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Fallowfields Residential Home

Inspection report

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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?	**Inadequate**

Overall summary

This inspection took place on 11 and 16 June 2015 and was unannounced. As part of the inspection, we checked that improvements to meet legal requirements planned by the provider after our inspection on 15 and 19 August 2014 had been made.

At this inspection we found some action had been taken. Improvements had been made, but the provider was still not meeting all fundamental standards of care and safety.

The home provides accommodation for up to 22 people, including people living with dementia. There were 22 people living at the home when we visited.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations about how the service is run.

People were satisfied with the cleanliness of the home. However, we found some areas, including the laundry and some bathrooms were not clean. Most people received their medicines as prescribed, although some medicine records had not been completed. Medicines were not stored safely as the medicines fridge was not working properly, the key to a room used to store new medicines was accessible to people and the 'use by' dates for topical creams were not always visible.

Fire safety arrangements had improved, but staff had not been trained to use evacuation equipment. Doors leading to fire escapes had not been alarmed. This had led to two incidents where people had exited them and come to harm. The provider subsequently installed suitable locks to the fire doors and made arrangements to upgrade their fire alarm system.

Individual risks to people were managed effectively, including the risks of people developing pressure injuries. A series of movement alarms had been installed to monitor people using the stairs, the front door and their bedrooms.

Staffing had been increased in the evenings, but people told us there were still times when there were not enough staff to meet their needs, for example if they wanted more than one bath or shower each week. People felt safe and staff had been trained to identify, prevent and report abuse. Recruitment procedures were safe and relevant checks were conducted to make sure staff were suitable for their role.

Staff did not follow legislation designed to protect people's rights and ensure decisions taken on behalf of people were made in their best interests. Some parts of the environment did not support the needs of older people, including those living with dementia. The conservatory was too hot in the summer and the lounge was cramped. Noise caused by alarms being activated constantly meant the environment was not conducive to relaxation.

Staff described a wide range of activities people took part in, including trips to local attractions. However, people had not been involved in planning these, they were not recorded and there was no evidence to show they met people's individual interests.

The provider and registered manager had introduced a programme of audits to help assess and monitor the quality of service provided. Whilst these had picked up and addressed most issues, they had not identified all the concerns we found. This showed the quality assurance system had not been developed fully or been embedded in practice.

Most people described staff as "kind" and "caring", although two people made less positive comments. We observed warm interactions between people and staff; staff were patient, spoke fondly about the people they cared for, and encouraged them to be as independent as possible.

People praised the quality of care and told us their needs were met. People received appropriate support to eat and drink enough. Staff ate with people and this made mealtimes a pleasant and sociable experience for people.

Staff were knowledgeable about the needs of people living with dementia and were supported appropriately through the use of supervision and appraisal. People had access healthcare services and saw doctors and specialists promptly when required.

Most people told us they received personalised care from staff who knew them well and were responsive to their needs. Assessments of people's needs were completed using information from a range of sources, including the person, their family and other health or care professionals. These were reviewed regularly and changes made promptly when required. Care plans reflected people's preferences and how they wished to receive care and support.

People were given opportunities to express their views about the service during meetings and monthly reviews of their care. They were listened to and changes were made as a result of their feedback.

Summary of findings

People and their families felt the home was run well. Staff felt valued and praised the management of the home, who they described as “approachable”. There was clear management structure in place, staff understood their roles and worked well as a team.

Since our last inspection and following a fatality, staff told us they had become more safety conscious. The provider was open with people and their families and they shared information about the concerns we had identified at our last inspection.

We identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not always safe.

Some areas of the home were not clean. Not all medicines were managed safely. Staff had not been trained to use fire safety equipment. There were not enough staff at all times.

Individual risks were managed appropriately. Staff knew how to protect people from abuse and recruitment procedures were safe.

Requires improvement

Is the service effective?
The service was not always effective.

Staff did not follow legislation designed to protect people's rights. Some parts of the environment were not suitable for older people.

People received appropriate support to eat and drink enough. Staff were suitably trained and supported in their role. People had prompt access to healthcare services.

Requires improvement

Is the service caring?
The service was caring.

Staff treated people in a kind and considerate way. They spoke fondly of the people they cared for.

People were encouraged to be as independent as possible and the privacy was protected. They were involved in assessing, planning and agreeing the care and support they received.

Good

Is the service responsive?
The service was not always responsive.

People were not involved in planning activities and they did not meet people's individual interests. A shortage of staff meant some people did not receive all the care they needed in a timely way.

Other people received personalised care and were supported to make choices.

Care plans reflected how people wished to receive care and support. People were given opportunities to express their views about the service and were listened to.

Requires improvement

Is the service well-led?
The service was not well-led.

Action had not been taken to mitigate known risks presented by fire doors that were not alarmed.

Inadequate

Summary of findings

Action had been taken to make improvements following our last inspection, but further concerns were identified in other areas.

The provider's quality assurance system was not fully developed or always effective.

People, their families and staff felt the home was run well and management were approachable. There was an open and transparent culture and staff told us they had become more safety conscious.

Fallowfields Residential Home

Detailed findings

Background to this inspection

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

This inspection took place on 11 and 16 June 2015 and was unannounced. The inspection team consisted of two inspectors, a specialist advisor in occupational therapy and social care, and an expert by experience in dementia care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we reviewed information we held about the home including previous inspection reports, the provider's action plan following the last inspection and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with eight people living at the home and three friends or family members. We also spoke with the registered manager, the deputy manager, six care staff, the cook and the cleaner. We looked at care plans and associated records for six people, staff duty records, staff recruitment files, records of complaints, accidents and incidents, policies and procedures and quality assurance records. We observed care and support being delivered in communal areas. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also received feedback from the clinical commissioning group, the local authority commissioning unit, the local authority environmental health unit and a community nurse.

Requires improvement

Is the service safe?

Our findings

At our last inspection on 15 and 19 August 2014, we identified that infection control arrangements were not adequate and there were not enough staff to meet people's needs in the evenings. We set compliance actions and the provider sent us an action plan telling us they would meet the requirements of the regulations by 28 February 2015.

At this inspection, most people told us they were satisfied with the cleanliness of their rooms. However, one person said, "It's not as clean as it should be, look over there" pointing to an untidy pile of aprons in their bedroom. Their carpet needed vacuuming and their bin was over-flowing with used tissues. In another bedroom we saw a plastic spouted beaker, the handles of which were ingrained with dirt. The shower cubicle in the ground floor bathroom had spatters of an unidentified brown substance on the sides. The end of a support arm beside the toilet in the upstairs bathroom was rusty and stained. Not all waste bins in bathrooms had lids, so used paper towels, gloves and aprons were accessible to people. These areas posed a risk of infection.

Providers are required to take account of the Department of Health's publication, 'Code of Practice on the prevention and control of infections'. This provides guidance about measures that need to be taken to reduce the risk of infection, including the need to maintain a clean environment that facilitates the prevention and control of infections. We found the home's two laundry rooms were not clean and hygienic. One of the rooms, which had been in a poor state of repair at our last inspection, had been refurbished and a hand washing sink had been installed. However, there were no arrangements in place to deep clean the laundry rooms and this had resulted in a build-up of dirt and fluff on shelving and behind the washing machines and tumble driers. We drew this to the attention of the registered manager on the first day of our inspection. On the second day of our inspection we found these areas had been cleaned and pipes to the rear of machines had been boxed in to make cleaning easier. However, shelving in one of the laundry rooms, where various products were being stored, had not been cleaned and was still covered in fluff and dirt. This created a potential breeding ground for bacteria and posed a risk of cross infection with laundry that was being processed.

There were appropriate arrangements in place for the safe handling and disposal of medicines. Medication administration records (MAR) confirmed that people received most of their medicines as prescribed. However, the MAR charts showed two people had not received a dose of a blood-thinning medicine on one day. The MAR chart for another person showed the administration of one of their medicines had not been signed for on three days, although the tablets were missing from the pre-prepared pack, indicating they had been given. Handwritten entries in MAR charts had not been checked by a second member of staff to make sure they were correct. The fridge used for medicines that needed to be stored at cooler temperatures was not working properly, so medicines stored in it may not have been effective when used. Staff recorded the dates of opening of topical creams to make sure they were not used beyond their 'use by' dates. However, some creams had not been dated and the dates on others had been rubbed off or were not visible. We brought these issues to the attention of the deputy manager, who immediately ordered a new medicines fridge and took steps to improve the way dates of opening were recorded on creams.

Improvements had been made to fire safety arrangements since our last inspection and further work, recommended by the Fire and Rescue Service, was in progress. Personal evacuation plans for people were in place. These included details of the support people would need if they had to be evacuated in an emergency. Staff were aware of the action to take in the event of a fire, but had not been trained in the use of evacuation sleds, which had been in place for six months. These were used to evacuate people from the first floor in the event of a fire and the lack of training meant and people's safety was compromised.

The continuing issues relating to the cleanliness of the home, the unsafe management of medicines and the lack of staff training in the use of evacuation equipment were breaches of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following our last inspection, the provider had increased staffing levels. People and staff told us this had been beneficial. However, people told us there were not always enough staff to meet their needs in a timely way at other times. Comments made by people about the staffing levels included: "My day is a Sunday for a shower and I would prefer one more often but they haven't got enough staff if you want one on another day"; "It can be manic at night"; "I

Requires improvement

Is the service safe?

think they need more. Like if two of them are giving someone a shower or getting someone up there's not enough around for everyone else"; "No, there isn't enough of them"; "I sometimes have to nag them if they're too busy"; and "If you say anything, they just say there are 22 other people here not just you". One person gave us an example of a time they had had to wait for support. They said, "One evening I had rung my bell twice as I needed [help to settle down]. Well, [the staff member] came in and said to me that I was safe and in bed and other residents needed her, so I had to wait until 10 O'clock at night before I could settle down." Two people had requested to bathe more often, but this had not happened due to staff shortages. One person said, "They haven't got enough staff if you want one on another day [in addition to the allocated day]". One person's care records showed they did not receive a shower on a day they were allocated it because "staff had gone sick".

Three members of care staff were on duty each day between 07:30 and 21:00 and two care staff between 21:00 and 07:30, to provide care and support to 22 people with varying needs. Care staff were supported by the registered manager during the day on weekdays, the cleaner for four hours each day on weekdays and the cook for four hours each day. Outside of those hours, care staff were required to prepare and serve meals, do essential cleaning and provide care. Staff had mixed views about their ability to meet people's needs. One told us that when the registered manager was not there to assist, "it sometimes goes a bit haywire" and during the day they "could do with an extra person". Another said "We always manage, but sometimes it's exhausting." A third staff member told us the increased staffing in the evenings was "working brilliantly" and allowed them to spend more time with people. The registered manager told us staffing levels were determined in negotiation with the provider, by seeking feedback from people and staff, and by observing care being provided. There was no formal process in place for calculating staffing levels based on assessments of service users' individual needs

The continued lack of sufficient staff to meet people's needs at all times was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In March 2015 a person died having fallen down an external fire escape. Staff told us this incident had had a profound impact on them. As a result, they said they were now "much more aware of risks". The provider had reviewed the safety of the environment and was taking action to address all identified risks. They told us "We just want people to be safe." On the first day of our inspection, we identified risks posed by a hot kettle in a small kitchen area to which people had access and a side gate that was not secure. On the second day of the inspection, we found the provider had taken action to reduce these risks. Following a fall on the main stairs, an alarm had been put in place to alert staff when people were using the stairs. A further alarm had been installed on the front door, so staff could monitor people entering or leaving the building. Nine alarm mats had been placed in or outside the bedrooms of people at risk of falling so staff would know if they moved to an unsafe position. However, the large number of alarms, which activated continually, made it difficult for staff to differentiate between the various levels of risk and respond to each alarm appropriately. This compromised people's safety as high-risk activations could not be identified or given priority.

Other risks to people were assessed, documented and managed effectively. Pressure relieving cushions and mattresses were in place for people at risk of developing pressure injuries and the condition of their skin was monitored effectively using body maps and photographs. Fall saving equipment was in people's reach at all times and staff encouraged people to use it properly.

Records showed the process used to recruit staff was safe and helped ensure staff were suitable to work with the people they supported. Appropriate checks, including references and Disclosure and Barring Service (DBS) checks were completed for all staff. DBS checks identify if prospective staff had a criminal record or were barred from working with children or people at risk. Staff confirmed this process was followed before they started working at the home.

People told us they felt safe at the home and would be able to raise concerns with the registered manager if they had any. Staff had received training in safeguarding adults and knew how to identify, prevent and report abuse. They followed local safeguarding processes and responded appropriately to any allegation of abuse by reporting

Requires improvement

Is the service safe?

incidents to relevant bodies and conducting thorough investigations. Staff were encouraged to raise concerns with the registered manager or the provider and were confident appropriate action would be taken.

Requires improvement

Is the service effective?

Our findings

We found the staff were not following the Mental Capacity Act, 2005 (MCA) or its code of practice. The MCA provides a legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision should be made involving people who know the person well and other professionals, where relevant. Most people living at the home had cognitive impairment to some degree. Staff had taken decisions on behalf of people in relation to their medicines, the delivery of personal care, the use of bed rails and the use of monitoring equipment. However, people's ability to make these decisions had not been assessed and family members had not been consulted. The provider was unable to confirm that the decisions had been taken in people's best interests and this compromised people's rights.

The failure to follow the MCA was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some parts of the environment did not support people living with dementia or those with visual perception difficulties. Signage to help people navigate round the building was limited and not prominent. Some corridors were not well-lit, which put people at risk of falling. Bedroom doors were all painted the same colour and were not personalised to help people find their own rooms. Some corridors had bare walls with no memory prompt pictures relevant to the people living at the home. Where there were pictures, these had been mounted high up on walls, where older people would struggle to see them.

Some floor coverings had busy patterns and sensor mats to monitor people's movements were covered with black plastic, which presented a slip hazard. In one case, two mats had been put together because the person had been known to step over the first mat. Staff had not considered whether the mats may have appeared as holes in the floor to people with visual perception difficulties. Between the lounge and the conservatory was a raised threshold strip which presented a trip hazard to people with reduced mobility. The conservatory became very hot during the afternoons and people asked to move out of it to the lounge that was cooler. However, the lounge was not big enough to accommodate everyone, so it became crowded and there were insufficient chairs. People then had to choose between the hot conservatory, the dining room where chairs were not comfortable or their bedrooms where they would be alone.

Alarms, triggered by people, staff and visitors, entering or leaving the building, walking up and down stairs or activating one of eight alarm mats inside or outside people's rooms, sounded constantly. These created a noisy environment in which staff were constantly rushing around to identify why alarms had been activated. It was not conducive to relaxation and there was a risk people could become over-stimulated by the levels of noise and activity. One staff member said, "The noise levels are an issue; they've increased enormously." Another told us the noise from alarms was "most annoying".

The unsuitability of the environment to support people appropriately was a breach of Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some positive adaptations had been made to the environment, including the installation of a passenger lift and two stair lifts. Records showed these were maintained regularly to make sure they were operating correctly. People's rooms were personalised with items important to them.

People praised the quality of care and told us their needs were met. One person said, "The food's good, all the meals are. You can have a cooked breakfast on set days too. The portions are a good size, there's always plenty." Another person said of the staff, "They seem to know what they're doing most of the time." A relative told us "The care is excellent. The food is good, they monitor how much [the person] drinks and they see specialists when they need to."

People received appropriate support to eat and drink enough. People who chose to eat in the dining room sat in groups. Staff ate with people at tables that had been laid with tablecloths, serviettes, cutlery, glasses and coasters. This helped make the mealtime a pleasant and sociable experience for people. People were offered varied and nutritious meals, including cooked breakfasts twice a week. Alternatives were offered if people did not like the menu options of the day. A person requested an alternative dessert and chose fresh fruit which they enjoyed. Drinks were available throughout the day and staff prompted people to drink often. People were encouraged to eat and

Requires improvement

Is the service effective?

staff provided appropriate support where needed, for example by offering to help people cut up their food. Special diets, including high calorie supplements were available for people who required them. People received portion sizes suited to their individual appetites. Staff monitored the food and fluid intakes of people at risk of malnutrition or dehydration. However, the only scales available to weigh people were domestic, stand-on scales. These would not be suitable for people if they became unable to weight bear and staff would not be able to monitor people's weight effectively.

At our last inspection on 15 and 19 August 2014, we identified staff training was not up to date and staff did not receive appropriate support. At this inspection we found staff were knowledgeable about the needs of people living with dementia and how to care for them effectively. Records showed staff were up to date with essential training and this was refreshed regularly. Most staff had obtained vocational qualifications relevant to their role or were working towards these. Staff received regular one-to-one sessions of supervision with a senior member of staff and yearly appraisals. These provided opportunities for them to discuss their performance, development and training needs. Where additional training was requested and considered relevant, the provider made sure staff received it as soon as possible. For example, the cleaner requested training in supporting people living with dementia and had received this. The cook was due to receive the same training in the near future. Following a traumatic incident, the provider arranged counselling for staff that were affected. Those involved told us this had helped and made them feel "supported" at a difficult time.

The provider had appropriate policies in place in relation to Deprivation of Liberty Safeguards (DoLS). DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after the person safely. The registered manager was aware of a recent Supreme Court Judgement which widened and clarified the definition of a deprivation of liberty. They had applied for DoLS for three people and were preparing applications for other people appropriately. Staff were aware of the support these people needed to keep them safe and protect their rights. Other people who were safe to leave the home unaccompanied were able to do so when they chose.

People were able to access healthcare services. Relatives told us their family members always saw a doctor when needed and were admitted to hospital promptly if investigations or treatment were required. Care records showed people were referred to GPs, community nurses and other specialists when changes in their health were identified. Comments from a health professional in a recent survey conducted by the provider stated, "We have always experienced very good quality care and have a very good relationship with all staff."

Good

Is the service caring?

Our findings

Most people told us they were cared for with kindness and compassion. One person said, "The staff are absolutely wonderful, everyone has been so very nice and I feel well looked after here." Another person said of the staff, "I think they're very kind and respectful. They seem happy amongst themselves and they're very friendly towards us." Other people described staff as "very considerate", "kind" and "caring". A family member told us "The turnover of staff is low, they have the right attitude and believe in what they do." A health professional described staff as "cheerful, respectful and supportive". However, two people made less positive comments about staff. One person said, "Most of them are nice girls but one or two are full of their own importance." And another person described a member of staff as "a bossy boots".

We observed warm interactions between staff and people. Staff were attentive and conversations were not limited to care tasks. They spent time kneeling, so they could engage with people at eye level. When people, for example those living with dementia, became anxious or confused staff remained calm and patiently encouraged them to accept help and support. We heard staff talking to people about their lives, families and interests. We also observed staff supporting people gently when moving around by holding their hands and offering reassurance and guidance. They encouraged people to move at their own pace, using expressions such as, "No need to rush." and "Take your time."

Staff spoke fondly of the people they cared for and described them as "like one big family". Regardless of their role, they expressed a shared view that they were responsible for meeting people's needs and making life as pleasant and comfortable for people as possible. They spoke with people in ways that showed they knew them well and understood their support needs fully. When it was difficult to understand what people were saying, they used facial expressions, body language and touch to reassure people and make them feel listened to.

People were encouraged to be as independent as possible. One person was able to visit local shops on their own. They told us, "I can come and go as I please and help myself to tea and coffee that I can make myself." Another person arranged and attended medical appointments independently. Comments in their care plan showed staff respected this and encouraged the person to attend to as much of their personal care as they were able to. People who wished to use the stairs were supported to do so for as long as they could manage them safely.

We observed that people's privacy was protected by staff knocking and waiting for a response before entering people's rooms. One person said of the staff, "They don't just walk in your room; they knock and wait for you to invite them in." When personal care was provided, staff ensured doors were closed and curtains pulled. Confidential information, such as care records, was kept securely and could not be accessed by people who were not authorised to see it. People had been asked whether they had a preference for male or female care staff; their preferences were known to staff and respected.

Prior to moving to the home, people (and their families where appropriate) were involved in assessing, planning and agreeing the care and support they received. Care plans were then developed to meet their needs. Comments in care plans showed people were continually involved in this process and family members were kept up to date with any changes to their relative's needs. People were asked about their likes and dislikes and staff respected people's preferences, remembering, for example, which people liked to sit together at meal tables.

Requires improvement

Is the service responsive?

Our findings

At our last inspection on 15 and 19 August 2014, we identified breaches of regulations. Care planning was not always personalised and activity provision was not adequate. We set compliance actions and the provider sent us an action plan telling us they would meet the requirements of the regulations by 28 February 2015.

At this inspection staff told us they had more time to engage in activities with people, particularly in the evenings, and described a wide range of activities people took part in, including trips to local attractions. However, these were not documented and there was no timetable of activities. The interests, hobbies and backgrounds of most people were not recorded in their care plans. There was no evidence to show that people had been involved in planning the activities or that those provided met their individual interests. One person told us "I just eat sleep and watch telly. They do this quiz in the evening but it's the same every day." Another person said, "There's nothing much to do. Even if I had some knitting it would be better."

People were allocated one day each week when they received a bath or a shower and there was no evidence to show the frequency of bathing suited people's individual needs. The shortage of staff meant some people did not receive as many baths or showers as they wished and staff were not always able to respond to some people's needs in a timely way. One person told us, "I did request at least two baths or showers each week but I only get one. I feel so dirty." Another person said "I sometimes have to wait an hour or two and just lie [in bed] and have to wait until somebody comes. It all depends who's on and how busy they are."

The lack of individual bathing arrangements and the continued failure to provide personalised activities and was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Other people received personalised care from staff who supported them to make choices and were responsive to their needs. One person said, "[The staff] know me really well, like they know I like my cooked breakfasts twice a week." Another told us "I'm happy enough here and I'd say if I wasn't." A relative said of the staff, "They know and understand [the person] really well. They keep him warm and he gets all the help he needs." Another family member said of their relative, "They have choices over everything, within reason."

Initial assessments of people's needs were completed using information from a range of sources, including the person, their family and other health or care professionals. These were reviewed regularly in consultation with people and their families (where appropriate). One family member told us a recent review had resulted in their relative being offered an alternative room. They said, "We discussed all aspects of his care and he is much happier now." When people's needs changed, staff responded appropriately. For example, at one review it was noted that the person was having difficulty with their hearing and had some lower body pain. Both issues were followed up with the person's doctor and they were referred to a specialist. The person's medicines had been reviewed and they were receiving additional pain relief.

Care plans reflected how people wished to receive care and support and recorded people's preferences and choices. For example, they contained detailed information about when people preferred to get up and go to bed, how they liked to receive personal care and where they liked to take their meals and spend their day. People told us staff followed the care plans and respected their wishes. For example, one person had been given adapted cutlery to help them eat but had chosen not to use it. We saw them using standard cutlery, which they managed to use with occasional support from staff. Staff understood people's individual continence needs, promoted their independence and supported them appropriately. A recognised assessment tool was used to help staff identify when each person needed pain relief and MAR charts confirmed people received pain relief when needed.

People were given opportunities to express their views about the service. Meetings with people and their families took place every six months. Minutes from the last meeting identified the need for staff to wear name badges. These had been purchased and were being worn, showing that people had been listened to. The provider was developing a new questionnaire survey to send to people and their families to seek further feedback about the service and how it could be improved. The views of people were also captured during monthly reviews of their care. People knew how to complain or make comments about the service and

Requires improvement

Is the service responsive?

the complaints procedure was included in the 'residents' handbook'. The registered manager was familiar with the provider's complaints policy; however, no complaints had been recorded.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 15 and 19 August 2014, we identified breaches of regulations. Quality assurance systems were not effective in identifying concerns. We set compliance actions and the provider sent us an action plan telling us they would meet the requirements of the regulations by 28 February 2015.

At this inspection we found the provider had completed their action plan. However, this had not been sufficient to ensure all regulations were met fully. We identified continuing beaches of regulations relating to the safety of care provided and staffing. We also identified new breaches of regulations relating to the environment, the need for consent and the provision of personalised care.

A programme of audits had been set up to monitor the quality of aspects of the service provided. However, we found these were not always effective as we identified concerns which the audits had not picked up. For example, an infection control audit conducted by the registered manager in April 2015 had identified gaps in cleaning schedules and action had been taken; but the audit had not identified the lack of cleanliness in the laundry rooms. A medicines audit conducted by the registered manager in April 2015 had identified no concerns, but was limited to checking medicine stocks and MAR charts each month. It did not examine the medicines management arrangements as a whole. A previous medicines audit by the provider was more thorough and had identified gaps in the recording of fridge temperatures, which had been addressed. Neither audit had picked up the ineffectiveness of the arrangements for ensuring creams and ointments were not used beyond their 'use by' date.

Care plans were reviewed monthly, but the reviews had not identified that the Mental Capacity Act, 2005 was not being followed or that activities were not being recorded effectively. This showed the quality assurance systems that had been put in place were not always effective, and had not been developed fully. We found no systems or processes were in place to ensure the environment supported people's needs or that staffing levels were sufficient.

There had been an incident in October 2014 where a person left the building unescorted through a fire escape and fell in a nearby street causing injury. Following the incident the registered manager sent us a notification stating they would alarm all fire exits. However, they did not do this. In March 2015, another incident occurred where a person left the building unaccompanied through a fire exit that was not alarmed. The person fell down the fire escape and received fatal injuries. Following this incident, the provider took immediate action to alarm all fire exits and upgraded their fire alarm system to help prevent further incidents occurring.

The failure to mitigate known risks relating to the health, safety and welfare of people and the continuing lack of effective systems to ensure compliance with regulations were breaches of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their families told us the home was run well and they knew the registered manager and the providers by name. One person said, "[The registered manager] has to spend more time in the office now but she always used to come round and go out of her way to help. She's been very good to me." Another person told us, "The home is well organised, it seems good to me." Most people said they would recommend the home to others, although two people told us they would not, based on their own experiences. One person said, "No I wouldn't, it's too big and there are too many people. If there were more staff you'd get quicker service."

Staff felt valued and praised the management of the home, who they described as "approachable". Comments included: "There's good management; it's a great place to work"; "[The provider] is good. He gets things done"; "I can't fault the way they treat me"; and "The owners are willing to listen and will make changes". Staff meetings were held regularly and were used as an opportunity for management to praise staff and reinforce safety messages. They were also used by staff to feedback their views about how the home was run and make suggestions for improvements. At a recent meeting, staff had suggested changing the menus to reflect the seasons, and this had been done.

Since our last inspection and following the fatality, staff told us they had become more safety conscious. One staff member told us, "The provider is more interested in making sure things are done." Another said, "Things are being done better now." A third staff member told us, "We've only to ask for something now and we get it." The

Inadequate

Is the service well-led?

registered manager kept a log of accidents and incidents to help spot any patterns, so remedial action could be taken. Apart from the issue with the fire escapes, no other themes had been identified.

There was an open and transparent culture within the home. The ratings from the previous inspection were displayed prominently in reception. The provider had written to people and their families to tell them about the concerns we identified at our last inspection and about the fatality in March 2015. There were good working relationships with external professionals and the provider notified CQC of all significant events. There was also a whistle blowing policy in place, which staff were aware of. Whistle blowing is where a member of staff can report concerns to a senior person in the organisation, or directly to external organisations. Visitors were welcomed and described the home as "welcoming" and "friendly". There were links to the community through local churches, volunteers who helped at the home and people's friends and family members.

There was a clear management structure in place. The providers took an active role in the running of the home, visiting several times a week, assisting with the maintenance, conducting some of the audits and talking with people to make sure they were being cared for appropriately. The home was managed by an experienced registered manager, who was supported by a deputy manager and senior head of care. Staff understood their roles and worked well as a team.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People were not involved in planning activities to meet their individual needs. Regulation 9(1) & 9(3)(a)&(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider was not following the Mental Capacity Act, 2005. Regulation 11(1)(2) & (3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment The provider had not ensured the premises were suitable and supported the needs of older people and people living with dementia. Regulation 15(1)(c).

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not always provided in a safe way in relation to infection control, the management of medicines and fire safety arrangements. Regulation 12(1) & 12(2)(a)(b)(g) & (h).

The enforcement action we took:
We issued a warning notice and required the provider to become compliant with the regulation by 11 September 2015.

Regulated activity	Regulation
	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider was not operating effective systems or processes to ensure compliance with the regulations or to ensure practice was improved following significant events. Regulation 17(1) & 17(2)(a) & (f).

The enforcement action we took:
We issued a warning notice and required the provider to become compliant with the regulation by 11 September 2015.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider had not ensured that at all times there were sufficient numbers of suitably qualified, skilled and experienced persons deployed to meet people's needs. Regulation 18(1).

The enforcement action we took:
We issued a warning notice and required the provider to become compliant with the regulation by 11 September 2015.