Archers Healthcare Limited

# Lower Farm Care Home with Nursing

## Inspection report

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05 September 2018

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## Ratings

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|---|---|
| Overall rating for this service | Inadequate |

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

# Summary of findings

## Overall summary

This inspection took place on 7 and 8 August and 5 September 2018. We carried out an unannounced inspection visit on 7 August out of hours, during the evening. This was done to help give us a more comprehensive picture of the service. At that visit we told the provider of our intention to carry out a daytime visit the following day on 8 August. The inspection visit on 5 September was unannounced and was carried out to gather further information following feedback from the local authority safeguarding team, the local clinical commissioning group and relatives.

Lower Farm Care Home with Nursing provides accommodation, support and care for up to 46 people, some of whom are living with dementia. People in care homes receive accommodation and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. At the time of our inspection 40 people were using the service. Lower Farm is an adapted older building on three floors. The building is spread out and people have access to the ground floor areas via a lift. It is near King's Lynn town centre but transport would be needed to access local facilities.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

At our previous inspection, which was carried out on 8, 13 and 19 September 2017, we rated the service as Requires Improvement. During that inspection we identified breaches of Regulations 9, 11, 12, 14 and 18. These breaches related to person centred care, consent, safe care and treatment, nutrition and hydration and staffing. Following the last inspection, we asked the provider to complete an action plan to show what they would do, and by when, to improve the all the key questions to at least good. At this inspection we found that, although the provider had made some improvements and introduced new systems, there were still some significant concerns about the management of risk and the leadership of the service. We have identified continued breaches of Regulations 9, 12 and 18 as well as additional breaches of Regulations 15, 17 and 20a. These new breaches relate to the suitability of the premises, leadership and a failure to display the CQC rating.

We could not be assured that medicines were always managed safely as stocktaking measures were not effective, medicines were not always in stock and medicines were not being stored safely. We also noted a medication error during our inspection.

Risks were not always well managed. Risks assessments were present in care records but the risks posed by an unfenced lake and doors which gave access onto a main road, had not been fully assessed and mitigated. Some risks had been noted at our previous inspection and the provider had not taken effective action to address them. Staffing levels meant sometimes people were left without staff support which

increased any potential risks. Systems did not fully protect people from the risk of dehydration or of developing a pressure sore.

Staff understood their responsibilities with regard to keeping people safe from the risk of abuse and appropriate safeguarding referrals had been made. We noted a safeguarding matter during our inspection and this was referred to the local authority by the service.

Infection control procedures were in place but some staff practice placed people at potential risk and had not been addressed by the provider.

Staff received a comprehensive induction and the training they needed to carry out their roles. Staff felt well supported but information systems were not robust and did not ensure that staff always had all the information they needed. This placed people at potential risk.

People had access to healthcare professionals and staff worked well with them to meet people's healthcare needs. People enjoyed the food and people's individual likes and dislikes were respected. Where people experienced unplanned weight loss, staff referred them to the dietician for advice and support. Improvements were needed with regard to the oversight of people's drinking, especially in the extreme hot weather.

The service was working in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA ensures that people's capacity to consent to care and treatment is assessed. If people do not have the capacity to consent for themselves the appropriate professionals, relatives or legal representatives should be involved to ensure that decisions are taken in people's best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation. We found that staff understanding of MCA and DoLS was adequate and appropriate DoLS referrals had been made for people. Some staff needed to ensure they asked informally for consent before providing care and treatment.

The environment had been refurbished and much improved since our last inspection. However further improvements were needed to ensure it was suitable and safe for the client group, especially those people living with dementia.

Staff were kind and caring and demonstrated that they had built up good relationships with the people they were supporting and caring for. People were supported to be as involved in decisions about their care where they could be. Although staff were respectful, staffing levels sometimes meant decisions were taken by staff which did not always reflect people's preferences and expressed wishes. Sometimes a lack of staffing meant people's dignity was compromised.

Opportunities for people to follow their own hobbies and interests were limited and feedback was negative. People were not meaningfully occupied during the day and many people spent a lot of time in their rooms watching television.

Care plans were being transferred onto a new electronic record. Those which had been reviewed reflected people's individual needs and preferences, others contained some contradictory and confusing information. Regular reviews of plans were taking place, although some current information had not been recorded.

Care for people at the end of their life required improvement. Records did not demonstrate how people were being cared for and did not assure us that people's individual needs were being met. People's

preferred priorities for end of life care were documented but information was very basic and did not give staff sufficient guidance.

A complaints procedure was in place and complaints were appropriately managed, although we did receive some negative feedback from two relatives. People who used the service and relatives were given the opportunity to raise any issues and informal complaints at residents' and relatives' meetings or in the regular surveys which were sent out.

The provider had not carried out all the actions documented in their action plan from the last inspection. We noted some issues had continued and there were further breaches of the same regulations. We found that in introducing new systems and improvements the provider had not had sufficient oversight of the service to ensure that it remained safe and staff were working efficiently.

Whilst we fully recognise the improvements the provider has made, and the scale of the job which faced them when they took the business over, they have failed to ensure systems were in place to fully protect people and maintain their wellbeing. We are, however, pleased with the level of engagement the provider and registered manager have shown and their willingness to bring about the further improvement.

The overall rating for this service is 'Inadequate' and the service is 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.

There were not always enough staff to make sure people were safe.

Medicines management required improvement. Ineffective stocktaking procedures, lack of temperature control and poor quality audits meant we could not be sure people always received their medicines as prescribed. Medication errors were noted during the inspection.

Risks were not all well managed and there were significant risks relating to the presence of an unfenced lake and access to a main road. People's risks relating to pressure care and dehydration were poorly managed due to ineffective recording systems.

Staff understood their responsibilities to keep people safe from abuse and staff made appropriate referrals to the local authority safeguarding team.

Infection control procedures required some improvements to fully protect people.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff were well trained but did not always display the knowledge and skills required. Ineffective recording systems meant staff did not always have quick access to the information they needed and were not fully informed.

Staff understood the requirements of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and appropriate DoLS applications had been made.

People's needs related to eating and to their health were managed reasonably but better oversight was required for those whose drinking needed to be monitored.

The service worked in partnership with other healthcare professionals to help maintain people's health.

The environment had benefitted from a programme of refurbishment but further work was required to ensure the premises were fully suitable and safe for this client group.

## Is the service caring?

**Requires Improvement**

The service was not always caring.

Staff were patient and treated people with kindness and respect.

People were involved in decisions about their care. Sometimes low staffing levels meant staff did not act in accordance with people's and their dignity was compromised.

## Is the service responsive?

**Requires Improvement**

The service was not always responsive.

Care plans did not always reflect people's current needs.

There was little in the way of meaningful occupation for people.

There was a complaints procedure in place and people were given opportunities to raise concerns formally and informally.

Systems supporting people's end of life care were not robust and there was a risk that peoples individual needs would not be met.

## Is the service well-led?

**Inadequate**

The service was not well-led.

The provider had not ensured that all the concerns from the previous inspection had been addressed.

There was poor oversight of health and safety which placed people at risk.

Systems designed to drive improvements at the service had been introduced without sufficient preparation, which placed people at risk.

# Lower Farm Care Home with Nursing

**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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 7 and 8 August and 5 September 2018.

The inspection was carried out by two inspectors on 7 August, by two inspectors, a specialist adviser and an Expert by Experience on 7 August and by two inspectors on 5 September. A specialist adviser is a person with particular knowledge and experience relevant to the service. Our adviser was a nurse. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Prior to the inspection, we also reviewed other information available to us. This included statutory notifications. Notifications relate to information about specific events that the provider is required to tell us about by law.

We spoke with 12 people who used the service. We also carried out a SOFI observation. This is a structured observation that helps us understand the experiences of people who are not able to communicate with us easily. We also spoke with seven relatives, four members of the care staff including two senior staff members, one member of the domestic staff, the cook, three nurses, the registered manager, and two directors of the business, one of whom works as a nurse at the service. We also spoke with representatives from the local authority quality assurance and
safeguarding teams and quality assurance staff from the local clinical commissioning group. We reviewed care records for ten people, nine people's medication records, three staff files and other records relating to the quality and safety of the service.

Inadequate

# Is the service safe?

## Our findings

At our last inspection on 8, 13 and 19 September 2017 we rated this key question as Inadequate and identified breaches of Regulations 12 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to the poor management of risk and the lack of skilled and experienced staff. Following our last inspection we required the provider to send us an action plan outlining a timeframe of how they would make the required improvements. At this inspection, although we saw the provider had made improvements in some areas of the service, we remained concerned about the staffing and safety of the service and both these regulations continued to be breached.

When we arrived at the service at 20.00 on 8 August we noted that three doors were wide open. These doors opened onto the carpark which gave free access onto the main road. At our last inspection we raised this concern but the provider had failed to mitigate the potential risk of people leaving the service or intruders gaining access to the service. The registered manager told us that there was only one person at the service who could be placed at potential risk from the open doors but said that they had never tried to leave the premises. This information was contradicted by a senior staff member who told us the person had tried to leave on several occasions but had always been stopped by staff. In addition to this issue we noted that a small lake in the back garden had steep sides and was unfenced. This posed another potential risk to people who used the service and we told the provider to take urgent action to fence it off. They confirmed to us in an e mail dated 20 August 2018 that they had put a temporary fence up.

This was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We continued to have concerns over the way risks were assessed and mitigated at the service. We noted good practice with regard to routine maintenance and the testing of fire equipment, emergency lighting, lifts, hoists and hot water. A good system was in place and records were well maintained by the maintenance staff who promptly actioned concerns as they found them. However, staff did not always use the reporting system correctly and it was not clear that all concerns had been communicated effectively. For example, we noted that one person's profiling bed was not working correctly and was stuck in one position. Staff supporting the person to eat in the bed did not know about the fault and were seen to feed the person their meal whilst they were at an unsafe angle, increasing their risk of choking.

Another person told us that their call bell was not working and said they had discussed it with staff. They then mentioned it to another staff member. Neither staff member reported the fault in the maintenance book and so the fault was not promptly repaired which placed the person at potential risk.

People's risks had been assessed and documented in their care plans. Assessed risks related to a variety of issues including choking, moving and handling, falls, the use of bedrails, scalding, and the risk of developing a pressure sore. We found that staff did not always know the information documented in care plans and therefore did not always ensure risks were fully reduced. For example, one person's risk assessment regarding pressure care stated that they should be repositioned every two to four hours. The nurse on duty

told us the person is repositioned every two hours. Records showed that this person was beginning to develop a pressure sore on 4 September at 01.16. The next recorded repositioning was at 09.27 and staff recorded that the person now had a grade one pressure sore. Further repositioning for this person was not in line with their risk assessment and care plan.

Another person's care plan stated they should be repositioned every two to three hours as they were unable to do this for themselves. Records showed that they were left for up to eight hours without a change of position. This placed them at risk of developing a pressure sore. We noted similar issues with other people's repositioning needs. When we spoke to nursing staff about pressure sores we found that staff were not clear about who had a pressure sore and what grade they were. At first staff told us that only two people had pressure sores and later during our inspection we found that seven people had pressure sores from grades one to three. We could not be assured that people's risks relating to pressure care were being well managed.

Risks relating to the storage of medicines had not been fully assessed. Our inspection took place during a period of exceptionally hot weather. We found that the medication room did not have an air conditioning unit in and was reaching temperatures which far exceeded the safe storage maximum for some medicines, routinely 25 degrees Celsius. No action had been taken to investigate this risk or to try to reduce it. The provider required staff to take the temperature of the room first thing in the morning, rather than doing this at the hottest part of the day. Even given that the temperature in the early morning was lower than later in the day, it still exceeded the safe storage temperature and no action had been taken. We were reassured however, that by the time of our final inspection visit on 5 September, the provider had purchased an air conditioning unit for the medication room and temperatures were being effectively monitored.

People were positive about how staff supported them to take their medicines. One person said, "The care is good. The nurse stays with me while I take my tablets." We observed staff administering medicines. We noted that staff ensured the medicines trolley was not left unattended and unlocked at any time so the medicines carried within did not pose any threat to people's safety. Staff received training in the administration of medicines, and a new system had recently been introduced. We found that staff had an understanding of people's medicines and demonstrated a working knowledge of issues such as side effects of particular medicines and time sensitive medicines. We were concerned that people might not always get their medicines on time. We observed a nurse administering the 21.00 and 22.00 medicines. They told us they usually did not finish the drugs round until approximately 23.00 or 23.30 as it took them over two hours each time. This meant some people were at risk of having their medicines too late or of already being asleep when the nurse reached them.

We noted that a person had been admitted to the service for an assessment period and within 12 hours two errors had been made with two different medicines. Although instructions about the person's medicines had been clearly recorded for staff, nurses made errors which meant the person failed to receive two doses of medicines designed to treat a serious health condition. This placed the person at risk of harm. It also potentially jeopardised the assessment process as they were not in receipt of all their medicines and so could be at risk of not presenting an accurate picture of their usual health needs.

Controlled drugs were well managed and records were accurate. However, we observed nurses looking for a missing morphine patch on a person who used the service. They were unsure when it had gone missing. Staff told us afterwards that the patch had gone missing the night before, although this was later disputed. We were concerned that there had been an unspecified period of time when the person's pain might not have been controlled. The service did not routinely record where pain patches were placed on the person's body. This meant there was a risk of placing a patch in the same site too frequently which risked the effectiveness of the medicine and risked the integrity of the person's skin.

Stocktaking measures were not robust. For example, stocks of one person's blood thinning medicine, the dose of which was regularly changed, had not been carried over from the previous month and recorded accurately. This meant we could not tell if the person had received the correct dose on each occasion.

We noted on the medication administration record (MAR) chart that a stock of one medicine had run out and the person had failed to receive twelve doses of one medicine. Although we saw evidence of the provider trying to obtain further stocks, they were not successful and the person did not receive their medicine as prescribed.

We looked at how the service assessed and reduced the risks posed by people not drinking enough. This was of particular concern during a period of extremely hot weather. We found that little thought had been given to minimising people's risk of dehydrating. People did not routinely have cooling flannels available, or iced water or any air conditioning units in their rooms, although many had fans.

People, who had previously been assessed as being at risk of dehydration, were on a fluid recording chart. We found that records were poorly completed which meant we could not be assured that dehydration risks were being well managed. On our first inspection visit on 7 August the service was using paper records and on our last visit, on 5 September, they had changed to electronic recording. Both were not robustly completed. For example one person's record for one 24 hour period stated that they had received 'two hot drinks, cordial, two cups of tea and a glass of juice'. The specific amounts of liquid were not recorded as the staff were unable to enter this information on the electronic record. Another person, whose record we viewed at 12.25, had a record of 'one cold drink'. There was no indication of how much had been drunk. Staff told us they thought it was approximately 50mls but they did not know how to enter this information in the electronic record. Another person, with a history of urinary tract infections, had a daily total of 170mls for one day, 450mls for the following day ad 500mls for the day after that. This was during a period of extremely high temperatures which far exceeded 30 degrees Celsius. We could not be assured that people's risk of dehydration was well managed.

This was a continued breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that staff did not always responded quickly if they needed to press their call bell to get help or support. One person said, "I always have a long wait for the toilet. I'm often left in a mess and they have to clean me up. I'm not checked on except for when the drinks or lunch come round." Another person commented, "Most carers are ok but one or two try to rush me when I'm on the toilet." A third person commented, "Some carers can be abrupt as I'm slow at times." A fourth said, "Sometimes [they don't come] at all." A relative told us, "[People who use the service] are left in the two lounges and not checked on. They call out for the toilet but no-one comes so I have to go and find a carer." Another person's relative commented, "They are really understaffed at weekends. My [relative] rang [their] bell and had to wait an hour for the toilet, by then it was too late."

Throughout all three inspection visits people raised the issue of low staffing. We observed that staff were very busy and had little time to spare. We noted times when there were no staff to be seen and people in their rooms and those in the lounges were shouting for help and attention. On our third inspection visit we noted that one person was still in bed and waiting to get up and dressed at 12.25. We had previously noted people having to wait until lunchtime to get up, on our last inspection in 2017. The provider was not able to carry out any audit to assess the response time to call bells as the call bell system did not facilitate this, although they carried out spot checks.

The service used a dependency tool which identified that they had enough care staff and nurses. We noted that approximately 30% of the time there is only one nurse for up to 34 people who required nursing care. It was not clear to us how one nurse could effectively carry out all the required nursing tasks to an acceptable standard with this staffing level.

The service did not use agency staff. This meant that people were supported by staff who knew then well. However, we noted from reviewing rotas that some staff, including the registered manager, were working a high number of hours. This placed additional stress on them and it was not clear to us how the registered manager could carry out their role effectively whilst taking on so many regular care shifts in addition to their full-time management hours.

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

We checked staff recruitment records and found that there was an acceptable recruitment procedure in place. This included face to face interviews, job references, proof of identity and a history of the applicant's previous work experience. The provider also carried out Disclosure and Barring Service (DBS) checks to make sure applicants did not have any convictions which would mean they were not suitable to work in this setting.

There were measures in place to protect people from the risk and spread of infection. Staff received training in infection control and demonstrated an understanding of how to reduce the risks. We observed nurses adhering to infection control procedures and using the aseptic techniques while giving wound care.

Personal protective equipment, such as gloves and aprons, were available to staff and we observed these being routinely used. However, we also noted that some staff had rings, bracelets and acrylic nails which increased the risk of cross contamination and of injury to thin skin. Three people required percutaneous endoscopic gastrostomy and this was carried out by nurses. This is a way of providing a person who is unable to swallow, with food and fluid. We observed one nurse carrying out this procedure without gloves or apron which increased the infection risk.

There were clear procedures in place for cleaning and disinfecting the service including the kitchen, although we did note that the milk machine was dirty inside and required a thorough deep clean. The rest of the kitchen was clean and well organised.

Staff received training in keeping people safe from abuse and knew how to recognise the signs that someone might be at risk of harm. Staff understood how to raise a safeguarding concern both within the company and externally. Two people told us they felt safe in the service and that staff treated them well. They had no concerns about their welfare or the attitude of staff. One said, "I feel safe with all the staff." Another said, "I feel safe with the carers. I always feel safe with them when I'm being hoisted."

On the day of our inspection we became aware of a safeguarding matter. We noted that a person had injured themselves on their bedrails. Protective bumpers for these rails had been removed but staff were unable to tell us who had removed these or why. We saw that the person's bedrails risk assessment stated, 'Offer to put bumpers on at night'. It was not clear from the assessment, which was for a person living with advanced dementia, how this would protect the person from injury. The care co-ordinator made a safeguarding referral for this incident. Other safeguarding matters had been appropriately referred to the local authority safeguarding team.

Requires Improvement

# Is the service effective?

## Our findings

At our last inspection on 8, 13 and 19 September 2017 we rated this key question as Requires Improvement and identified breaches of Regulations 9, 11 and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches relate to the provision of person centred care, consent and the management of food and drink. Our current inspection identified some improvements had been made with regard to consent, but further improvements are still required and we identified continued breaches relating to person centred care and the management of food and drink.

People's needs were assessed before they began using the service to ensure that the staff team could support them effectively. The assessment included information about people's physical and mental health needs as well as their preferences. We noted that information about a newly admitted person was brief and staff on duty were not clear about the person's needs and one member of staff did not know that a new person had been admitted and had to look for the written record for information. Basic information was recorded on this person's assessment but the nurse on duty did not know about the person's diagnosed health condition or what their name was.

Staff received the training to help them carry out their roles effectively. A lot of training had been delivered since our last inspection and more training was planned. When staff were first employed they undertook a structured induction. Staff received a variety of training and nurses also had opportunities to increase their skills and knowledge. Staff told us they felt more supported than at the time of our last inspection and we saw that there was a supervision and appraisal system in place.

Although staff had received additional training and support we found that a lack of effective communication systems meant that staff did not always know people's specific care needs. For example, two nurses were unclear about whether one person was still having a pureed diet. Information in the person's room said they had swallowing difficulties and needed a soft mashable diet. However, the manager told us that the person had been nil by mouth for three days as they were at risk of choking. This was not recorded in their care plan and staff were not clear.

A nurse was not able to tell us about the specific healthcare needs of one person telling us they did not have any condition, when in fact they had a diagnosed condition which had potential serious complications if not treated correctly. Some staff were unclear about who had pressure sores, with one nurse telling us 'Around seven [people].' The registered manager had told us there were two people. Records did not always make clear if people's pressure sores were deteriorating or resolving. We found that while staff worked hard to care for people there was a lack of a consistent approach as they did not always have the information they needed to carry out their roles effectively and meet people's individual needs.

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

During the course of our inspection visit, we observed staff working with members of the district nursing

team and with local GPs. Staff also worked in partnership with other healthcare professionals such as chiropodists, occupational therapists, dieticians, diabetes nurses and staff from the Dementia Intensive Support Team (DIST). We noted that staff made referrals to the falls team when a person had demonstrated an increased number of falls. Where people had met a threshold for significant weight loss they were referred to the dietician for further advice and support promptly. People's weights were monitored and the registered manager had oversight of concerns about people's weights. We noted that on one occasion a referral was not chased up and a person had to wait a very long time to receive the specialist support they required. One person was observed to have a pressure sore on 3 July. A referral was not made to the specialist tissue viability nurse until 15 July and it was not clear from records why the referral had not been made at the first sign of a concern. However, we did note that when the tissue viability nurse contacted the service by phone on 20 August they were happy with the way nurses had managed the wound.

Wound care records were poor which meant we could not be assured that people were always receiving care in line with their assessed needs. For example, one person's record stated they should have their dressings changed every three days but records stated they had only been changed four times during July. Records were kept in various places and the wound care folder contained out of date information which was confusing for staff. By the time of our last inspection visit the wound care folder had been much improved and now only contained information about people's current needs.

People told us that they liked the meals provided. One person said, "There's a choice of two meals for lunch. I always like one of the choices." A relative commented, "My [relative] is coeliac….the cook went out to get gluten free food for [their] meals." We observed lunchtime services. On one occasion, out of 15 people, 12 remained sitting in their wheelchairs for the duration of the meal. The dining chairs were not particularly supportive and so would not be wholly suitable for some people. There were no menus on the tables but a display board outside the dining room had photographs of the meals. We asked three people what they were having for lunch and none of them was able to tell us. One person said, "I don't know. We never get told." Choice appeared limited as there was only orange squash on the tables and salt and pepper, although on the table, was often not within people's reach and staff did not offer this. We also observed staff, who were very busy, putting food down in front of people without explaining to them what it was.

Staff supported people to eat sensitively and we observed staff taking time to help people eating their meals in their rooms. A list of people's preferences and likes and dislikes was displayed in the kitchen, although it was not up to date for all people. When people told staff they did not want the meal which had been prepared, other options were offered.

The Mental Capacity Act 2005 (MCA) provides a legal framework for decision making on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that people's capacity to make their own decisions is assessed. As far as possible, people should be supported to make their own decisions but where they lack the mental capacity to do this, decisions are taken in their best interests according to a structured process. People who lack the mental capacity to consent to care and treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS.

Staff demonstrated an understanding of the Mental Capacity Act 2005 (MCA) and DoLS, and had received training, but there was also some confusion. For example one person's care records stated that they were living with advanced dementia but the record also stated on the individual assessment 'Mental Capacity: No problems'. The person had bedrails in place but the care plan did not contain a record of consent relating to this. We judged that this was a records issue.

We observed a mixed picture with regard to staff asking people for their consent before providing treatment. We saw both good and poor practice. We noted one staff member carefully explaining to a person that they were going to reposition their legs and asking the person if this was ok. However, we also saw staff checking a syringe driver without saying anything to the person first and another staff member changing a person's pain patch without explaining what was going to happen.

Appropriate DOLS applications had been made for some people but, due to the insecurity of parts of the premises, it was clear that people were not always adequately protected even though a DoLS had been granted. The provider told us they had ordered a keypad lock for the back door but we saw other doors either open or unlocked during our inspection.

The building had been refurbished since our last inspection and new flooring had been put down in many areas of the service. The whole building looked fresher and more welcoming. A small lounge had been upgraded but we noted it was only ever used by staff and relatives told us people never accessed it. There was an ongoing programme of redecoration and refurbishment in place. Many people commented on how much nicer the home looked with one relative saying, "[My relative's] had [their] room decorated. It's lovely." The garden was a secure and pleasant space but the unfenced lake and uneven pathway presented risks which the provider assured us they would attend to as a matter of urgency. There was no signage on toilet and bathroom doors and no signs to help people living with dementia navigate their way round the service. People's rooms had basic nameplates only with no other visible sign to help people recognise their own room.

Requires Improvement

# Is the service caring?

## Our findings

At our last inspection on 8, 13 and 19 September 2017 we rated this key question as Requires Improvement. At this inspection we had similar concerns about people's dignity. Staffing levels, rather than failures on the part of individual staff, meant people's care was sometimes rushed.

People who used the service, and their relatives, told us staff were kind to them. One relative said, "They have done so much for [my relative]…When I take [my relative] home [they] are clockwatching to come back. The girls really pamper [them]." Staff were very busy and had limited time to chat and we observed staff occasionally failing to knock when entering a person's room or failing to explain why they were there. However, we also saw some lovely examples of kind and caring relationships. We observed one of the nurses tenderly repositioning a person who was receiving care in bed. They chatted to the person while they were carrying out their tasks and they were very gentle and made sure the person was comfortable before they left them.

We noted staff having a laugh and a joke with people and managing to use distraction techniques to help refocus people when they became confused or distressed. Although staff naturally carried out these actions, because there were not enough staff at times, people sometimes remained confused and upset. We saw people calling out for several minutes, waiting for staff to come to them.

We noted that staff had done their best to help one person who had been nursed in bed for a long period of time because they had not been assessed for a suitable chair. After a protracted period of chasing up the relevant healthcare professionals, staff at the service had sourced their own chair for the person. Whilst it had not been officially sanctioned and authorised by the healthcare professionals concerned, the person was very positive and grateful to the staff. They told us, "I much prefer being out of bed." However, this service user described, and their records indicated, they were subsequently left in this chair for prolonged periods during the day, despite their care plan indicating 2-4 hourly repositioning was required for pressure area care.

We saw evidence that people, or their advocates or next of kin if appropriate, had been involved in making decisions about their care and support. Where people had capacity to do this we saw that they had been involved in reviews of their care. Care plans had not always been signed by the people concerned but people who used the service and relatives told us they were given the opportunity to contribute. A keyworker system was in operation but it was not clear how this worked. One person spoke about their keyworker saying, "I know who she is but she doesn't do anything."

Staff respected people's privacy and their personal space. Staff spoke respectfully to people and kept people's confidential information private. Although it was clearly important to staff to try and maintain people's dignity, the lack of staff at times meant people were observed in states of undress, or with their clothes tucked up so that their underclothes were visible. Most were unable to attend to their own needs with regard to their dignity and required an increased vigilance on the part of staff to ensure their dignity

was maintained. Four people told us they had to wait such a long time for staff to come to help them when they needed the toilet, that they had had an accident. This was very embarrassing for people.

Requires Improvement

# Is the service responsive?

## Our findings

At our last inspection we rated this key question as Requires Improvement. We found that care plans did not always accurately reflect people's needs or give staff adequate guidance about how to meet people's individual needs. At this inspection we noted that the provider and registered manager had been working to improve the quality of the care plans and had introduced a new electronic care planning system. This was a work in progress and some plans still required transferring. We found that plans did not always detail the specific care needs people had and so did not ensure people received the individualised care which met their assessed needs. For example, there was confusion over the care of one person's skin condition. Their plan did not contain any specific information about this condition, even though a dermatology nurse had visited the person on 1 August 2018 and left instructions for staff to follow, this had not been transferred to their plan. Following our inspection, the provider sent us an updated version of this person's care plan which now contained the correct information.

Plans did not always give staff enough guidance. For example, one person's plan stated that oxygen saturation levels should be at least 98%. A reading of 94% was recorded and no action documented to say what staff did in response to this. The plan stated that in the event of breathlessness 'give me time to catch my breath'. This minimal guidance did not give staff the information they needed to ensure the person remained well. Although experienced members of staff knew people's needs well, there remained a risk if new staff consulted care plans for advice and guidance.

The care plans for people described as being at the end of their life were poor and lacked detail. This meant we could not be fully assured that all of people's needs were being met. We saw, for example, that people's fluids and repositioning needs were not well monitored. Staff told us that one person had regular epileptic seizures but there was no seizure management plan in their records. Staff were unclear about people's needs regarding food and fluids and there was confusion about whether people were indeed 'end of life' or were in receipt of 'palliative care' for a condition which could not be treated. None of the people staff told us were receiving end of life care had a specific end of life care plan, although their basic wishes regarding funerals and whether they wished to be resuscitated were recorded in their preferred priorities of care. We noted that these documents had not been revisited in response to the people's deteriorating condition and both the records we viewed dated back to 2017.

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

Procedures for handing over information from shift to shift were not robust when we carried out our first inspection visit, as staff shifts started and finished at the same time. A new handover procedure had been implemented by the time we carried out our third inspection visit on 5 September and included a protected time of 10 minutes. We remained concerned that staff could not easily get a full picture of people's changing needs in a ten-minute handover.

The service was without a regular member of staff to oversee activities for people so they could follow their

own hobbies and interests. Staff did their best to provide people with meaningful occupation, but this was limited as they were so busy. On the day of our inspection the registered manager had been due to carry out an activity session. On our second day of inspection one of the director's led a singsong session which people clearly enjoyed. However, people, and their relatives, told us there was usually little for people to do. One relative said, " This is the first time I've seen activities". Another told us that there had been very little stimulation for people when they had visited recently saying, "There's no music or TV. [My relative] was just sitting in the lounge."

There was a timetable of events and activities displayed in the main corridor but, in reality, people spent a lot of time in their rooms or in front of a television. One person, who liked to read, told us they had had the same books for a long time. They said, "I'm sick of these. I've read this five times!" We noted that this person, along with several others, was sitting in the dark and staff had not thought to ask them if they wanted their light on.

The service had a complaints policy and formal complaints that we viewed had been investigated and responded to appropriately in writing. One relative told us they were still waiting for a formal response to their complaint. We fed this back to the registered manager who told us they would address this. Another explained their frustration about a matter they had raised informally saying, "They do listen to me eventually."

We asked people who used the service how they would make a complaint if they needed to. People were able to tell us they would speak to the registered manager or would ask their relatives to.

Inadequate

# Is the service well-led?

## Our findings

At the last inspection this key question was rated as Requires Improvement. At the time of that inspection the new provider had only been in charge a matter of weeks and had taken over a service which was not providing high quality care. We required the service to supply us with an action plan outlining the improvements they intended to make within a specific timeframe. At this inspection we found that, although some improvements were evident, the provider had not made all the improvements they stated on their action plan. We identified further breaches of regulation during this inspection and many of these related to poor oversight by the registered manager and the provider. We found that systems, designed to give the management of the service an overview of issues, were not fully fit for purpose.

It is a requirement for registered services to display their current CQC rating on their website as well as at the service itself. We noted that Lower Farm's website did not have a link to the last inspection carried out in September 2017. This lack of information has the potential to mislead the public. When we asked the registered manager about this they told us that the directors were no longer able to access this website to change it.

This was a breach of Regulation 20a of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were positive about the new provider and the registered manager. They told us they felt that support and training had improved. There was an understanding that the culture of the service had needed to change and that this was bound to be a disruptive process. Staff were very stretched but told us they could manage on the numbers they had as long as there was no sickness or other unplanned absence. The registered manager held regular staff meetings which gave staff an opportunity to raise issues and give feedback. We viewed the most recent staff meeting minutes from 20 June 2018 and, although staff had contributed to the meeting, the tone of the minutes did not suggest the meeting was inclusive or collaborative. We noted phrases such as 'this needs to stop', 'it is getting stupid', 'the atmosphere is getting silly and it needs to be discussed and squashed today' and 'you're not five-year olds, sit down and sort it out'.

Whilst staff were individually doing a good and caring job, we found that often they were working in isolation because information systems were not effective which meant there was a risk of people receiving inconsistent care or care which did not meet their assessed needs.

Between the first inspection visit on 7 August and the third visit on 5 September, the service had introduced new electronic recording system. Staff had received a training session but many were not clear about how to access the information they needed. The system was also not fully ready to be used. For example, staff had no way of recording how much fluid a person had received as this was not enabled. Paper records had continued in some parts of the service but not in others. The effect was chaotic and placed people at considerable risk. We asked the care co-ordinator about who had oversight of fluids and repositioning charts and they replied, "I don't know". It took more than half an hour for staff to find all relevant records

about what one person had had to drink in the last 24 hours and, when we added the total up, it was very low.

The system had been in operation for three days when we visited on 5 September. The registered manager told us that the system had a function whereby they could download a daily report which would flag up any concerns or outliers, such as a person receiving low fluids. We asked to see the daily reports for the two previous days but the registered manager and director did not know how to find the information. The provider had not adequately risk assessed the introduction of the new electronic system. No additional staff had been put on the rota, the registered manager was covering care shifts on the week it was introduced and staff were not confident in using the new system. This had the potential to place people at risk as important information could easily be missed.

Other systems, designed to ensure the quality and safety of the service were not always effective. The maintenance reporting system was flawed, as staff had not reported certain faults and passed on information about broken equipment to other staff.

Staff were recording information in different places which made it almost impossible to establish a clear picture. For example, on our first inspection visit we found that people's wound care was being recorded in four different places. This had improved significantly by the time we carried out our third visit but we were concerned that neither the provider, nor the registered manager, had identified this issue before our inspection.

Audits were comprehensive and we viewed audits which monitored health and safety matters such as falls and pressure sores, medication, infection control, cleaning and maintenance. The registered manager produced a comprehensive monthly report for the provider, which summarised this information. The system should have given the provider good oversight of the service but information in audits was not always correct and so the findings did not present an accurate picture. For example, the medication audit noted no issues with stock control or temperature checks whilst we found issues in both areas.

In addition to the lack of accurate information in the audits, we found it concerning that the provider had not fully risk assessed the safety of the building with regard to the lake and the open doors. This being in spite of us raising the issue with the open doors at our previous inspection. When we discussed our concerns we found the provider and registered manager very open, honest and willing to listen and take action. However, we expect the provider to anticipate such risks and take action to mitigate them before we inspect and not as a result of our inspection process.

Although the provider's own dependency tool identified that the service was overstaffed for the numbers of people, feedback from people who used the service and relatives was not positive. The provider had forums to meet with people who used the service and their relatives, as well as contacting people for feedback in regular surveys. We saw that occasionally people had raised the issue of low staffing numbers but the staff numbers had always been defended by the provider. If systems improved and staff were working more cohesively the current staffing ratios might be appropriate. However, we found that chaotic information systems and unclear lines of accountability meant we remained concerned about staffing levels.

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

Both the registered manager and the directors demonstrated a willingness to engage with CQC and drive improvements at the service. They accepted the feedback we gave and quickly began addressing some of

the concerns we raised. We found a commitment to continued improvement at the service and honesty about the issues which still required attention.

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 |
| Treatment of disease, disorder or injury | The provider failed to ensure people received care and treatment which met their needs and reflected their preferences. Regulation 9 (1) (b) and (c). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 12 HSCA RA Regulations 2014 Safe care and treatment |
| Treatment of disease, disorder or injury | The provider failed to ensure that risks relating to health and safety had been assessed and mitigated and had also failed to ensure the safe management of medicines. Regulation 12 (1), (2) (a) and (b). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment |
| Treatment of disease, disorder or injury | The provider failed to ensure that the premises was secure and properly maintained. Regulation 15 (1) (b) and (e). |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | The provider failed to ensure that systems were operated effectively to assess, monitor and improve the quality and safety of the service. Regulation 17 (1) (2) (a). |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments<br><br>The provider failed to ensure that their rating was displayed on their website. Regulation 20A. |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The provider failed to ensure there were enough competent, skilled and experienced staff to meet people's needs. Regulation 18 (1). |