Michael Goss

The Friendly Inn

Inspection report

Gloucester Way
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Website: www.friendlycare.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?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We carried out an inspection at The Friendly Inn on 4 and 11 May 2016. The inspection was unannounced.

The Friendly Inn provides personal care and accommodation for up to 30 older people. A number of people were living with dementia and had high physical care needs. There were 30 people living at the home when we carried out our inspection. This included one person who was in hospital on our second visit.

The service was last inspected on 11 January 2016. At that inspection we found a number of improvements were required and the registered manager told us they had plans in place to ensure these were made.

Following the last inspection we received information of concern from various sources about the quality and safety of care provided at the home. This included concerns in relation to the management of risks associated with people experiencing falls and there not always being enough staff available to provide care and support. We therefore undertook a further comprehensive inspection in response to these concerns.

There was a registered manager in post . A requirement of the service's registration is that they have 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 2008 and associated Regulations about how the service is run.

People we spoke with had mixed views about whether they felt safe at the home. We found risks associated with people's care, in particular around falls, were not always identified, assessed and monitored to make sure people were protected from the risk of harm. We spoke with the Local Authority and Clinical Commissioning Group (CCG) about concerns we had identified.

Medicines were not always managed safely. We could not be sure creams were applied as prescribed. Accidents and incidents had been recorded however; it was unclear how this information had been used to identify any patterns or trends, to help prevent them from happening again. Safeguarding referrals to protect people from abuse had not always been made.

Staffing levels and arrangements were insufficient to maintain people's safety. Staff were not always available at the times people needed them. Care staff were required to complete additional duties such as laundry and meal preparation, which meant they were not always able to meet people's needs and keep them safe.

Overall, individual staff members demonstrated a caring approach and people were offered choices however, staff had limited time to spend with people and we saw little interaction between staff and people throughout our visits. It was not clear how people had been involved in planning their care to ensure they received care and support that met their needs and preferences. People were not supported to pursue their

hobbies and interests, particularly for people living with dementia.

The provider did not have sufficient systems and processes in place to assure themselves that people received a good quality service that met their needs. People's opinions of the service were not always sought and listened to. Quality monitoring processes were not effective to ensure improvements to the service were identified and acted upon in a timely manner, for the benefit of people who lived there.

People knew how to make a complaint if they wished to do so. However, some people were not satisfied with how their complaint had been handled.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We formally wrote to the provider and asked them to submit an urgent action plan to tell us how they were going to mitigate the risks. We also imposed a condition on the provider's registration which meant that they required our written consent before admitting or re-admitting people into the home. We met with the provider to share our concerns and gave them the opportunity to provide assurances of actions taken to ensure the safety of people who lived at the home. You can see what action we told the provider to take at the back of the full version of the report.

The overall rating for this service is 'Inadequate' and the service will therefore be placed in 'Special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

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.

Staffing levels were not sufficient and the deployment of staff was not effective to maintain people's safety and meet their needs. Risks associated with people's care were not always managed well and actions were not always taken to reduce risks to keep people safe. Management of medicines meant people did not always receive their medicines consistently, as prescribed. Accidents and incidents had been recorded but were not analysed to identify any patterns or trends to help prevent them from happening again. Safeguarding referrals had not always been made to protect people.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff knowledge of the Mental Capacity Act (2005) was limited, which placed people at risk of not being appropriately supported if they lacked capacity to make their own decisions. People were satisfied with the food and drink provided. Staff demonstrated good knowledge of people's dietary needs, but we could not be sure some people's nutritional intake was being effectively monitored. Support from health care professionals was sought when needed to ensure people's healthcare needs were met.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Individual staff members demonstrated a caring approach. People and their relatives were mostly positive in their comments about the staff and the home and staff told us they wanted to provide good care to people. However, staffing arrangements meant care was task focused and not focused on people. People were not always involved in making decisions about their care.

Is the service responsive?

Inadequate

The service was not responsive.

Care and support was not responsive to people's individual needs and was provided in a task orientated way. It was not evident people had been involved in planning their care. Opportunities for people to follow their interests or be involved in social activities were limited. People knew how to make a complaint if they wished to do so. However, some people were not satisfied with how their complaint had been handled.

Is the service well-led?

Inadequate

The service was not well-led.

The provider had not ensured that effective quality assurance procedures were in place to assess and monitor the quality and safety of the service people received. There were ineffective processes and systems to seek the views of people who used the service. Staff told us they would feel better supported by the provider if they had more staff. However, actions had not been taken to address this.

The Friendly Inn

Detailed findings

Background to this inspection

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

We carried out an inspection of the Friendly Inn on 4 and 11 May 2016. The inspection was unannounced. The inspection team consisted of three inspectors on day one and two inspectors on day two.

The Friendly Inn provides personal care and accommodation for up to 30 older people. Some people were living with dementia. There were 30 people living at the home when we carried out our inspection. This included one person who was in hospital on our second visit.

Prior to our visit we spoke with the local authority commissioning team. Commissioners are people who contract services, and monitor the care and support when services are paid for by the local authority. Commissioners told us they had visited The Friendly Inn in April 2016. They had identified some areas for improvement and they were working with the home in relation to these. Following our inspection visits, we notified the local authority commissioners and the CCG about the serious concerns we had identified related to the safety and quality of care that people received.

We reviewed the information we held about the service and the statutory notifications that the registered manager had sent to us. A statutory notification is information about an important event which the provider is required to send us by law. These may be any changes which relate to the service and can include safeguarding referrals, notifications of deaths and serious injuries.

We looked at seven care plans and other care documentation such as people's risk assessments, food and fluid intake charts, medication records and behavioural charts. We looked at the complaints information, staff training records, accidents and incident records and quality monitoring information.

We spent time observing how staff interacted with people in the home. We also used the Short Observational Framework for Inspection (SOFI). This is a specific way of observing care to help us

understand the experience of people who were not able to talk with us. We also completed observations during both visits, including mealtimes in the dining room and the lounges to see what people's experiences of the home were like.

We spoke with eight people who lived at the home five relatives and ten staff members including the provider, the registered manager, the deputy manager and senior care staff.

Inadequate

Is the service safe?

Our findings

During our last inspection in January 2016, overall, staff were available to support people at the times they required. However, we were concerned that care staff were expected to undertake additional duties alongside their caring role. We discussed this concern with the registered manager, who assured us they would address this issue; we found this had not happened.

Prior to our visit we received concerns about the number of staff available to provide safe care to people who lived at The Friendly Inn. Information included concerns that a number of people had fallen at the home because staff were not always available to provide support and supervision at the times people required. The concerns reported to us reflected the findings of our inspection visits. The provider had not identified that people were at risk because their care and support needs were not being safely met.

Relatives told us there were not enough staff available to meet people's needs. One relative said, "There should be more staff; care staff should not be expected to cook meals and provide activities to people." Another said, "There is rarely enough staff on shift to provide safe care. Far too many residents are having falls because the home is understaffed."

Staff told us that more of them were needed to supervise and support people. They told us this particularly applied to the level of care required by a number of people who had higher dependency care needs, including those people who lived with dementia. They also told us this applied to peak times of the day, such as during the late afternoon and tea time. Most staff we spoke with expressed concerns in relation to additional 'non caring' tasks they carried out. These duties included laundry and catering duties, which took them away from supervising and providing support to people. One staff member told us, "The staffing levels here are a problem." They explained having to prepare meals took their time away from supporting people and said, "Extra staff would help, and then we could always have someone 'on the floor' to keep people safe."

During our visit we observed there were not enough staff to effectively meet the care and support needs of some of the people who lived at the home. We saw that staff were busy and shifts were task orientated which meant staff had little time to interact with people. Some people required close observation and supervision to keep them safe, for example, from the risk of falls. We saw how insufficient staff numbers impacted negatively on people's experience of living in the home and how the risks associated with their care and support were managed. For example, at 4.30pm on day one of our visit we observed a member of staff was working in the kitchen to prepare the evening meal. This was because the cook was on a period of long term absence. This reduced the number of care staff available at that time to supervise and support people who lived at the home. The failure to appropriately cover absent staff meant people were not kept safe from the risk of harm at this time. We saw that some people were in communal areas of the home and other people were in their bedrooms. Therefore, it was difficult for the remaining staff to observe the people who required supervision. This included a number of people who had been assessed as at a high risk of falls. For example, at this time we observed a person who had experienced falls walking unsupervised on a wet floor, which posed an increased risk of them falling again.

Staffing arrangements at night time were insufficient to keep people safe. For example, two members of staff were on duty and some people required assistance from both of these to get into bed. We could not be sure other people in the home would remain safe at these times, because staff would not be available to supervise or support them.

We discussed staffing with the registered manager. They told us, "We thought we had enough staff, but we have been thinking about this." The registered manager showed us the dependency tool they used to determine how many staff were needed to provide safe support to people. They told us it was reviewed every six months and people's level of need had been assessed as being as high, medium or low. However, it was not clear how this information had been used to determine the staffing levels or whether people's care needs had been accurately assessed. We asked the manager to explain it to us and they said, "We work it out with pen and paper."

Following day one of our visit, the registered manager told us they had reassessed each person's level of need using the dependency tool to determine the support they required. The outcome of these assessments identified that more staff were required at certain times of the day and night. The registered manager told us they were aiming to employ more staff and informed us of their intention to do this as soon as possible, so staffing levels could be increased. Until this happened, management hours had been adjusted to ensure a manager was on duty between 7am and 9pm each day. This person also provided the additional staff member cover during the peak afternoon time.

Despite this change, staffing arrangements remained ineffective. For example, at tea time on day two of our visit we continued to have concerns in relation to how staffing arrangements impacted on people's safety. For example, at 5.05pm we intervened to keep a person safe because staff had not been available to give them their Zimmer frame when they needed it and they were at risk of falling. We discussed this with the registered manager and they told us their opinion was that some senior care staff were not effectively managing the deployment of staff on the shift. They and the deputy manager told us they agreed this placed people at unnecessary risk. They assured us they would address this immediately and support senior care staff to increase their competence in managing the staff on shift.

This was a breach of Regulation 18 (Staffing) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people if there were enough staff to meet their needs and we received mixed feedback. Comments included, "Sometimes there is enough and other times there are not." "Yes, usually there is enough." And, I think there is plenty of staff; if you are in trouble usually someone always helps." We noted that this positive feedback was obtained from people who required low levels of support from staff to meet their needs.

The registered manager and the deputy manager told us they understood their responsibilities to protect people and to report potential safeguarding concerns. However, we identified two safeguarding concerns which had not been reported. This related to two people who had fallen multiple times recently resulting in a number of injuries. These concerns had not been reported, so they could be appropriately investigated to protect people. After day one of our visit we made two referrals to the local authority to ensure risks to people's health and safety could be followed up.

Following this, the local authority notified us that a decision had been made to complete welfare checks to identify whether it was safe for people to remain living at the home.

We saw one safeguarding referral had been made by the registered manager in February 2016 when a

person had fallen several times. The outcome of this was unknown and no action to follow up on this referral had been made. The registered manager told us they would immediately review the way they reported incidents and review the training needs of staff to ensure if further safeguarding incidents occurred they were correctly reported.

This was a breach of Regulation 13 (Safeguarding) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A member of staff told us they thought that people were not safe. They said, "People are at high risk of falling over, there would be less falls if we had more staff. We can't monitor people and do everything else expected of us." We asked one person if they felt safe at the home, and they said, "I am ok, I look after myself, but other people keep falling over, they [care staff] have to help them get up." Another person said, in relation to being safe, "Yes, I am alright."

During our last inspection we found recording around the management of falls required improvement. Despite assurance being provided by the registered manager, no action had been taken to make improvements. We saw referrals had been made to the specialist falls team but these were not consistent. One senior care worker told us, "We make a referral after someone has fallen a few times." Staff were not always clear of when people should be referred for specialist support and this posed a risk people would not be supported correctly.

Some staff we spoke with did not have the sufficient knowledge and skills to manage people's falls effectively. For example, we asked how they prevented one person from falling. A staff member said, "[Person] won't use their frame, they just fall, and sometimes they put themselves on to the floor." Another said, "We manage [Person] falling by walking alongside them." However, we did not always see staff doing this. We saw that no staff were present in the communal lounge for several minutes on three occasions when the person was walking. Therefore, staff were not available to provide assistance.

A number of people were at high risk of having falls; however staff did not know how to mitigate the risks of further falls occurring. Staff had not received training in falls prevention and a falls management policy was not in place at the home. Therefore, no plan was in place to ensure falls were managed consistently. We discussed this with the registered manager on day two of our inspection. They said, "Fall's training is needed, it has now been booked and I am in the process of writing a falls management policy." They told us this would be completed by the beginning of June 2016.

Risks associated with people's care were not always managed well. Risk assessments were in place, but were not always up to date and did not contain detailed information for care staff to follow to minimise the risks.

We saw in one person's care plan they were at high risk of falls. It was documented they had fallen multiple times in the past three months. Some falls had resulted in injuries and the person had required medical treatment. The plan for staff to follow to reduce falls stated, 'Staff to encourage [Person] to use Zimmer frame when walking. [Person] forgets to use it.' Care staff told us due to the person living with dementia, the plan in place was not effective. It was not clear what other options to reduce the risks had been considered and we could not see that additional safety measures had been implemented. Therefore this person continued to experience falls.

Despite this, the person's care record had been reviewed on 4 April 2016 and stated the plan was 'still meeting needs'. A referral had been made to the specialist falls team on 5 April 2016 to try and mitigate the

risk. The falls service had advised the registered manager they could not offer further assistance as they had already provided some equipment to aide the person whilst walking. Since the referral had been made, this person had experienced further falls which had resulted in injuries which had required medical treatment. However, there was no information to show the provider had taken action or implemented preventive measures to reduce the risk of falls occurring.

Despite discussing with the provider and registered manager our concerns about how the risks associated with people's care were being managed, shortly following our visits we were notified that a further person had fallen and had sustained an injury which required a hospital admission. The registered manager told us that prior to this further fall they had requested the person's family purchase some equipment to reduce the risk, as they did not always provide this at the home. The delay in the required equipment being provided put the person at unnecessary risk as the equipment was not in place at the time of this person's most recent fall.

Reviews of risk assessments were not taking place in line with the provider's procedures. For example, a person was assessed as at 'medium' risk of falls. This person had experienced one fall which resulted in an injury that required medical treatment. Their falls risk assessment had not been reviewed since February 2016, despite the provider's procedure being that it should have been reviewed each month. A senior care worker told us, "Risk assessments are in the process of being updated over the next few weeks." An updated care plan could not be located during the visit therefore, we could not be sure risks were being monitored and reviewed.

This same person was at risk of skin damage because they sat in a chair for long periods of time. Their skin care record stated, 'Check skin daily'. Their care plan had not been reviewed since January 2016 despite the provider's procedure being that it should have been reviewed each month. We asked a senior care worker whether these daily checks were taking place. They explained the checks did take place and it was recorded in the person's records, however we were unable to see this. On day two our inspection this person's risk assessment or care plan had not been reviewed despite us raising concerns.

Individual accidents and incidents had been recorded, but it was not evident they had been analysed to identify any patterns or trends to help prevent them from happening again. For example, analysis of accidents including falls had not been completed since February 2016, despite a number of people having experienced a number of falls since this time. The registered manager said, "March analysis had not been done due to safeguarding's." We asked what action had been taken and the registered manager told us, "Possibly nothing." The system for recording falls was inconsistent because the registered manager and the deputy manager completed the analysis in different ways. The registered manager told us, "I am going to get the deputy manager to change everything over to the most effective system."

During our visit we found that prescription creams were not always being administered correctly. Records of when these were applied were not kept. Creams were stored in people's bedrooms and were accessible to people who lived with dementia, which presented a risk. Creams were applied by care staff, but the plans in place to ensure these were applied as prescribed were not sufficient. This was because the plans did not detail how often or where the cream needed to be applied. Therefore we could not be sure these were applied as prescribed. The dates of when creams had been opened were not being recorded, and we saw one had expired in February 2016, however was still in use. This presented a risk because after the expiry date, prescription creams may not be safe or they may lose their effectiveness. The registered manager acknowledged this practice was not safe and told us they would make immediate improvements. On day two of our inspection actions had not been taken to address this.

This was a breach of Regulation 12 (Safe care and treatment) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they received their medicines as prescribed. One person said, "I get my tablets on time and I have regular pain killers." Another told us, "They [care staff] are really good with my tablets, I used to have pain killers and they always got them for me, but I don't need them now."

Prior to our visit, we had received a concern in relation to how people's medicines were being administered. This related to medicines being given out to several people at once without the person's individual MAR charts being signed to confirm they had taken it.

On day one of our inspection we observed a medication round and reviewed four people's medicine administration records [MAR's] to check medicines were being managed safely. We saw staff followed good practice. For example, they took medicines to people, provided them with a drink and watched them take their medicine before returning to sign the MAR to confirm they had taken it. The staff member locked the medicines trolley when they left it to give people medicine, so there was no risk these were accessible to people. Staff who administered medicines had received training and their competency had been assessed by the registered manager. This ensured they remained competent and continued to manage medicines safely in line with good practice guidelines.

The provider had taken measures to minimise the impact of unexpected events. The fire procedure was on display in a communal area of the home which provided information for people and their visitors on what they should do in the event of a fire. Each person had a personal emergency evacuation plan which detailed their individual needs for support in an emergency. This should ensure people could be assisted to evacuate the building safely if required. However, these plans were not kept in a central place and we saw people's plans were kept in different places within the home. We asked a senior care worker what they would do to keep people safe if a fire occurred at the home. They said, "I am not sure. We are in the process of updating the plans, eventually they will all be kept in one file." We could not be sure people would be supported safely in an emergency. We discussed this with the registered manager and they told us they would ensure all plans were moved into the central file immediately.

We observed one member of staff moving a person in a wheelchair without foot plates. This was unsafe and posed a risk of injury to the person. We asked where the footplates were and the member of staff told us, "They always go missing." We asked if they were aware of the risk to the person and they told us, "Well if the plates are missing what I can do?" We reported this to a senior care worker who reminded the care worker this was unsafe practice. The maintenance person explained they constantly put footplates back onto wheelchairs, but some care staff continued to remove them.

We were aware the registered manager had discussed this issue with care staff on two previous occasions, however we observed the unsafe practice had continued. The registered manager told us they would address this issue and on day two of our inspection we saw this had happened.

We saw procedures were in place to protect people from harm. For example, we saw the provider's safeguarding policy was accessible to people, their visitors and staff. However this had not been reviewed since May 2013. Staff we spoke with did have some understanding of what constituted abusive behaviour and they knew what to do if they suspected abuse. One care worker told us, "I would report to the manager if I had any concerns." Another said, "We follow the safeguarding policy."

Staff confirmed the provider had a whistle blowing policy which was available to them if they needed to use

it. They told us they were confident to speak out if they witnessed any poor practice. (A whistle blower is a person who raises concerns about wrong doing in their workplace). One care worker told us," If I was concerned I could tell the CQC, that's whistle blowing."

Recruitment procedures were in place to ensure people were supported by staff with the appropriate experience and skills. Prior to staff starting work the provider checked they were suitable to work with people who lived at the home. One care worker told us, "I had an interview and I had to wait for my references to be checked and DBS clearance certificate before I could start working." The Disclosure and Barring Service (DBS) helps employers to make safer recruitment decisions by providing information about a person's criminal record.

A maintenance person visited the home weekly to undertake general repairs and maintenance checks of the building. They were working in the home on day one of our inspection and they completed checks, for example to make sure the fire doors were closing when the fire alarm was activated. Checks and maintenance of some equipment took place by external organisations to ensure this was safe for people to use. For example, an annual safety check of the fire extinguishers in the home had taken place on 16 February 2016 to ensure they were working correctly.

During our last visit in January 2016 we had been concerned because one domestic assistant had been on duty instead of two, and a persistent unpleasant odour was present in one area of the home. During this inspection this had improved, more domestic assistants had been employed and communal areas were visibly cleaner. People were satisfied with the cleanliness of the home. One person said, "My room is kept clean and I am happy". A relative said, "The carpets are a bit worn, but they are frequently steam cleaned to get rid of any odours." A domestic assistant told us, "There is enough cleaning staff now. I work between 8am and 2pm."

Requires Improvement

Is the service effective?

Our findings

We asked people about the staff support they received. Comments included, "Most of them [staff] are good. There is the odd one or two who are not so good". And, "The care staff do seem to know what they are doing."

Relatives told us they were satisfied overall with the support their family member received. One told us, "The staff are good, [Person] seems happy enough." And, "I am not as concerned as I used to be but I am not 100% happy." They explained they had previously raised concerns about the staff being too busy to meet their relations needs but things had improved over the last few months. This had made them more confident their family member was now being cared for well.

Staff told us they had received an induction so they were aware of their roles and responsibilities when they had started working at the home. One staff member said, "I started in January, I have completed all of my training." New staff members were supported by more experienced care staff and completed induction and training to help them meet the needs of people who lived in the home. Staff had worked alongside experienced staff and observed how people preferred to be supported before they worked unsupervised.

Staff told us they had completed some training to meet the specific needs of the people who lived at the home. One said, "I have completed dementia training, it was useful and it helps me to do my job." Records showed some staff had not yet completed the training the provider considered essential to meet the health and social care needs of people. For example, two staff members had not yet completed mental capacity awareness training. The registered manager told us this training would be completed as soon as possible.

We asked the registered manager how they assessed staff competence to ensure they had the skills and knowledge to care for people safely and effectively. They told us daily 'walk arounds' of the building were undertaken. They told us this was so they had an overview of how staff were providing care and support to people.

Handover meetings took place at the beginning of each shift as the staff on duty changed. The health and well-being of each person living in the home was discussed and changes were communicated. A staff member told us the meetings were, "Really useful," so that staff had up to date information. We asked staff how they knew if a person's need had changed. They told us messages were often passed on verbally and a communication book was in use.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interest and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Most staff were working within the principles of the MCA. Improvements had been made since our last inspection when we had found capacity assessments had not been in place for all people who required them. Since the last inspection these had been completed.

During the visits we saw most people made daily decisions for themselves such as what they would like to eat and drink. Some staff members demonstrated an understanding of the principles of the MCA as people verbally consented to their care and we saw staff respected decisions people made. We asked staff what they would do if people refused care or were anxious. One member of staff said," I would step back and give the person time to relax and then I would try and help them again." Another said, "If someone refuses care that's their decision, I would try again or get someone else, as sometimes that helps."

However, not all staff we spoke with demonstrated a good understanding of the key requirements of the MCA, so they could ensure people's human and legal rights were respected. For example, we asked a member of staff if a named person had capacity to make their own decisions, but they were unsure. They said, "My view is they do not have capacity". We asked them if the person could make some decisions. They said, "Yes, if you can give them a choice of clothes to wear, they can choose." Therefore, the person did have capacity in some areas. This was a risk staff may not identify when people could make decisions for themselves or require further support with decision making. People may not be supported correctly under the principles of MCA.

Where people were at risk of dehydration or malnutrition this was identified through the risk assessment process. Some people needed their food and fluid intake monitored by staff using a chart system. During our last inspection we could not be sure people had received a sufficient intake to remain healthy as quantities were not being clearly recorded.

During this inspection our concerns remained as charts were still not being completed. We could not be sure the charts were accurate and this posed a risk people were not being supported correctly. One person was underweight and required their food intake to be monitored to ensure they had eaten enough. 'Chicken and vegetables ' and, 'Ate all' were written on records but the original quantity was not recorded, so we were unclear how much this person had eaten. This person's charts had been audited by the deputy manager in February 2016 and it had been identified charts were not being completed correctly. Despite this, no action had been taken to improve the records.

Another person was at risk of dehydration and needed to drink 1500mls of fluid per day to remain healthy. Their intake was not being monitored consistently and this posed a risk to their health. We discussed the charts with the deputy manager who explained the senior care staff were responsible for evaluating the charts each day. We found the audit process in place to check the charts and what was written on them was not effective to ensure any risks to people's health were identified and minimised.

People told us they were satisfied with the food and drink provided. Comments included, "Yes, you get enough to eat; overall you have a choice, but not much." And, "One day they offered me something to eat and I did not like it. I asked for toast instead, they [staff] went and got me something else, so I was happy." Prior to our visit, we had received a concern from a person about the mealtime experience at the home. We spent a period of time observing mealtimes to see if this was a positive experience for people. Mealtimes were a busy time of the day and most people chose to eat in the dining room which meant the room was busy and noise levels were high which was not supportive of people living with dementia.

On the first day of our inspection people did not appear to be given a choice of food, although portion sizes were sufficient for most people. A member of staff explained people had previously chosen what they would

like to eat and an alternative would be provided if they did not like what was on the menu. On the second day of our inspection we found people were given limited size portions at tea time. Options were either soup and a bread roll or a sandwich. One person said, "That's not enough for me." A second helping of soup was then provided.

Staff we spoke with demonstrated a good knowledge of people's nutritional needs. For example, they knew who needed encouragement to eat, who was diabetic and who enjoyed a vegetarian diet.

People were referred to other professional when this was required. One person told us, ""They [staff] will organise a doctor for me if I need one." Another said, "We have a doctor come in and I have seen him twice." We did not see any health care professionals on the days of our inspection; however care records showed that people had seen their GP and other healthcare professionals. For example, an appointments diary showed us an optician had recently visited the home.

Requires Improvement

Is the service caring?

Our findings

People told us most staff were caring. Comments included, "They [Staff] look after me, the carers are good." However, one person told us, "[Staff member] is not so good, there are not many words exchanged between us, they are all smiles and lovely until the visitors have gone."

Relatives told us some staff were caring. Comments included, "I never really have concerns [about staff]." However, others commented, "Some staff are good, but some could not care less." And "Some of the carers are work shy."

Prior to our visit, we had received a concern from a person about the limited interaction between the staff and the people who lived in the home. During our visits we saw staff trying their best to provide supportive care. They were caring in their approach but the lack of staff, ineffective staffing arrangements and the additional duties they undertook meant they had little time to spend with people. For example, we saw interactions with people were focussed on when they offered support or completed a care task.

Staff told us they wanted to provide a caring service. We asked them if they had time to sit and chat with people to get to know them. One said, "Not really, it's frustrating, I would like to but I just don't have the time." Another said, "I would love to but, I am too busy." However, some staff did not always take the time to engage and communicate with people when they had the opportunity. For example, we saw staff spent periods of time in the lounge completing records sat behind a desk rather than talking to or engaging with people.

People were encouraged to maintain relationships important to them. People told us their visitors were welcome at any time. One person said, "My family like the home, my [relative] is local." We saw visitors stay for long periods of time during the day to support their relations and provide company for them.

We saw staff treated people with dignity and respect and they addressed people by their preferred names. One person told us, "[Staff member] is lovely, they always ask, Do you want me to come back later." We observed staff knocked people's bedroom doors and waited for permission before they entered.

Some people had limited opportunities to be involved in making decisions about their care and we could not be sure care plans were accurate so that people were being supported to be as independent as they wanted to be. One person's care plan stated 'Prompt for a wash, fill basin only.' However, staff told us the person was unable to wash themselves.

Prior to our visit, we had received a concern about people's confidentiality not being maintained. During our last inspection in January 2016, we saw that records containing people's confidential information were not locked away. We could not be sure confidentially was always maintained as other people could access this information. The registered manager assured us suitable storage would be purchased. However, this had not been done on day one of this inspection. During day two the records had been moved into the registered manager's office. However, we observed two people's files on a table in a communal area which

had been left unattended, confidential information could still be accessed by people or visitors. The registered manager told us they would remind all staff that people's records needed to be stored in their office.

Inadequate

Is the service responsive?

Our findings

We observed staff tried to be responsive to people's needs. However, assistance was not always provided at the time people required or preferred because staff were not always available. For example, on the first day of our inspection one person wanted a cup of tea. A member of staff said, "Give me ten minutes and I will get you one, I am just helping someone else." The cup of tea had not been provided 30 minutes later.

People told us they had a drink at 'set' times rather that when they wanted one. One person said, "We have to wait for the tea trolley." We saw drinks were not available to people whist they ate their meals on day two of our inspection. A member of staff told us, "People have a drink after." We discussed this with the deputy manager. They told us they would ensure drinks were offered at all mealtimes in the future.

At tea time on the second day of our inspection we saw two people were assisted to eat their meal by a member of staff in the lounge. One person was not asked if they would like to eat their meal in the dining room. When we asked why, the member of staff said, "It's because they are hoisted." They explained there was not enough room in the dining room to accommodate the hoist.

Staff told us people were taken to the toilet between 2pm and 3pm in the afternoon each day. When we asked why, one said, "We always do it this way, but people can say no." This practice demonstrated that people were not being treated as individuals and this did not promote person centred care.

We saw eight pairs of spectacles in a box in the lounge. This posed a risk to the people who they belonged to as they might not be able to see clearly without them. When we asked why people were not wearing them, one staff member told us, "It's a challenge; those glasses are all lost property." They did not know who the spectacles belonged to. We asked what action had been taken to find out who the spectacles belonged to and they said, "Not much, people lose them."

People's care plans were developed from assessment information obtained to help staff ensure people's' needs were met. Staff told us they tried to read them but this depended on how busy they were. A visiting professional told us some people's care plans contained conflicting information. This could confuse staff because they would not know which information was correct.

We looked at a selection of care plans and saw there were inconsistencies in the level of information recorded and it was not always clear what specific support staff needed to provide to people. For example, 'Full assistance' was recorded in one person's mobility care plan so it was unclear how the person needed their support to be provided. A senior care worker explained care plans were in the process of being updated to include more detailed information. We could not be sure that all care plans contained up to date accurate information on how people preferred to live their lives.

During our last inspection we saw guidelines based on the advice from health professionals to manage people's behaviours were not always followed. The registered manager and quality manager had assured us they were in the process of supporting staff to improve record keeping. Our concerns remained during this

inspection because necessary improvements had not been made.

We looked at ABC charts for one person who was living with dementia. (An ABC chart is an observational tool that records information about a particular behaviour. The aim of using an ABC chart is to better understand what the person is trying to communicate). This person was often resistant or refused support from staff to maintain their personal hygiene. This person's decisions about their personal care had a potential effect on their health and wellbeing as they did not have the capacity to understand the consequences of refusing personal care. Guidance for staff to follow in the person's care plan stated, 'Put on a DVD or music to settle [Person].' It was not evident if any action had been taken to explore why the person was resistant to personal care.

Records showed staff were not following the guidance they had been given to support this person. This could cause unnecessary distress and increase the person's levels of anxiety. For example, on two occasions staff had written, 'I told [person] to stop, wasn't acceptable.' And, '[Person] became aggressive hitting out at two carers, told [person] it was not acceptable. We discussed this with a senior staff member who said, "All staff need to complete further training to make sure care plans are followed." We could not be sure staff had an understanding of the person's needs as they were not using care plans and risk assessments to manage their care effectively.

It was not evident people had been involved in planning their care. One person said, "No, I don't think I have never been asked." Another said, "Care plan, what's that?" Therefore, we could not be sure the provider had taken action to ensure people's wishes and preferences were identified, listened to and considered when delivering care.

People were not satisfied with the social activities provided. One person said, "We never have any trips out. I read and watch TV, without that I would go 'barmy'." Another said, "We sit there and go to sleep. There is not enough to do, nothing goes on." Some activities were available, but we could not be sure these were planned in accordance with people's interests and preferences. During our visits, we saw very little to stimulate people. We did not see any resources which would provide good dementia care, such as reminiscence books, or activities to stimulate people's interests or senses and give people a sense of purpose.

This was a breach of Regulation 9 (Person centred care) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed people who needed staff to help them walk spent long periods of time sitting in the lounge. However, some people were independently mobile and they told us they decided how they spent their time. Comments included, "I get up when I want, and it is up to me." And, "I like to walk outside in the garden area and you can smoke." We saw this happened during our visit. During our last inspection the registered manager told us that recruiting a member of staff to provide more activities was a priority. At this inspection a member of staff had been recruited, but they had not yet started work at the home.

People and their relatives did not have the opportunity to formally feedback any issues or concerns. Meetings for people who lived at the home and their relatives did not take place. One person said, "No, we don't have anything like that here." Therefore, people did not have the opportunity to get together and discuss any issues they had. The registered manager told us this was due to not many people attending previous meetings. They explained they would now hold meetings again in the near future.

One relative explained they did have meetings with the registered manager to talk about their relation's care

and this made them feel involved and informed about their relative's well-being. However, they explained they had requested the meetings took place.

We observed staff offered people some daily choices. For example, what channel they would like to watch on the television. Staff told us how they offered choices to each person as people's communication styles and abilities were all different. Some people were living with dementia and were unable to communicate verbally. We asked staff how they supported these people to make choices. One said, "[Person] makes hand gestures when they need me to help them. Sometimes it is a process of elimination to find out what they need."

Prior to our visit we had received complaints from people's relatives regarding the quality of care provided. One person told us they had raised their concerns at the home and they were not satisfied with how their complaint had been handled. They told us they felt, "Passed from pillar to post and fobbed off."

We asked a staff member how they would know if someone was unhappy if they were unable to tell them. They said "I know people well, I would know if they were unhappy and I would let a manager know."

A copy of the provider's complaints procedure was on display in the home and people we spoke with knew how to make a complaint if they wished to do so. One person said, "I cannot complain about anything, but I would if I was concerned. I would go and see the managers in the office." Another said, "I've never had to make a complaint, but if I did I would tell [deputy manager]." A relative told us. "If I saw anything concerning, I would be down on them like a ton of bricks." They explained they had recently spoken with the registered manager about some concerns and felt they had been listened to.

Inadequate

Is the service well-led?

Our findings

Since our last inspection undertaken in January 2016 we have received a number of concerns from relatives and other sources about the quality and safety of service provided at The Friendly Inn.

At this inspection we found that the provider did not have effective systems and quality assurance processes in place to monitor and improve the quality and safety of services provided to people. The management of risks related to the health of people living in the home were not sufficient and staff had not undertaken training in relation to the prevention of falls. Staff were not able to demonstrate how they managed risks and care plans were not being used to ensure safe care was delivered in accordance with instructions. This resulted in a number of people receiving unsafe care. Accidents and incidents including falls were recorded but the analysis so that lessons could be learnt and any action needed could be taken to keep people safe was not effective. This had resulted in people experiencing multiple falls.

A system to identify the on-going dependency needs of people, so the provider could assess how many staff were needed to support people safely, was not sufficient. The registered manager told us that not all staff were competent to lead the shift. However, no action had been taken to address this prior to our inspection. This had resulted in there not being enough staff available to support and supervise people at the times they needed them.

The arrangements in place to check the quality of people's care plans were not effective. A number of care plans were out of date and did not contain sufficient detail to support staff in delivering person centred care that was safe, appropriate and in accordance with people's preferences and wishes. It was not clear how people were involved in making decisions about their care.

The registered manager told us, "I complete the audits of people's care plans; monthly evaluations are completed by senior care workers to make sure information is correct. We have a system to check one evaluation is completed each day." However, we saw some care plans had not been reviewed for five months and people's support needs had increased during this time. A senior care worker told us this was because they had been busy updating other records. Actions had not always taken place when audits had identified improvement was needed. For example, how staff recorded people's daily nutrition and fluid intake had already been identified as a concern by managers and had not been addressed.

There were ineffective systems to seek feedback from people about the service they received. Group meetings involving people who lived at the home did not take place. During our last inspection in January 2016 we looked at questionnaires which had been completed in October 2015. The registered manager had assured us this information would be sent to the provider's head office to be analysed to assess if action was required to make improvements. This had not happened.

During this inspection we looked at analysis that had been completed from questionnaires completed in January 2016. This meant people had been given the opportunity to complete satisfaction surveys, so that the provider could identify what they achieved well or areas which required improvement. Twenty six

questionnaires had been sent out and ten responses had been received. Most of the responses were positive however, it was not clear how this information would be used to make improvements. For example, one person thought their involvement in planning their care was poor. Another person thought their complaint had been handled poorly. It was not evident how the provider had listened to these people's views or if they had taken any action to make improvements.

Staff were not always given opportunities to meet with managers where they could contribute their views on the running of the home and discuss their training and development needs. One to one supervision meetings were not routinely completed to ensure staff were given opportunities to talk about their role, raise any concerns they had or discuss their training and developmental needs. One staff member said, "We don't get regular supervision; I would like to have more." Another commented, "I have had some meetings; managers ask if I have concerns and what my goals are." The registered manager told us, "Supervisions with staff take place every 8 weeks." However, records showed this was not happening. Some staff had not received supervision in the last five months. The registered manager confirmed this was correct. They assured us meetings with staff would take place within the next five days following our visits.

Staff told us they would feel better supported by the provider if they had more staff. They voiced their concerns about the leadership of the service. One member of staff said, "We have told the managers there is not enough of us and we feel under pressure to care for people." Another explained they didn't feel listened to by the provider and management team and staff meetings did not take place. This meant they had limited opportunities to share their concerns and this made them feel frustrated and had a negative impact on staff morale which meant staff often went off due to illness. We discussed this with a senior care worker who told us staff sickness levels had recently been high, but had now reduced.

This was a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had submitted most of the notifications we required by law about important events in the home. However, they had failed to notify us when potential safeguarding incidents had occurred and when people had sustained injuries from falls. The registered manager assured us they would submit these notifications in the future. It is important that the CQC receives all necessary notifications so we can monitor the service and take action when required.

The provider's management team consisted of a registered manager who had been in post for several years and a deputy manager. Support was provided to the managers by the provider's quality assurance manager who visited the home approximately once a month to complete compliance audits. The registered manager explained their challenges to us which included not always receiving timely support from other professionals when they requested it and ensuring staff worked together as a team.

Overall people told us the managers were approachable and they had positive views about the leadership of the service provided at the home. Comments included, "I personally think it is a wonderful place." I know who the manager is." And, "I would not change anything."

We received mixed feedback from relatives. One said, "I would not change or improve anything. Overall I think it is good." However, another relative told us, "I have more confidence in the deputy manager; I prefer to approach her if we have any problems." They explained the deputy manager did listen to them and did try to make improvements.

Following the concerns we identified during our inspection we notified the local authority commissioners

and the Clinical Commissioning Group about the serious concerns we had identified related to the safety and quality of care that people received. We wrote formally and then met with the provider to give them the opportunity to provide assurances of actions taken to ensure the safety of people who lived at the home. We asked them to submit an urgent action plan to tell us how they were going to mitigate the risks. We have imposed a condition on the provider's registration which means they require our written consent before admitting or re-admitting people into the home.