Foxley Lodge Residential Care Home

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Inspection report

24-26 Foxley Hill Road
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Tel: 02086684135

Date of inspection visit:
19 April 2016
26 April 2016

Date of publication:
28 September 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 19 and 26 April 2016, the first day was unannounced. At our last inspection in April 2014 the provider met the regulations we inspected.

Foxley Lodge is registered to provide accommodation and personal care for up to 22 older people who are living with varying stages of dementia. Accommodation is arranged over three floors with access via a passenger lift. 18 of the 22 bedrooms are en-suite. On the ground floor, communal areas include two separate lounges, a kitchen, dining room, bathroom and toilet facilities and an office. There is an enclosed rear garden with paved area for people to access. There were 20 people using the service at the time of our inspection.

The service had a registered manager who was also one of the owners. 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.

The service did not follow consistent safe practice for the recording and safe administration of people's medicines. Medicines documentation was not always completed appropriately and there were not always clear instructions for how medicines should be administered. This meant that people may not receive their medicines safely.

The provider did not ensure appropriate skilled and experienced staff were deployed at the home to meet the various needs of people who used the service. There was not enough staff on duty to provide activities or respond to people's needs in a timely way.

Staff were familiar with people's needs, and received regular training to keep their knowledge and practice up to date. We were not assured however that staff had the skills and expertise to support the specialist needs of the people using the service.

The arrangements to monitor service provision did not always identify shortfalls and ensure that people were well cared for and safe. The provider's systems were not used effectively to keep checks on standards, develop the service and make improvements.

People using this service did not always experience responsive care and support that was appropriate to their needs. Care plans did not always record all the information staff needed to care for and support people effectively. We also found that records relating to staff and the management of the service were not up to date or consistently maintained. Incidents and accidents involving people who used the service were not always reviewed or investigated to check that appropriate action had been taken. In addition, people's care and monitoring records were not consistently maintained to accurately reflect the care and support provided to people.

Where people lacked capacity to make decisions, staff were aware of how to support these people in line with the law although the reasons for making decisions on people's behalf were not clearly recorded. Appropriate applications had been made to the supervisory body to restrict people's liberty where required.

We found that areas within Foxley Lodge could be decorated and equipped more suitably for people living with dementia. The provider agreed to look at ways to improve the environment to provide more engagement and stimulation.

People had positive relationships with the staff who they described as caring and helpful. Staff respected people's privacy and treated individuals with kindness and patience. Staff made sure people's dignity was upheld and their rights protected. Staff were knowledgeable about the risks of abuse and the procedures for reporting any concerns.

People were supported to maintain good health and had access to healthcare services when they needed them. The service had made timely referrals for health and social care support when they identified concerns in people's wellbeing. People were encouraged and supported to eat a nutritional diet that met their needs and recognised their choices.

The registered manager was aware of when to send us a statutory notification to tell us about important events which they are required to do by law.

We found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to managing risk for people using the service, staffing levels, the systems for monitoring the quality of service provision and record keeping. You can see what action we told the provider to take at the back of the full version of this report.

We have made recommendations about staff training on the subjects of dementia and person centred care. We have also made recommendations about the environment and some aspects of record keeping under the Mental Capacity Act 2005.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

The provider did not have appropriate arrangements in place to manage all aspects of medicines safely.

There were not always enough staff to meet people's needs and the provider did not ensure staff were deployed effectively.

People told us that they felt safe and staff knew about their responsibility to protect people from harm and abuse. They were aware of any risks and what they needed to do to make sure people were safe.

Care records included guidance about managing risks to people's health and welfare. However, incidents and accidents were not always reviewed or investigated which put people at risk of unsafe care.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Staff understood the importance of gaining consent to care and giving people choice. The provider acted in accordance with the Mental Capacity Act 2005 Code of Practice to help protect people's rights. However, where people need help to make decisions, their individual circumstances had not always been fully assessed and recorded.

The environment did not fully meet the needs of people who used the service living with dementia. The provider recognised the need for refurbishment to address this.

People had a choice about what they wanted to eat and drink. Their individual dietary needs and preferences were known and respected and they were protected from the risks of poor nutrition and dehydration.

People received the support and care they needed to maintain their health and wellbeing and had access to health care professionals when required.

Is the service caring?

Good

The service was caring. People were treated with kindness and staff knew their background, interests and personal preferences well.

Staff understood and promoted people's dignity and independence.

People were supported to maintain relationships with those that were important to them. People and family members told us staff were kind, considerate and caring.

Not all people's care records were person centred and reflected a task orientated approach at times. The provider recognised the need to improve this.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

People did not always receive personalised care that was responsive and met their assessed needs. There was a lack of consistency in the information contained within the care plans which put people at risk of inappropriate care.

Arrangements were in place for dealing with complaints and responding to people's comments and feedback.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

There were systems for auditing and monitoring the service but these were inconsistently applied and had not effectively identified the shortfalls or improvements needed.

People's care and monitoring records were not consistently maintained to accurately reflect the care and support provided to people.

There was a registered manager and staff felt well supported. People using the service and their relatives had opportunities to provide feedback about the services they received.

Foxley Lodge Residential 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.

Before the inspection, the provider completed a Provider Information Return (PIR). 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. Prior to our visit we also reviewed the information we held about the service. This included any safeguarding alerts and outcomes, complaints, information from the local authority and notifications that the provider had sent to CQC. Notifications are information about important events which the service is required to tell us about by law. We also reviewed the inspection history.

This inspection took place on 19 and 26 April 2016. The first day was unannounced and the inspection was carried out by two inspectors. We spoke with seven people who used the service, two visitors, one visiting professional and four members of staff. We also spoke with the providers, one of whom was the registered manager. Due to their needs, some people living at Foxley Lodge were unable to share their direct views. We therefore spent time observing how care and support was provided to people. Along with general observation, we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We reviewed records about people's care, including seven files of people who used the service.

We checked staff recruitment records for five staff and the records kept for staff allocation, training and supervision. We looked around the premises, external grounds, all of the bedrooms and checked how the premises were maintained. We checked records for the management of the service including health and safety records. We reviewed how the provider managed complaints and checked the safety and quality of the service. We also checked how medicines were managed and the records relating to this.

Following our inspection the manager sent us some information about staff training and a copy of the most recent Statement of Purpose for the service.

Requires Improvement

Is the service safe?

Our findings

We found that staffing levels did not always meet the needs of the people using the service. The PIR completed in February 2016 stated that there were 16 people using the service. The registered manager told us four people had moved in to the home since that time but staffing levels had remained the same. Two of these people had complex dementia care needs and we found this impacted on the care provision for other people. Individuals told us they were sometimes affected by other people living there who became angry or upset. One person said, "I'd prefer to be in my own home, too much noise." Another person commented, "They are always screaming and shouting" referring to some people in the communal lounge. We observed examples where individuals got angry with other people using the service when they were walking around. Staff were seen to respond appropriately, however, we saw instances where there were no staff present in the lounge to intervene in a timely way. Staff spoke about how busy they were and said that they needed additional staff to fully meet people's needs. One staff member said, "Some people need one to one attention." Another staff member said, "We try our best but there are no one to one staff provided." A third staff member said that there were no laundry staff which meant they had to go off the floor to do this during their shift.

We observed that staff were constantly busy and were always called away when they sat down with people to spend time with them. For example, the activity session using memory boxes was frequently interrupted with staff being called to help when other people became angry or upset. We saw one instance where a person using the service was left unattended and they started to climb the main stairwell of the home despite this being very hazardous for them to do so. Staff responded only when they were discovered doing this. We raised concerns with the registered provider that people's safety could be compromised due to this person's needs and the level of support they required. During our inspection the registered provider made arrangements through an agency for additional one to one staffing. When we returned for our second visit, we saw this had been implemented.

The communal lounge was set out on two levels with connecting stairs at each end. We saw examples where people were walking and had to be assisted by staff to use the stairs safely. Some people were left unattended for brief periods in the lower level lounge on more than one occasion. In addition to supporting people with their care needs, staff were responsible for organising activities, laundry tasks and cleaning at the weekends.

The registered manager told us staffing levels were calculated according to funding from the local authority. There was no tool to determine number of staff based on the dependency needs of people who used the service. We saw that individual people required periods of one to one care which had not been accounted for. There was no systematic approach to determine the number of staff required, to review the service's staffing levels and to ensure that the deployment of staff met people's assessed or changing needs and circumstances.

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

Agency staff were working in the home, but for one member of staff there were no records to show that they had undergone the required recruitment checks. This meant the provider did not have complete information to assess whether the staff member was suitable to work with people using the service. During our inspection the registered manager contacted the agency and obtained evidence that the required recruitment checks had been carried out. This included a satisfactory check with the Disclosure and Barring Service (DBS). Other staff files we checked confirmed that the provider followed safe recruitment practice.

Accidents and incidents were recorded although the detail within the reports varied and did not always provide relevant information about actions taken. For example, during March 2016 there had been eight accident or incidents involving one person. These showed occasions where staff had found them on the floor with unexplained bruises. Staff had recorded when an incident or injury had occurred, informed relevant professionals such as the GP or safeguarding and passed the report to the registered manager or deputy for review. However, when we checked these records, we were not always able to see where an investigation had taken place or where a review of people's care had occurred as a result. This would have identified any triggers, patterns or trends so people's risk assessments and the care provided to them could be reviewed accordingly.

People were not always protected against the risks associated with medicines because the arrangements to record and administer medicines were not always effective. Protocols for 'as required' (PRN) medicines were in place to guide staff when these might be needed. A PRN protocol describes the circumstances when a person can take a certain medicine so that it can be administered safely and consistently. There were inaccuracies with the protocols and medicines administration records (MAR) and we were not assured that people received these medicines as prescribed. Three people were prescribed PRN medicines to reduce their levels of anxiety. The information available to guide staff about when these should be administered was generic and did not consider people's individual needs. Information was limited and directions for administration included, "When required for agitation." MAR charts showed that staff had recorded the reasons for administration as "behaviour" and the outcome as "calmed down." In one example staff had recorded "behavioural problem" on the MAR but had not completed the section on the effect or outcome for the person. We cross checked people's daily notes and found that staff had recorded the reasons for giving these medicines on some days, but not on other days. The provider told us the home's policy required staff to record the reasons why PRN medicines were given, but staff were not always complying with this policy. Therefore the provider was unable to demonstrate that people were receiving all their medicines safely and as prescribed. It also meant people's behaviour was at risk of being controlled by medicines rather than seeking more appropriate ways to manage and support the person's behaviour. We spoke with the registered manager who agreed to develop protocols to guide staff in supporting people to manage their behaviour in other ways before medicine was administered. At the time of our second visit, protocols had been put in place although these contained generic information.

We found that not all prescribed medicines were recorded or accounted for. The quantity of medicine held in the box did not correspond with the quantity received for two people. For one person, we found half a tablet loose in the box. We also saw boxes of unlabelled topical skin creams. Monthly stock audits were carried out by staff but the latest audit had failed to identify these discrepancies. This demonstrated that recording methods used by staff were not robust.

Information about a medicine and the prescribed dose was not recorded on one person's corresponding MAR. The manager told us that the medicine had been discontinued and needed to be returned.

The above issues were a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other aspects relating to medicines management were safe. All medicines were stored securely in a locked trolley that was secured to a wall. Relevant temperatures were monitored and recorded. There were profiles which included the person's details, how and where they liked to have their medicines, any allergies and an up to date photograph. We looked at references to medicines within care plans. Some people were taking specialised medicines and specific risk assessments and guidance were available to staff to ensure these medicines were administered correctly. We looked at a selection of MARs. Aside from the above discrepancies with PRN medicines, administration records showed that people received their regular medicines when they needed them.

The majority of people said they felt safe living at Foxley Lodge. They said staff were kind and treated them well. A visitor told us, "I have never witnessed anything that causes concern."

Staff understood their responsibilities in keeping people safe from harm and knew who to contact if they had concerns. Policies about safeguarding people from abuse and whistleblowing provided staff with clear guidance on how to report and manage suspected abuse or raise concerns about poor practice. There were contact numbers displayed in the home that staff, people who used the service or visitors could use to report any concerns regarding abuse. The local authority had provided refresher safeguarding training for staff in recent months. Staff we spoke with felt able to raise any concerns with management should they have any. One staff member told us, "I feel able to talk to them. If they did not do anything, I would report to the council, I have no qualms about doing that." Another staff member said, "Yes, I can talk to the managers here." A third staff member said, "If I saw anything, I would talk to the manager."

Safeguarding referrals had been made to the local authority safeguarding team where necessary in respect of people's care. CQC records showed that these safeguarding matters had been reported appropriately and the provider had cooperated with the local authority and other professionals to investigate events. At the time of this inspection two safeguarding investigations were still in process.

People's care records included assessments where potential risks associated with their individual needs had been identified. Examples included nutrition, mobility, falls and risk of developing pressure sores. These were used to develop risk plans to promote people's safety. The plans provided staff with information about the support people required; managing risks safely and where appropriate using the correct equipment. The registered manager told us, and records confirmed that the service sought the support of healthcare professionals such as the falls intervention team and community mental health team where this was appropriate.

There was appropriate documentation for servicing and routine maintenance in the premises. This included records of maintenance contracts concerning utilities such as gas and electrical safety. Fire alarms and equipment were tested to ensure they were in working order. Fire evacuation drills were held regularly involving both people using the service and staff. People had up to date personal emergency evacuation plans (PEEPs). These provided details about the help individuals would need to safely leave the building in the event of a fire.

Requires Improvement

Is the service effective?

Our findings

Training records showed that staff were currently undertaking Care Certificate training. This is a nationally recognised framework for good practice in the induction of staff. Individual staff records included certificates for online / booklet based training in dementia, safeguarding, Mental Capacity Act 2005 (MCA), Deprivation of Liberty Safeguards (DoLS) and nutrition. Induction records were available for new staff. A training schedule identified when staff had completed training and when it was next due. This helped the registered manager prioritise and plan training that the staff needed.

We asked about specialist training, as the home provided a service for people living with dementia. Some staff said they would welcome further training around the needs of people living with dementia. One staff member said they had completed a booklet and answered questions about what they had learnt whilst another staff member said they completed online training. They said they would like additional training around responding to behaviour and keeping people safe. The registered manager told us they planned to access further training through the local authority's care support team.

We recommend that the service finds out more about training for staff, based on current best practice, in relation to the specialist needs of people living with dementia and provide this as a mandatory course for all staff working at Foxley lodge.

Records confirmed one to one supervision meetings and appraisals took place regularly with a schedule in place to ensure this. Staff supervision records were detailed and included discussions about people using the service. One member of staff told us they felt supported and could report any concerns to the manager. Staff told us they received regular supervision from their line manager where they could discuss their practice and identify any training needs.

We observed the lunch time meal to help us understand people's experience. Comments about the food provided to people were positive. One person said, "I like the food." Another person said, "Not bad, quite nice." A third person said, "It's alright." People said they were given choice and were offered an alternative if they did not like what was on offer. We observed one person being given a number of alternative dishes with the staff encouraging the person to eat and drink. Special diets, including pureed and fortified meals were available for people who required them.

Further work could take place to enhance the mealtime. We observed inconsistency between staff when they served meals with some staff telling people what was on their plate whilst others were just told, "Here's your lunch." Some staff were called away during the mealtime and this led to different staff helping individuals during their lunch. There was one instance where staff did not explain to a person that they had to go. Daily menus were written on a board in the dining room and there was a separate photo album of available meals. We discussed the use of pictorial menus for the tables so people could see the menu options available to them on a daily basis. The registered provider agreed to look into this.

Staff spoken with said that management were very keen to make sure that people ate and drank well and

this was a strength of the service. One staff member said, "People here are fed very well." Another staff member reported that "They really keep an eye on the food. They try their best to get people to eat." Care documentation included nutritional risks and any action required by staff to help people to eat and drink. Good detail was included in one person's plan about what they liked to eat and how staff could encourage them.

There were some signs and adaptations although further work could take place to make the home dementia friendly. The layout of the home meant that there was a lack of space for people to walk freely and safely on one level. For example, access from the upper lounge to the lower one was via a set of steps. Access to the pleasant garden with a sensory area had to be facilitated by staff which we saw some people enjoy. Some people had pictures on their doors to help them find their room but this provision was inconsistent. The provider told us that they had introduced colour schemes on different floors to help people find their way around. The lounge and dining areas were homely but quite plain in appearance lacking points of interest and pictures or photographs reflecting the lives of the people using the service. Bathrooms were clean but presented as being tired in appearance, requiring further decoration to make them more pleasant places for people to bathe or shower in comfort. Staff felt that this would be an improvement which would benefit people using the service. The registered manager told us he had identified these issues and that plans were in place to improve the environment for the people living there. We saw an action plan to support this.

We recommend that the service consider current guidance on improving the environment for people living with dementia.

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 interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). DoLS is a lawful process whereby a person could be deprived of their liberty because it was in their best interests. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Care plans and MCA assessments were completed for people around capacity however these were not consistently recorded and were generalised in content. For example, for people living with dementia their plans stated that they had been assessed as being "unable to make informed decisions that affect their life and wellbeing." This meant people's individual needs in relation to their ability to consent to specific decisions had not been assessed. Two people were receiving medicines covertly in their food although the recorded agreements were dated in 2013. We brought this to the attention of the registered manager who agreed to consult with the GP and arrange a review.

We recommend that the service consider current guidance on record keeping in line with the Mental Capacity Act 2005 Code of Practice.

Staff demonstrated that they gained people's consent and involved people as fully as possible in day to day decisions. During our inspection staff always sought people's permission before carrying out any care or

support. The registered manager and staff had received recent training on MCA or DoLS and understood their responsibilities. For example, they were aware that family and other professionals must be involved in a best interests meeting if a person lacked capacity to make a decision. Records supported what they told us. Where a person had a do not resuscitate (DNAR) in place records confirmed there had been consultation with the GP and family, where relevant.

The manager had assessed where people were being deprived of their liberty and made appropriate referrals to the supervisory body, for example, where people required staff supervision because it was unsafe for them to access the community unaccompanied. Records confirmed that applications for DoLS authorisations had either been approved or were in the process of being approved by the local authority. There was information and guidance available to staff about the MCA and how this legislation impacted on the care they provided to people.

People had access to the health care services they needed and other multi-disciplinary services were available when required. Care records reflected individuals' healthcare needs and people had seen other specialists where appropriate. Where people had specific health conditions there was information available alongside the care plan which explained more about the condition and how to support someone with it. There was correspondence which showed that the staff team worked closely with other healthcare professionals to ensure that people received the services they need. Records of all health care appointments were kept in people's files. These records detailed the reason for the visit or contact and details of any treatment required and advice given. Care plans contained hospital transfer forms detailing essential information about each person should they be unable to communicate their needs and preferences to external health professionals.

Good

Is the service caring?

Our findings

People using the service said they were treated with dignity and respect by staff working at Foxley Lodge. People told us that staff were kind and caring towards them. One person said, "The staff talk to me nicely." Another person said, "The staff are very kind , I can't complain about that." A third person commented, "They're alright." One visitor told us, "People are well cared for. My relative always looks well cared for, well presented." Another visitor said, "I have always been quite happy with the care provided, no problems."

Staff understood how to deliver care with dignity and respect and communicated with people effectively. Staff told us that the team worked well together to make sure people were well cared for. One staff member said, "Very good care here, we put the client first." Another staff member told us, "People are treated fairly." Staff spoke about the importance of giving choice and ensuring that people's wishes were respected. They gave examples of how they did this including using picture menus and holding up choices of clothing.

Staff wrote daily reports about people's care and support. These included reference to visits made by relatives, people's safety, welfare and daily activity. The care records also showed details of any contact people had with external professionals and other relevant events such as healthcare appointments.

Care documentation varied as to how the personalised the information presented was. Some people's files included a completed 'This is me' document which contained detailed information about their own history, likes and dislikes. There was also good information about people's needs associated with memory loss. One example included, "Assistance such as reminiscence therapy, memory albums and similar may help me to maintain a sense of selfhood." Desired outcomes were recorded as "I wish to maintain my current level of independence, ability and confidence." However, other care plans kept for people were generic and not useful in enabling person centred care.

We noted that some of the language used in the care records did not always uphold the individuality and dignity of people using the service. There was a list of duties for night staff to complete which reflected a task orientated approach. Examples included, "Toilet all residents before putting them to bed", "Put residents who require help to bed and ensure they are properly covered" and "Soak residents false teeth (dentures) overnight." The registered manager agreed to review these records and acknowledged that guidelines were not person centred. In the medicines cupboard, we also saw a basket containing a collection of used and unlabelled hairbrushes, combs and toiletries. The manager removed these during our inspection and agreed to speak with staff.

We recommend that the service finds out more about training for staff, based on current best practice, in relation to person centred care.

Records confirmed that staff supported people to maintain relationships and social links with those that are close to them. These also showed that relatives and family representatives were invited to review meetings and kept informed about any significant events. We reviewed written survey comments from people's relatives which included feedback about the strengths of the home. Examples included, "The friendliness

and caring staff" and "Residents are treated with dignity and compassion." There were also a number of complimentary letters from relatives thanking the registered manager and staff for the care their family members received.

Care records included details about people's ethnicity, preferred faith and culture. People were provided with cultural foods of their choice and supported to follow their chosen faith. Individuals' bedrooms were personalised with family photographs and other possessions that were meaningful to them.

During our inspection, people chose where they wished to spend their time. Staff gave us examples of how they made sure the privacy and dignity of people was upheld. We observed staff prompting people discreetly when supporting them and making sure that bathroom doors were closed to give people privacy. Staff knocked on people's doors before entering their bedrooms. People had been supported with their personal hygiene and to maintain their appearance as they preferred.

People's personal information was kept secure and their records were stored appropriately in the service. Staff addressed people respectfully and maintained confidentiality when discussing individuals' care needs. Staff had received training about respecting people's privacy and dignity. The registered manager told us there were plans for staff to refresh their training in dignity in care through the local authority.

Requires Improvement

Is the service responsive?

Our findings

Feedback from people about the activities provided to them was mixed. One person said, "They do activities each day, it's all set out, the same every day." Another person told us, "I get a bit bored being here every day." A third person said, "There is not much going on, it's a bit like today each day." A visitor said, "There seems to be plenty to do but perhaps people could do with more encouragement to take part."

We observed an activity session taking place using memory boxes kept for people to stimulate conversation and reminiscence. One staff member engaged very positively with one person but this was not sustained as they kept being called away to help with other people. The session was disrupted consistently as staff needed to help other people and this meant that some individuals did not receive much interaction. Staff had responsibility to undertake activities with people whilst managing the other roles they had to complete within the home.

A piano was provided and we listened to one person play on the afternoon of our visit much to the pleasure of other people using the lounge area.

Arrangements were in place to assess the needs of people prior to admission although we were not assured that the assessment process was managed appropriately. People with complex needs had moved to the home and this had impacted on other people using the service due to the level of support these individuals required. The home's Statement of Purpose stated that people were offered a one month trial before deciding whether to move in permanently. Although the registered manager had taken steps to consult with other professionals where needed, there was no evidence of a review for the three newest people to determine whether the placement was suitable. The registered manager told us that people used the service for short stay breaks as well as long term care. This was not included in the Statement of Purpose and the manager agreed to update information about the types of services provided at Foxley Lodge.

Care plans varied in quality and consistency. For example, a nutritional plan for one person contained detailed information as to their likes and dislikes. A care plan for another person around their dementia contained generic information and had limited use for staff when responding to the person. The plans for two people around behaviour contained generic phrases and there was no evidence that the plans had been reviewed to ensure they were working. Monthly evaluations reflected that there had been no changes in each care plan we looked at for multiple months. For example a behavioural plan for one person showed no changes between February 2015 and March 2016. In another example, one person's plan was reviewed and amended in December 2015 but staff had recorded "reviewed, no changes" until April 2016.

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

In some cases, care plans included information about how dementia might impact upon people's care. There were details about how the dementia affected people's daily lives, what their concerns were or what actions staff should take to ensure care remained appropriate and met their needs. There was evidence of

discussion with family about people's care. A relative confirmed they were consulted about their family member's preferences and life history or background.

Residents meetings were held regularly to obtain the views of people using the service. Records showed that people were consulted about daily life in the home and able to contribute their ideas. The minutes for recent meetings held in February and March 2016 included discussion about the food, activities, complaints and the care provided. People's views were recorded, however, there was no clear audit trail as to whether action had been taken following each meeting.

People and their relatives told us they knew how to make complaints about the service. We looked at complaints for the previous twelve months. Records were available to show how these were dealt with and responded to by the registered manager. We saw evidence that complainants had received a letter explaining what had changed following their comments.

There was a complaints procedure and comments box available in the entrance hall. We noted however that the procedure was not displayed where people using the service could see it and did not include accurate information about who to refer complaints to. We discussed this with the manager who agreed to review and update the details.

Requires Improvement

Is the service well-led?

Our findings

Due to a lack of effective governance within the home important procedures to keep people safe had not been followed. For example, medicines were not managed safely and the registered provider/manager had not monitored the impact of staffing levels on people and staff following the recent admission of four people into the home. The manager and staff undertook audits but records showed there were inconsistencies in monitoring the service quality and acting on any identified shortfalls.

We did not always see evidence of how the service learnt from themes and trends. We looked at the overview of accidents and incidents for people living in the home. The deputy manager completed an audit every month and recorded the total number. We saw that the number of incidents had increased over a period of months. There was no system in place that analysed the outcomes of incidents and accidents in order to learn from these and to improve the quality of the service.

We saw evidence that where improvements had been identified and steps taken to implement change, this had not been sustained. At three consecutive staff meetings between January and March 2015 staff were reminded about completing hourly monitoring records for people during the night. This action was then repeated again for June 2015 and more recently in January 2016. Similarly there had been recurrent discussion about the need for staff to keep accurate records when completing accident forms. Our review of accident reports showed this had not been addressed.

We found further evidence that record keeping was inconsistent. People's records were not always up to date to enable staff to meet people's needs effectively. In one care file, we found conflicting information had been recorded about the management of a person's behaviour. Individual guidelines for supporting people were not dated in some cases which meant that staff could read information that was no longer relevant or accurate. Accident/ incident reports and monitoring charts for people's behaviour were not always complete.

Other records relevant to the management of the service were not always accurate and fit for purpose. The home's policies and procedures were not up to date and had not been reviewed in line with new legislation. Documents included reference to the 'Essential Standards of Quality and Safety' and not the 'Fundamental Standards' that were introduced on 1 October 2014. An information file for staff contained guidelines that had not been reviewed for several years. This meant that staff did not have the most current guidance to support their practice.

The provider's governance systems were not always applied in the home and they had not identified the issues that we found during the inspection. This meant the systems used to monitor, review and assess the service were not always effective.

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

Aside from the shortfalls above, other systems were used effectively to monitor the quality of the service, including surveys for people and relatives and internal audits. Areas included looking at cleaning and hygiene, the environment and health and safety. Where improvements had been identified action points were recorded for each month and followed up. The registered manager had completed a maintenance plan for the year. Planned improvements included redevelopment of the rear garden to meet the needs of people living with dementia and converting the first floor bathroom to a walk in shower facility.

There were meetings for staff to share their views and keep updated about people's individual needs and matters that affected the service. We looked at some staff meeting minutes which were clear and focused on people's needs and the day-to-day running of the home. Records of these meetings included discussions around the care provided and keeping staff aware of good practice such as reporting safeguarding, dignity in care, the duty of candour and the care certificate. Staff also shared information through a communication book and shift handovers. Staff spoke positively about the new deputy manager. Staff confirmed daily handovers took place so they were kept up to date with any changes to people's care and welfare.

There was a duty of candour policy in place to help ensure staff were open and transparent in their dealings with people and their families.

There was a registered manager in post, who was also one of the registered providers that owned the home. He had a good knowledge of all the people who used the service and was able to offer guidance and support to all the staff. During our inspection, the manager welcomed any guidance we gave. The manager had identified areas where the service needed to improve and recognised that further work was needed to meet the fundamental standards of quality and safety. For example, he had identified that further training would support the development of the staff team.

The service was prepared to work in partnership with other agencies. We saw that the registered manager had been engaging with external stakeholders, such as the local authority in reference to the quality of care that was being delivered from the service. This included audits and investigations into specific incidents following safeguarding referrals.

Registered persons are required by law to notify CQC of certain changes, events or incidents at the service. Our records showed that since our last inspection the registered manager had notified us appropriately of any reportable events.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that service users received person centred care that reflected their individual needs and preferences. Regulation 9 (1) (a) (b)(c) 3(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not always protected from unsafe care or treatment because the registered person had not done all that was reasonably practicable to assess and mitigate identified risks to them. Regulation 12 (2)(a)&(b) People were not protected against the risk of unsafe management of medicines. Regulation 12 (2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not have effective systems in place to assess, monitor and improve the quality and safety of the services provided to people. Systems were not used effectively to evaluate and improve practice. Regulation 17(1)&(2)(a)(b)&(f) Records of care and treatment provided to

	people were not consistently accurate or complete. Records relating to the management of the service were not accurate or complete. Regulation 17 (2)(c).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of suitably deployed staff to meet people's needs and keep them safe. Regulation 18 (1)