthly and would evolve to be more person centred. The action plan stated that a health and safety audit would be implemented and hand washing products distributed around the home. They stated that relevant checks would always be completed in the future when new staff were employed. They told us that these actions would be completed by 31 October 2014.

We carried out this unannounced inspection on 22 and 23 January 2015 to see if the required improvements had been made.

The provider and registered manager were still not meeting the required standards in any of the areas where concerns had been identified in July 2014. In addition, we found that the provider and registered manager were failing to meet the required standards in a further six regulations.

Summary of findings

Freegrove Care Home is a small family owned residential care home located in a residential area of Lymington. The home is arranged over two floors and can accommodate up to 17 people but at the time of our inspection there were 12 people living at the home. The home supports people with a range of needs. Most people were quite independent and only needed minimal assistance. Some people were more dependent and needed assistance with most daily living requirements including support with managing their personal care and mobility needs. A small number of people being cared in the home were living with dementia and could display behaviour which challenged.

The home had a registered manager. 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 and associated Regulations about how the service is run.

The provider and registered manager had not taken proper steps to ensure that each person was protected against the risks of receiving unsafe or inappropriate care as people did not always have accurate and detailed care plans and risk assessments which helped staff to deliver their care safely. People's records did not always contain enough information about their needs to ensure that staff were able to deliver responsive care.

Recruitment procedures were not safe. The provider had accepted Disclosure and Baring (DBS) certificates issued by previous employers without first carrying out their own checks to ensure that these did not reveal any new information of concern about potential new workers. Appropriate references and employment histories had not been obtained for one person.

The provider did not have appropriate arrangements in place for effective prevention and control of infections. Whilst people told us the home was kept clean, we found that two rooms had an unpleasant odour. Staff were not always using protective clothing such as gloves and aprons and relevant guidance was not always being followed in respect of food storage and the disposal of contaminated waste.

The provider and registered manager had not ensured there was an effective system in place to assess and monitor the quality of the service. We identified concerns in a number of areas. These issues had not been identified by the provider or registered manager.

When a person's capacity to make decisions about their care was in doubt mental capacity assessments had not always been completed. We were not able to see that appropriate best interests consultations had been undertaken.

CQC monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which apply to care home. The provider and registered manager had not made any applications for Deprivation of Liberty Safeguard authorisations; even though some people were not free to leave the home unsupervised and were subject to a high degree of observation.

Whilst people told us they felt safe living at Freegrove Care Home, we found that people were not adequately protected from abuse. The provider's safeguarding policy was not fit for purpose as it did not contain relevant information about how and to whom staff should report allegations of abuse. Safeguarding training was not always being updated regularly and some staff demonstrated a poor understanding of safeguarding. We asked the provider to make an urgent referral to the local Adult Services safeguarding team as we were concerned about how some aspects of one person's care was being delivered.

People's medicines were not managed safely. The provider and registered manager had not ensured that there were appropriate arrangements in place for the obtaining, recording, handling, safe keeping, safe administration and disposal of medicines.

The programme of training needed to be further developed to ensure that staff continued to receive all of the essential and relevant training required to carry out their roles and responsibilities effectively. Staff had not received supervision in line with the frequency determined by the provider.

Staffing levels required improvement. Target staffing levels were not always met and staffing levels were not always sufficient to meet people's needs in a timely manner.

Summary of findings

Whilst information about people's dietary requirements was recorded in their care plans, staff were not always aware of these which increased the risk of people being offered inappropriate foods. A range of nutritious food was provided but there was limited choice. People told us, however, that they could always ask for an alternative and this would be provided. People told us the food was of good quality and tasty.

People spoke positively about the care provided by the staff as did their relatives. One person described the staff as "My saviours". A relative said, "They are exceptionally kind and loving".

People said they had no concerns about the leadership of the home. People felt they were listened to and told us that the registered manager and provider were attentive and often spent time talking with them and knew their needs well.

People knew how to make a complaint and information about the complaints procedure was included in the service user guide.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which now corresponds to breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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

Recruitment procedures were not robust. There was a risk that staff may not be suitable as appropriate checks had not been carried out.

Risks to people were not managed safely, including risks relating to infection control and risks from malnutrition.

People's medicines were not managed safely.

Staffing levels required improvement to ensure that people's needs were met in a timely manner. Target staffing levels had not always been met.

Is the service effective?

Requires Improvement

The service was not always effective

Mental capacity assessments were not being undertaken when people's capacity to make key decisions about their care was in doubt. The provider had not considered as part of their care planning processes whether people lacking capacity might be subject to a restriction which could constitute a deprivation of their liberty.

Further improvements were needed to ensure staff received all of the training relevant to their role and regular supervision which helped to ensure they understood their role and responsibilities.

People had not always received co-ordinated care, treatment and support when their needs changed.

People told us the food was tasty and provided in sufficient quantities and were able to have snacks or light meals at any time. Friends or family were encouraged to join people for a meal.

Is the service caring?

Requires Improvement

The service was not always caring

Improvements were needed to ensure that people and those important to them were involved in planning their care.

People were treated with kindness and with dignity and respect. Staff had developed positive and meaningful relationships with people and knew their likes and dislikes and the things that were important to them.

People relatives and friends were able to visit without restrictions. We observed relatives visiting throughout the day and sharing in aspects of their relatives care and support.

Summary of findings

Is the service responsive?

Requires Improvement

The service was not always responsive

Care plans contained gaps or omissions or were not sufficiently detailed and had not been updated when people's needs changed. There was a risk of people receiving care that was inappropriate, unsafe or not in line with their individual wishes.

Improvements were needed to ensure that each person was supported to take part in leisure activities that were meaningful to them.

People knew how to complain and information about the complaints procedure was available within the home. All of the people we spoke with said they would be comfortable and confident raising concerns with the registered manager or provider.

Is the service well-led?

Inadequate

The service was not well-led.

Action had not been taken to address previous breaches of regulations we had identified and a number of new breaches were also identified. Systems were not in place to regularly assess and monitor the safety and quality of the service and drive improvements.

During the inspection, we found the provider was open to receiving our feedback about the service and showed a desire to improve. They have implemented a range of immediate improvements since the inspection and are developing a longer term action plan to address each area of concern.

Freegrove Care Home

Detailed findings

Background to this inspection

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

This inspection took place on 22 and 23 January 2015 and was unannounced.

The inspection team consisted of two inspectors.

The provider had not been asked to complete a Provider Information Return (PIR) before the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. However we referred to other information we held about the home to plan the inspection. We reviewed previous inspection reports and notifications received by the Care Quality Commission. A notification is where the registered manager tells us about important issues and events which have happened at the service. We used this information to help us decide what areas to focus on during our inspection.

We spoke with seven people who used the service and four relatives. We also spoke with the registered provider, registered manager, four care workers and a member of the housekeeping staff. We reviewed the care records of five people in detail, the training records of five staff and the recruitment records for two staff. We also reviewed the Medicines Administration Record (MAR) for all 12 people. Other records relating the management of the service such as staff rotas and policies and procedures were also viewed. We also spoke with two healthcare professionals who shared their views about the home and the quality of care people received.

The last inspection of this service was in July 2014 when concerns were found in five essential standards of quality and safety.

Inadequate

Is the service safe?

Our findings

At our last inspection in July 2014, we found the service was not meeting a number of essential standards. People's care and support was not always planned and delivered in a way that ensured their safety and welfare. People were not adequately protected from the risk of infection and proper steps had not been taken to ensure that staff were of good character before they started work. We asked the provider to take actions to make the required improvements. At this inspection, we found that not all of the required improvements had been made.

The registered manager had not made all of the necessary improvements required to ensure effective prevention and control of infections and we identified a number of new concerns. Registered managers and providers are required to take account of the Department of Health's publication, Code of Practice on the prevention and control of infections (The Code). This provides guidance about measures that need to be taken to reduce the risk of infection. We found this guidance was not always being followed. For example, The Code states that providers should have a programme of audit to ensure that key policies and practice are being implemented appropriately. The registered manager had not ensured a programme of audit was in place, despite stating that this would be implemented following our last inspection. This meant that the registered manager was still failing to follow relevant guidance in relation to infection control.

Personal protective equipment (PPE), including disposable aprons and gloves, was not readily available to staff and was not used routinely. The provider told us PPE would be in the bathroom, but when we checked there were neither gloves nor aprons available. We observed staff that had been providing people with personal care moving freely around the home including the kitchen without using or changing their PPE. A staff member told us, "No-one enforces wearing aprons".

A cleaner was employed for 2.5 hours each weekday and brief cleaning schedules were in place that set out the frequency with which areas of the home and items of furniture were to be cleaned. Records were maintained to show that the cleaning schedules were followed. At weekends, staff had to complete cleaning tasks alongside their caring duties. A member of staff told us they would use an anti-bacterial spray to clear up spilled bloods or bodily fluids. This would not be an effective product for dealing with these types of contamination.

Whilst people told us the home was kept clean, we found that two rooms had an unpleasant odour. Some equipment such as toilet seats and carpets needed to be replaced as these were too worn to be effectively cleaned and could therefore be harbouring germs. The cleaning schedules did not include arrangements for cleaning the carpets. The provider told us that approximately every quarter, carpet cleaning equipment was hired and the communal carpets cleaned. However there were no arrangements to ensure that the carpets in people's rooms were washed on a regular basis to help manage odours and stains which again could harbour germs.

Relevant guidance was not always followed in respect of food storage. Several containers of food in the fridge were not dated and so it was not clear how long they had been there. This increased the risk of people being given food which was unsafe or unsuitable to eat.

The provider did not have appropriate arrangements in place to ensure the effective prevention and control of infections. This was a continuing breach of Regulation 12 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 (2) (h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not made the required improvements to the way in which risks to people's welfare were assessed and managed. Staff were not consistently informed about risks to people's health and wellbeing. Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) decisions were in place to show if people did not wish to be resuscitated in the event of a healthcare emergency. However, some staff were not aware of which people had such a decision in their records. This could present a risk of people receiving inappropriate care or treatment. Some staff were also not aware of which people had health conditions which impacted on their care needs, for example, who had diabetes.

Risk assessments were not always in place and were not always reviewed or updated when people's needs changed. One person was at risk of falls as they could attempt to stand without calling for help. Daily records showed this

Is the service safe?

person had fallen on the 12 January 2015; however their falls risk assessment dated from August 2014 and had not been updated in light of the recent fall. The registered manager had told us all risk assessments were updated on a monthly basis. There were no arrangements in place to monitor people following a fall to ensure they were not experiencing any ill effects. The provider told us that they had a developed a post-falls protocol but that this was not yet in use.

One person could at times display behaviour which challenged, however staff were managing this behaviour without any detailed and specific risk management strategies or support plans. Whilst a referral had been made for a professional assessment, the lack of a care plan and risk management plan meant there was a risk this person, or others, might not be protected from harm or might not receive their support in a consistent way.

Assessments were in place which could help to assess and monitor the risk of potential skin damage; however these were not used consistently. A Waterlow assessment helps staff to determine or predict a person's risk of experiencing pressure ulcers. Two people were known to be at potential risk of skin damage, but their Waterlow assessment chart was blank.

The arrangements to identify, monitor and manage risks to people's nutrition were not robust. For example, one person ate very little at lunch-time. Staff told us this person often did not eat well and was very particular about the foods they would eat. This detail was not reflected in their care plan. They did not have an eating and drinking plan which detailed how staff could encourage dietary intake. The provider had used a screening tool to assess and monitor the person's risk of becoming malnourished. This had been completed monthly until November 2014 but not since. The person's weight had been recorded between September and November 2014. There was no record for December 2014 and it was noted that the person had declined to be weighed in January 2015. Whilst there was no evidence that this person was losing weight, we were concerned that in light of their poor dietary intake, no further attempts had been made to weigh the person or to use other methods of assessing whether they might be losing weight. We saw that two other people's records showed that since May and June 2014, they had declined to be weighed each month but no action had been taken to consider other ways in which their weight could be monitored in order to ensure this was not presenting any risks to their wellbeing. We asked a staff member how they would identify is a person was at risk of poor nutrition, "They told us, "I'm not sure what would alert me to that risk".

Care was not always delivered in a manner which ensured the welfare and safety of people. A care worker told us that one person was lifted under the arms by some staff, rather than being hoisted. They told us that this happened as staff said it was "quicker and easier". This is not an appropriate or safe way in which to support people to move. Adult services have been asked to make an urgent assessment of this person's needs to ensure they are safe.

Personal emergency evacuation plans (PEEPs) were kept in an accessible place near to the front door. However there was no PEEP for four people living at the home and a further four PEEPs were for people no longer living at the home. In two cases the PEEP did not reflect the person's current needs. This could impact upon the emergency services being able to safely evacuate the home in the event of an emergency such as a fire.

Proper steps were not taken to ensure that each person was protected against the risks of receiving unsafe or inappropriate care. Tools used to assess and monitor risks were not being consistently used and. This is a continuing breach of Regulation 9 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 9 (3) (a) (b)-(h) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People's medicines were not managed safely. The provider and registered manager had not ensured that there were appropriate arrangements in place for the obtaining, recording, handling, safe keeping, safe administration and disposal of medicines. Medicines delivered to the home were not checked against a record of those ordered. This is important as it helps to make sure that all medicines have been prescribed and supplied correctly. A medicine for one person had not been received between 18 and 22 January. This meant the person did not have their prescribed medicine during this period. Staff were not clear why these medicines had not be obtained and there was no evidence that advice had been sought from a GP about the possible implications on the person's health and wellbeing of not having this medicine for five days.

Inadequate

Is the service safe?

People's medicines were always not administered safely. One person had declined a medicine which had been due at 8am. At 12.30pm this medicine was still in the medicines trolley. The care worker told us they were going to try again later. We were concerned they had not checked or sought relevant clinical guidance to ensure that it was safe to offer this medicine at a later time. This is important as some medicines require a certain length of time to pass between each dose and in this case one of the medicines was scheduled to be administered again at 6pm. Another person had a prescribed cream which was to be applied three times a day. Records showed this was only being applied twice daily.

The medicines administration records included a number of codes which could be used to record why a person had not received their prescribed medicines. We found seven examples where there was a gap in a person's MAR, but no code had been used to indicate the reason. Codes were not being used consistently which meant that it was not possible to effectively monitor the records to assess the reasons why people had not received their prescribed medicines.

Medicines were not stored safely. We found a large box of various medicines in the registered manager's office. The box also contained printer cartridges and Christmas decorations. The medicines were a mix of excess stock and medicines awaiting disposal. Four tablets were loose in the bottom of the medicines trolley and had not been accounted for. Staff were not able to explain where these might have come from. There was also a pot containing in excess of 30 different tablets in the medicines trolley. We were told that these were medicines which had been refused. NICE guidance states that medicines for disposal should be stored separately in a tamper proof container within a cupboard whilst awaiting disposal. We noted that some of the medicines stored in the trolley need to be stored below 25°C to ensure that they remained effective. The home were not monitoring the temperature of the areas where medicines were stored.

The home did not have effective arrangements for the disposal of medicines. NICE guidance states that providers should have processes for the prompt disposal of medicines. Records showed that in 2014, drugs had been disposed of on just two occasions. The most recent disposal date was the first day of our inspection. However we found that there remained a large number of medicines in the home still awaiting disposal such as those we found in the registered managers office and in the medicines trolley. We were told about two medicine errors which had occurred. There had been no safety review following these errors to support learning and to ensure similar errors did not occur again. Staff did not know the procedures to follow in the event of a medicines error.

People's medicines were not managed safely. This is a breach of Regulation 13 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 12 (f) & (g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were not adequately protected from abuse. The provider's safeguarding policy was not fit for purpose. It did not contain relevant information about how to report allegations of abuse. The local authority's Safeguarding Adults Multi-agency Policy, Procedures and Guidance were not available within the home. Safeguarding training was not always being updated regularly. Four out of five staff had last completed this in 2013. The registered manager told us this was completed on an annual basis. Staff demonstrated a poor understanding of safeguarding and the correct procedures to follow if they had concerns about abuse. We asked the provider to make an urgent referral to the local Adult Services safeguarding team as we were concerned about how some aspects of one person's care was being delivered. There was a risk that people would not be protected from abuse. This is a breach of Regulation 11 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing levels were not based on the assessed needs of people at the home. The provider did not adjust staff numbers to take account of changing circumstances within the home. For example, the home had been without a cook for approximately three months and care staff were covering this role although there had been no increase in care staff numbers to take account of this. One care worker said, "When we had a cook it was better as didn't have to worry about the kitchen…there are three care staff on duty, but one has to cook so really there are two care staff on duty". When the housekeeping staff were not on shift at weekends, care staff also had to cover these roles. Actual

Inadequate

Is the service safe?

staffing levels were sometimes below the target staffing levels. During December 2014 and January 2015 staff rotas showed the staff numbers were short by either one or two members of staff on four occasions.

There were mixed views on whether there were enough staff to meet people's needs. One person said, "Yes, [staff] come quickly, unless they are looking after someone else". Another person said, "Sometimes, there could be more staff, everything's done, it's just a bit slower". A relative told us, "They are drastically understaffed; they haven't had a cook for months". They added that there was very little stimulation for people, they said, "The TV is on all the time, the buzzers are always going and they never go out. I feel sometimes they are run off their feet and feel an extra one would be good". Another relative said, "I feel the staff are stretched, if they have an issue with a person in a room and need two staff, then there is no-one around, sometimes we just feel they are hard pressed. Another relative said, "I have personally seen one person ask to go to the toilet and because there was not enough staff, they sat there so long the chair was wet". This was confirmed by a staff member who told us, "Sometimes, [a person] is incontinent due to staff not being able to get to them in time for the toilet". This indicated that there were not always sufficient numbers of staff to meet people's needs. This is a breach of Regulation 22 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

At our last inspection we found that the provider had not taken proper steps to ensure that the staff they employed were of good character by obtaining comprehensive and appropriate information about them before they started work. No new staff had been appointed since our last inspection and so we were not able to check whether the provider was now ensuring that new staff were subject to all of the relevant checks. We will check this at future inspections.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in July 2014, we found the home was not meeting the requirements of the Mental Capacity Act 2005 (MCA). People who lacked capacity to make decisions about their care did not have a clear mental capacity assessment. The MCA is a law that protects and supports people who do not have the ability to make decisions for themselves. We asked the provider to take action to make the required improvements. At this inspection, we found some of the required improvements had not been made. Staff had received training and were able to describe some of the basic principles of the MCA. However the provider had not always carried out mental capacity assessments when people's capacity to make key decisions about their care was in doubt. Our observations indicated that there were a small number of people using the service who might not be able to give valid consent to their care. One person had a mental capacity assessment, but this was not decision specific. There was also no evidence of wider consultation with relevant people such as relatives and professionals to agree what actions would be in the best interests of the person lacking capacity.

Mental capacity assessments and best interest's consultations were not being completed appropriately. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had not acted in accordance with the Deprivation of Liberty Safeguards (DoLS). These safeguards protect the rights of people lacking capacity by ensuring that, if there are any restrictions to a person's freedom or liberty, these have been agreed by the local authority as being required to protect the person from harm. A recent Supreme Court judgement has widened and clarified the definition of a deprivation of liberty. The registered provider and manager were not adequately informed about the implications of this. They were not considering as part of their care planning processes whether people lacking capacity might be subject to a restriction which could now constitute a deprivation of their liberty. Staff told us that some people living in the home would not be free to leave the home due to concerns for their wellbeing. One of these people was also subject to regular observation by staff to ensure they were safe. The registered manager had not however made any DoLS applications. They told they did not understand a briefing that had been issued by the Care Quality Commission on this subject. The need to improve how DoLS were managed by the service was discussed with the provider at our inspection in July 2014; however they had not taken any action to ensure that people were not having their freedom restricted unlawfully. This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff training was not up to date. For example, two staff who regularly administered people's medicines had last undertaken medicines training in 2011. Staff did not have an annual review of their knowledge, skills and competencies to manage and administer medicines as recommended by relevant guidance. The registered manager told us, "I feel they are competent if they have completed the training, however we had however identified a number of failings in the way in which medicines were managed within the home. In addition, one staff member had last completed their food hygiene training in 2006. This was of concern as staff were currently preparing and cooking all of the food within the home whilst they were recruiting a cook. This could mean that they were not up to date with current best practice in relation to food hygiene and this could present a risk to people's health. The registered manager did not monitor staff training effectively, to ensure staff had sufficient training to develop their skills and knowledge.

Staff were not always receiving supervision in line with the frequency determined by the service. Supervision is an important tool which helps to ensure staff receive the guidance required to develop their skills and understand their role and responsibilities. In each of the records we viewed, the member of staff had only received two supervision sessions in 2014. The provider's supervision agreement stated staff should receive six supervision sessions each year.

Staff did not have all of the training relevant to their role. Improvements were needed to ensure the supervision arrangements within the home operated in line with the provider's policy and were an effective tool in the on-going development of staff. This is a breach of Regulation 23 of

Requires Improvement

Is the service effective?

the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 18 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

New staff received an induction within the home which involved shadowing more experienced staff and learning about the needs of the people using the service and the policies and procedures of the home. A member of staff told us, "I went round with another carer for two weeks observing and being observed". The registered manager told us that new staff, who did not already have a nationally recognised qualification in health and social care, were enrolled on a Level 2 Certificate in Preparing to Work in Adult Social Care at a local college. This course covered a range of topics fundamental to working in adult social care such as safeguarding and personalised care. There was however no evidence that the registered manager was assessing the competence of staff following the completion of this external induction programme. A competency assessment helps to ensure that staff are competent and can put their learning into practice within the care home setting.

Staff did not always support people's needs effectively. For example, staff had not sought relevant expert advice from healthcare services when people's mobility deteriorated. This is important as it helps to ensure that staff are using the safest methods and the right equipment to move people. One person was being hoisted using a sling which had not been assessed as appropriate for their size and weight. A care worker told us, "Sometimes, [the person] wiggles in their sling and it cuts their leg as their skin is so thin". We asked the registered manager how people were assessed for their sling size, they told us, "We just use the slings we've got".

Two people's records showed that staff had noted they had areas of reddened skin. The notes reported that creams had been applied, but there was no evidence that a medical review had been sought. The registered manager told us, "I would expect staff to monitor people's skin, record and report to me and phone the district nurse. If skin is just discoloured, we just put cream on it". Changes in skin colour can be an early sign of pressure ulcers and relevant medical advice should be sought. There was a risk that people might not have the best possible health outcomes because they did not always have prompt access to professional advice. A visitor told us they had arranged for a chiropodist to visit their relative because the home did not appear to be taking action. They said, "I did raise a concern about the chiropody referral, nothing got done, so I did it myself.

There were other examples where prompt medical reviews had been sought. For example, one person had complained of pain and their GP had been called for advice. People told us they felt their healthcare needs were met and that they were supported to see their doctor when this was required. One person said, "If you want a doctor they sort it, they noticed that I had swollen legs, the doctor was here by lunch-time". Another person said, "Without these [carers] I would have died, they have been my saviour".

A healthcare professional told us they had been visiting the home since 1996. They told us, "It's a high standard of care, very happy, homely and caring home… they are good at holding onto patients at the end of their lives when we get support in". This professional told us they had no concerns about health outcomes of people living at Freegrove. They added, "We have always held the home in high regard for holistic care". We saw evidence that other professionals visited the home such as community dentists and opticians.

People were mostly positive about the food and comments included, "The food is lovely, beautiful…they ask me what I want and I always get some fruit and the vegetables are lovely". Another person said, "The food is good, I have put on two stone, there is some choice, but they would always find me something else if I didn't want what was on offer". A third person said, "Dinner is always excellent, I asked the other day for sweet and sour, it was done, it was beautiful". Each day one main course option was prepared at lunch, but an alternative was made available if a person did not like this. At supper, people were given a choice of range of lighter meals. We saw evidence that people were able to have snacks or light meals at any time. People were able to choose where they ate their meals and were encouraged to have friends or family join them for a meal. No-one needed assistance to eat or drink but adapted cutlery or drinking cups were available and used when necessary to support people's independence.

Requires Improvement

Is the service caring?

Our findings

Every person we spoke with told us they were supported by staff who were kind and caring. They were all happy living in the home and were confident that they would recommend the home. One person said, "They are kind, caring and fair…some of the old fellows are grumpy, but they are very patient with them". Another person said, "This is a friendly and homely place". A relative said, "They are exceptionally kind and loving…they come and give [my relative] a cuddle, brush their hair and do their nails". Another said, "The staff are very obliging, happy to help, they are always happy and smiling". A social care professional told us, "Without a shadow of doubt this is one of friendliest, most homely care homes…it's their home and it's treated like that, it's a happy place to be".

It was not always evident that people and those important to them had been involved in developing their care plan. People were not aware of what was recorded in their care plans and we only saw one example, where the person had signed to confirm they consented to their care plan. Where monthly reviews had taken place, there was no evidence that the person or their family had contributed to these. A relative told us, "Up to a point we are involved in [their parents] care". They told us for example, that there had been occasions when the doctor had come, but they had not been made aware of this. They said, "I don't always get feedback until I ask".

We saw that staff had good relationships with people and readily chatted with them about every day matters such as the food or the news. We noted that people knew staff and the management team by their names and clearly felt at ease talking with them or sharing a joke; we heard a lot of laughter throughout our visit. We observed that staff spoke to people kindly, respectfully and cheerfully. A number of people and relatives spoke positively about the birthday celebrations organised by the staff. One relative said, "They are good on birthdays, we have a cake and buffet and we had a Christmas party". Staff appeared to know people well and the little things that were important to them, such as what condiments they liked with their food and which of the activities or quizzes they enjoyed the most. A number of people, relatives and professionals told us that the strength of the home was its homely nature and the friendliness of the staff. One relative said, "This home is just the right size for [my relative] familiarity is very important and that is good here".

Staff were mindful of people's privacy and dignity. Staff knocked on people's doors before entering room and we saw that doors were kept closed when staff attended to people in their rooms. Staff described examples of how they ensured people's dignity. One staff member said, "I turn by back when assisting people to use the toilet, whilst keeping an eye on them…I think about people as my grandma, with dignity and respect". A person told us, "They [staff] always knock on my door and wait for me to open it….they always ask my permission before coming in".

People were encouraged to remain as independent as possible. Staff explained how they encouraged people to care for themselves even if this was by completing a small task. One care worker said, "I give people a warn flannel to wash their face, simple things like that". We heard staff explaining to people what they were intending to do and checking that the person was happy to be assisted.

People relatives and friends were able to visit without restrictions. We observed relatives visiting throughout the day and sharing in aspects of their relatives care and support.

Requires Improvement

Is the service responsive?

Our findings

People told us they received care and support when they needed it. They felt that staff were responsive to their needs and took action to ensure they saw their doctor quickly if they were unwell. People had mixed views about the activities offered within the home and some people felt these could improve. People knew how to complain and were confident that their concerns or worries would be listened to. Whilst people told us they felt the service was responsive to their needs, through our observations and following a review of records and discussions with staff we found that this was not always the case.

At our last inspection in July 2014, we found that people were not always protected against the risks of unsafe or inappropriate care because information about them and their care records were not always complete and accurate. We asked the provider to take action to make the required improvements. At this inspection, we found that the required improvements had not been made.

Guidance from the National Institute for Health and Care Excellence (NICE);Managing medicines in care homes, states 'Health and social care practitioners should ensure that records about medicines are accurate and up to date'. There were a number of examples where people's medicines administration records (MAR) included drugs they were no longer prescribed. As we also found that discontinued or no-longer-required drugs were not being disposed of in a timely manner, the inaccurate records increased the risk that staff could continue to administer discontinued medicines.

Accurate records were not always being maintained of the medicines administered. For example one person was prescribed a PRN or 'as required' drug to help manage agitation. On three occasions this drug had been administered but this had not been recorded on the person's MAR. This meant there was a risk that the person could be given too many doses of the medicine as staff might not be aware of when the person last received the drug. Maintaining accurate records of the administration of PRN medicines on the MAR is important as it enables staff and healthcare professionals to monitor and assess the effectiveness of 'as required' medicines.

Care plans contained inaccurate or out of date information. One person's mobility plan was dated December 2013 and did not reflect their current needs as it stated that the person was able to walk with the use of a frame. Whilst all of the staff we spoke with were aware that this person now required a hoist to help them to move, there was a risk that new or inexperienced staff would not know the correct way to support this person with their mobility. Their personal care plan recorded that they were independent with dressing and undressing. This was not the case. This plan had not been updated since November 2011. We saw similar inaccuracies in another two people's records. For example, the eating and drinking plan for one person said they required a pureed diet. We observed that this person was eating a normal diet. Staff told us that the person had not required a pureed diet since early December 2014. There care plan had not been updated to reflect this.

Whilst staff demonstrated an understanding of people's needs and preferences, this was not reflected in the care plans. The care plans rarely contained personalised information that described how people liked to receive their care. For example, we were told by a visitor that it was possible to effectively communicate with their relative who was very hard of hearing if you spoke with them in a certain way. This information was not reflected in the person's care plan. One person, who had lived at the home for over three months, did not have a full set of care plans which detailed their specific needs and how these should be delivered.

We found other examples where people's care plans contained gaps or omissions or were not sufficiently detailed. We were told that care plans were reviewed monthly, but this was not the case. The care plans we viewed had not been updated when people's needs changed. A member of staff told us, "Care plans and risk assessments are not always up to date"

Freegrove Care Home is a small home with regular staff and little use of agency or temporary staff. This enabled a lot of information about people's needs to be shared between staff informally via the daily records, word of mouth, and via a communication book. However without an accurate and detailed record of people's needs, there was a risk that they might receive care that was not responsive to their needs and not in line with their individual wishes. This was a continuing breach of Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 (2) (d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Requires Improvement

Is the service responsive?

We received mixed feedback about the activities programme offered by the service. Three people told us they were satisfied with the activities on offer. One said, "The activities are very good. Most afternoons we do something and in the summer we get out in the garden". Two people were less positive, one person told us a number of musical activities were laid on, but that they were "not really my cup of tea". The second person said, "There's not a lot going on that I enjoy, I do like reading and they get books for me". A relative said, "There is very little stimulation here, there are music sessions every three weeks, other than that it's the TV on all the time". They raised concerns about the lack of trips out into the community and said, "I wish they would do more with them". The small number of people who spent most the day in their rooms received little regular or meaningful interaction, other than when receiving their routine care.

The provider told us they tried to do an activity every day such as cards, games, quizzes or chair exercises and everyone was invited to take part in these. The provider had also made arrangements for outside entertainers to visit the home on a regular basis and provide music and exercises classes. At Christmas people had been taken to shops to buy the ingredients to make a Christmas cake and then had made this together. Fireworks and hot dogs had been enjoyed by people on Bonfire night. A local vicar visited each month so that people could receive holy communion if they wished. However, a small number of people spent most of the day in their rooms. We found a lack of evidence they received regular and meaningful interaction, other than when receiving their routine care. Improvements were needed however, to ensure that each person was supported to take part in leisure activities that were meaningful to them. This is important as it helps to improve and enhance people's quality of life.

People knew how to complain and information about the complaints procedure was available within the home. All of the people we spoke with said they would be comfortable and confident raising concerns with the registered manager or provider. One person said, "I would go straight to the top" and another said, "I would tell [the registered manager], they come in and see me most mornings".

Inadequate

Is the service well-led?

Our findings

People using the service were positive about the management of the home. One person said, "I think it is well run, good staff and a good lady in charge". Two people told us how the registered provider often came and spoke with them regularly, checking if there was anything they wanted. People told us they felt they did have opportunities to provide feedback about the quality of their care and felt their views were acted on. A relative said, "There is always someone in charge you can speak with".

At our last inspection in July 2014, we found that the home had failed to ensure there were arrangements in place to check and monitor the quality of the service and for identifying, assessing and managing risks to the health, safety and welfare of people. We asked the provider to take action to make the required improvements. They told us they would implement relevant checks by 31 October 2014. At this inspection, we found that this had not been done. The home had not undertaken any audits of the care plans, the safety of medicines or the hygiene and infection control arrangements within the service. We continued to identify concerns in all of these areas.

The registered manager and provider did not have systems in place to reflect upon the nature and cause of incidents and accidents to ensure that appropriate actions were taken to reduce the risk of similar events occurring. We saw two examples where accident forms had not been completed following a person suffering a fall. We were also told about two medicine errors involving controlled drugs. NICE Guidelines for Managing Medicines in Care Homes, states that provider should ensure there are 'robust processes in place for identifying, reporting, reviewing and learning from medicines errors'. We asked the manager how medicines errors were investigated and managed. They confirmed that they did not have a procedure for this and incident forms were not completed.

Some health and safety checks such as those relating to fire equipment or the maintenance of the lift had been outsourced to local contractors, but there were no routine checks being made of the safety or suitability of the environment. We found for example, that a window on the first floor landing was not fitted with a suitable restrictor and could be opened in excess of safe limits which could have allowed a person to climb or fall through the opening. This was not in line with relevant health and safety guidance. A person told us they were cold and asked that we shut their bedroom window. We were unable to do this as the window did not have a handle. These issues had not been identified and rectified by the registered manager or the provider.

The provider did not have a business continuity plan. This is important as it sets out the procedures for dealing with emergencies such as loss of power, and the steps that would be taken to mitigate the risks to people who use the service. The provider also did not have a service improvement plan. A service improvement plan is a detailed formal plan that sets out the improvements that the provider hopes to make to service delivery. It considers the resources needed to achieve these and the timescales within which the improvements should be made. These plans help to drive continuous improvement. The provider told us that they did have a number of improvements planned such as the installation of Wi-Fi so that people could make use of software packages to allow them to hold video calls with family members or friends who were not able to visit regularly.

The registered manager did not demonstrate an adequate knowledge of relevant legislation or best practice guidance within the social care sector. They were not well informed about the Mental Capacity Act or the Deprivation of Liberty Safeguards. They were not informed about the NICE guidance on the management of medicines in care homes. They had not always sought relevant professional or expert advice to ensure they were continuing to meet people's needs in a safe and appropriate manner. The registered manager did not undertake competency or knowledge checks to help ensure that staff understood their role and responsibilities. The provider had not checked that the registered manager had addressed the concerns noted during our previous inspections or that the required improvements had been made and maintained.

A number of the provider's policies and procedures were out of date or not fit for purpose and needed to be reviewed. For example, the medicines policy had not been updated since 1999 and the safeguarding policy was not sufficiently detailed to ensure that staff would know how to take the appropriate actions in the event of an allegation of abuse being made. Whilst staff were informed about how

Inadequate

Is the service well-led?

to raise concerns about poor practice, the provider's whistle-blowing policy did not include relevant information about the external organisations that concerns could be shared with confidentially.

The registered provider and registered manager were not taking adequate steps to ensure their continued compliance with the regulations that governed their registration with the Care Quality Commission (CQC). For example, the CQC had not been notified of certain important events which had happened within the service and the provider's statement of purpose dated from 2002 and referenced out of date care standards and regulatory frameworks.

The provider did not have an effective system for assessing and monitoring the quality of the service. The provider did not always seek appropriate professional advice and have regard to relevant legislation and guidance. Incidents and accidents were not investigated and reviewed to ensure that relevant measures were taken to prevent similar events from happening again. This was a continuing breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

People told us the provider regularly sought their views about their care, although this was done in an informal manner and not through the completion of satisfaction surveys or by arranging resident or relative meetings. However, people told us they were satisfied that they could comment on the effectiveness of their care and they felt that the provider would take action. Staff also told us that they felt able to make comments or suggestions about how the service might improve. For example, one staff member told us, "If I notice something that can be improved, I suggest it". They gave us an example which demonstrated that the registered manager had taken action in response to one of their suggestions.

The registered manager and provider promoted a friendly and homely culture within the home. The provider told us that it was very important to her to maintain the small, friendly nature of the home, underpinned by family values. They said it was important that people felt Freegrove was their home and that the procedures and routines of the home did not detract from this. People, their relatives and visiting health and social care professionals told us that the homely nature of the home was one of its main strengths, along with the friendliness of the staff. Our observations confirmed this and throughout our visit, people appeared relaxed and settled and the atmosphere, whilst quiet and calm, was friendly with staff engaged in conversation with people or their relatives. Staff told us they enjoyed working at the home. One staff member said, "I love working here, the residents and the staff are like a close knit family…I can go to the provider or manager about anything and they would put my mind at rest".

The provider was open to receiving our feedback about the service and showed a desire to improve. They have implemented a range of immediate improvements since the inspection and are developing a longer term action plan to address each area of concern.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The registered person did not have suitable arrangements in place for obtaining and acting in accordance with the consent of service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment The registered person had not made suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means of responding appropriately to any allegation of abuse The registered person had not ensured that where any form of control or restraint was being used in the carrying out on of the regulated activity, arrangements were in place to protect service users against the risk of such control or restraint being unlawful or excessive.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The registered persons had not taken appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. Regulation 18 (1).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	The registered person did not have suitable arrangements in place to ensure that persons employed for the purposes of carrying on the regulated activity were appropriately supported in relation to their responsibilities, to enable them to deliver care and treatment to service users safely and to an appropriate standard by means of receiving appropriate training, supervision and appraisal. Regulation 18 (2).
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The registered person had not ensured that service users were protected against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity. Regulation 12 (f) & (g).

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care The registered person had not taken proper steps to ensure that each service user was protected against the risks of receiving care or treatment that was inappropriate or unsafe, by means of the planning and delivery of care and, where appropriate, treatment in such a way as to meet the service users' needs and ensure the welfare and safety of the service user. Regulation 9 (3) (b) - (h).

The enforcement action we took:
Warning notice served on registered manager and registered provider requiring them to become compliant by 11 May 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control The registered person had not ensured the maintenance of appropriate standards of cleanliness and hygiene in relation to premises occupied for the purpose of carrying on the regulated activity and equipment and reusable devices used for the purpose of carrying on the regulated activity.

The enforcement action we took:
Warning notice served on registered manager and registered provider requiring them to become compliant by 11 May 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered person had not protected service users, and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of

This section is primarily information for the provider

Enforcement actions

the effective operation of systems designed to enable the registered person to regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity.

The enforcement action we took:
Warning notice served on registered manager and registered provider requiring them to become compliant by 11 May 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use services were not protected from the risks of unsafe or inappropriate care and treatment because information about them was not always complete and accurate.

The enforcement action we took:
Warning notice served on registered manager and registered provider requiring them to become compliant by 11 May 2015.