Archers Healthcare Limited

Lower Farm Care Home with Nursing

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 8, 13 and 19 September 2017. Each inspection visit was unannounced.

The service provides residential and nursing care for up to 46 people, some of whom are living with dementia. At the time of our inspection 34 people were using the service and two people were in hospital.

A registered manager was in post. A registered manager is a person who has registered with the 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.

Archers Healthcare Limited had taken over this service in May 2017. The service had been rated Inadequate under the previous provider and placed into special measures following an inspection on 4 and 5 July 2016. This inspection was carried out to ensure that improvement had been made in the intervening period. CQC would usually give any new provider a longer period to address the issues we found but a number of complaints and safeguarding issues were raised with us and so we brought our inspection forward.

During this inspection we established that many of these issues, which were raised by relatives and by staff acting as whistleblowers, were not fully substantiated. However we did find evidence of a poor staff culture. This impacted negatively on the staff and in turn on the people who used the service. We found the provider and the registered manager to be dedicated to driving the improvements that the service required but questioned the intimidating management style of the provider.

We found the service had improved under the new provider but further improvements were required. It was encouraging that both the provider and the manager were already aware of many of the issues we raised and had tried to start tackling them. The provider had only been registered for a matter of weeks and had many areas of poor practice to address. This meant that our inspection was likely to see only the beginnings of a change and this was the case.

The manager and provider had worked hard to introduce new systems and procedures and to overhaul paperwork and staffing levels. Some areas had been more successful than others and we continued to have some significant concerns regarding the safety of the service. However we found the manager to be open and honest with us and had confidence that any issues raised in this report would be addressed as a priority.

Risks were assessed, documented in care plans and measures put in place to reduce them. However routine health and safety checks were not always undertaken and audit systems did not identify this. Where risks to people's health and safety were identified action did not always follow to address this. The risks related to pressure care were not well managed. Staff practice with regard to the prevention and management of pressure ulcers was not always effective and records were not detailed and did not guide and inform staff.

Staffing levels, and the deployment of staff, were a concern for some people and had an impact on the timeliness of care provided. Measures had been put in place to review staffing levels and these were viewed positively by some people. Our observations were that, in particular on the third day of our inspection, staffing was not adequate and people did not receive the care they needed.

Staff were patient, caring and treated people with kindness. People's dignity was occasionally compromised as staffing levels meant that staff did not always have the time they needed to provide care which met people's needs promptly.

Medicines were managed safely and people received their medicines as prescribed. Staff were confident in the management of medicines and were knowledgeable about people's healthcare conditions and the medicines they required to support them.

Infection control measures were in place and staff had an appropriate understanding of how to limit the risk and spread of infection. Training and induction for new laundry staff could have been more robust.

Staff were not all trained in safeguarding people from abuse but demonstrated an acceptable knowledge of how to keep people safe. The manager referred incidents appropriately to the local authority safeguarding team for investigation and ensured CQC were notified of any safeguarding incidents.

Staff received a comprehensive induction but some training which could have benefitted staff, was not provided. A new training programme was being prepared and the manager demonstrated a commitment to improving training for all staff. Staff were supported with regular meetings, supervision and appraisal.

Staff had received training in the Mental Capacity Act 2005 (MCA) and the 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 and 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.

Practice related to MCA and DoLS was not always in line with legal requirements. Staff sought consent appropriately for day to day care support but did not demonstrate a good understanding of the principles of the MCA which left people at risk of receiving care to which they had not consented. People who used the service, and their relatives, were not always sufficiently involved in planning and reviewing their care.

Oversight of people's nutritional needs required improvement. People who used the service praised the food and food was of a good quality. Those at risk of not eating or drinking enough were not appropriately monitored which placed them at risk.

People were supported to access the healthcare support they needed promptly. There was evidence of good partnership working with the GP, matron service and other healthcare professionals such as district nursing team. Feedback from healthcare professionals was positive.

Care records identified people likes, dislikes and preferences and guided staff but guidance was not always followed and some people did not receive the care they wished to receive.

People received care that met their individual needs and took account of their likes, dislikes and preferences. Staff respected people's individuality.

People were supported to follow a range of hobbies and interests and new activities. Staff were transforming the activities programme to reflect people's preferences. Further improvement was needed to ensure people who needed one to one input also received social and recreational opportunities.

A complaints procedure was in place and formal complaints were well managed. Informal complaints were not raised as people found the provider could be intimidating to them. People who used the service and staff expressed that they would be hesitant to raise a complaint.

The new provider and registered manager had introduced new systems and procedures to drive improvements. Their approach had been well received by the some people who used the service, relatives and staff. Others had expressed concern about how some changes had been implemented and were worried about the culture of the service.

Audits were in place to monitor the safety and quality of the service and but they were not always effective in identifying concerns and effecting change. The provider and manager were aware of many of the shortfalls we identified and expressed a willingness to continue to drive improvements. Where issues still required some further work we had confidence in the provider to continue to address these and to take on board people's concerns.

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 skilled and experienced staff to meet people's needs promptly.

Medicines were managed safely and people received their prescribed medicines as directed.

Risks management needed to be more robust. People were placed at risk from poor monitoring of their health and wellbeing.

Staff understood their responsibilities with regard to safeguarding people from abuse but most had not received appropriate training

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received a comprehensive induction but additional training was required in some key areas.

Staff had received training in MCA and DoLS but knowledge and understanding was poor which meant the service was not always operating in line with legal requirements.

People were positive about the food but monitoring of food and fluids for some people was poor and left people at risk of not eating or drinking enough.

People were supported to access appropriate healthcare professionals when they needed to. Assessment and management of pressure care wounds was not robust and systems needed to improve to ensure people had the care and treatment they needed.

Is the service caring?

Requires Improvement

The service was not always caring.

Feedback was positive about the kindness and patience of the staff.

People's privacy and dignity was not always maintained and sometimes people's support was rushed.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care needs were assessed before they were admitted to the service but care was not always delivered in line with people's preferences.

Care plans were person centred but sometimes lacked detail.

People were supported to follow their own interests and hobbies and they were very positive about the new opportunities for activities.

A complaints procedure was in place and formal complaints were well managed. A culture of fear meant that people who used the service and staff were unwilling to raise issues with the provider.

Is the service well-led?

Requires Improvement

The service was not always well- led.

The management team was focussed on continuous improvement but oversight of all issues facing the service needed to continue improving.

The new provider and registered manager had introduced numerous new systems and procedures to drive improvement and create a new culture. Sometimes the methods used had resulted in very negative feedback and a failure to achieve an open and honest culture.

Staff felt supported by the manager who was an effective role model for good practice.

There was a comprehensive system of audits in place to monitor the quality and safety of the service. Action did not always follow when concerns were identified. This left people at risk of poor and unsafe care.

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 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.

The inspection took place on 8, 13 and 19 September. All three inspection visits were unannounced.

The inspection team on 8 September consisted of one inspector and a nurse specialist adviser. The inspector carried out the second visit on 13 September alone and on 19 September two inspectors carried out the inspection.

Before we inspected we reviewed the information we held about the service. This included any statutory notifications that had been sent to us. A notification is information about important events which the service is required to send us by law.

We spoke with 15 people who used the service, six relatives, two visiting healthcare professionals, four care staff, four senior care staff, an activities co-ordinator, two kitchen supervisors, two kitchen assistants, the domestic supervisor, three domestics, a nurse, an agency nurse, the registered manager and two directors of the business. We observed staff providing care and support and 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 communicate with us easily.

We reviewed 17 care plans, eight medication records, eight staff files, staffing rotas for the weeks leading up to the inspection and records relating to the quality and safety of the service and its equipment.

We received feedback from the Norfolk County Council safeguarding team and from the West Norfolk

Clinical Commissioning Group Quality Assurance team both before and after the inspection visit.

Inadequate

Is the service safe?

Our findings

People who used the service, and their relatives, praised the staff and told us that they felt the staff did their best to keep them safe. However we received mixed feedback about the staffing levels. Some people told us that there were not enough staff at times and this made them anxious. One person said, "Sometimes people are got up quick but sometimes it takes hours". Another person told us, "There are not enough – no". A relative voiced their concerns to us saying, "My family member's care is compromised due to staffing levels". They went on to explain that their relative sometimes had to wait a long time for care and support. Another relative said that there was often a wait of' "Up to half an hour" for carers to offer the support needed.

Other people who used the service, and relatives, commented on recent improvements in the staffing levels. One relative commented, "There seems to be more people about" and another said, "There may be less of them but they seem to be working smarter".

The provider had recently reviewed staffing levels according to their dependency tool and had made some changes. Some staff were not aware of these changes or did not understand the rationale for them. Staff gave us mixed feedback about the staffing levels. One person said, "It's so much better now. I painted a lady's toenails today – [there's] time to do things. You have downtime but you must prioritise. I speak to service users and say 'I'll be there in 15 minutes' and they're fine". Another commented, "Staffing levels are fine – you're not rushed." Nursing staff were positive about the staffing levels and found them adequate for the number of people they had to support and care for.

However other staff made comments such as, "It's not enough" and "We do not get our breaks". A visiting healthcare professional told us that the staff were 'run ragged' when they had visited the previous week. One staff member told us that they wanted to speak with us but could not spare the time.

On all three days of our inspection we observed that staff were extremely busy and worked tirelessly. This made it difficult for them to complete their basic caring tasks in a timely manner and meant they had very little time to spend chatting to people. We observed some poor practice and felt this was not because staff were uncaring or disrespectful but because they were so very pressured. For example we saw staff entering people's rooms without knocking and leaving equipment unattended which could have placed people at risk of harm.

On our third inspection day it was clear to us that staffing levels were not always adequate. On this day a staff member said, "The night staff got eight people up but it's not enough as now there are only two [staff] to get the other seven up". Three people were still in bed and waiting for staff to assist them to get up at 12.30. We noted that there was a strong urine odour in one person's room and were concerned that urine might have been in contact with their skin for a long time presenting a risk of developing a moisture lesion. They were also very anxious about missing their lunch and we heard them calling out for someone to take them down for lunch. They had a call bell but did not appear to know how to use it and depended on staff to be in the vicinity. Staff finally took them down to the dining room at 13.22.

The call bell system was not able to automatically identify and print out how long each call bell had taken to be answered. The registered manager carried out spot checks and we saw that there was often a very lengthy wait for these call bells to be answered. Waits of between eight and 17 minutes were recorded. One call bell, which was set off in an unused room, was not responded to at all. The manager had addressed this lack of response with the staff and we were assured that they were now aware that they had to check unused rooms when the call bell was set off. The manager aimed for staff to respond to call bells, other than emergency call bells, within ten minutes. We found this a considerable time to wait for a response. Many people who used the service were living with dementia and we were not assured that they would understand the difference between a call bell and an emergency call bell.

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

Staff employed at the service had been through a recruitment process before they started work. Staff, including agency staff, had checks in place from the Disclosure and Barring Service to establish if they had any criminal record which would exclude them from working in this setting. Interviews took place to establish if staff had the skills and qualities needed to carry out the role safely and effectively.

We found a mixed picture with regard to how risks were assessed and managed. We observed staff working safely according to people's moving and handling care plans and people told us they had confidence in the staff to support them in a safe way. Moving and handling risk assessments identified equipment people required and gave staff the information they needed to support people with their mobility. People's risk of falling was quite well managed. Equipment, such as sensor mats to alert staff that a person had got out of bed, were in place for some people who were at high risk of falling.

Risks relating to infection control were mostly well managed with staff demonstrating an understanding of how to keep people safe by limiting the risk and spread of infection. We noted that some people's rooms had a strong odour of urine, although relatives told us this was improving and ceasing to be an issue. Equipment such as aprons and gloves was available for staff to use, although we did observe that an agency nurse did not have access to the correct size of gloves. The kitchen was very clean and temperatures of fridges and freezers were well monitored. Food was stored to ensure that no cross contamination could occur and stocks were rotated so that no food was used past its expiry date.

When we arrived for our inspection on 8 September we were able to let ourselves into the property and wander around for several minutes without being challenged. This security lapse posed a possible risk to people who used the service. The manager told us that normally the administrator would oversee the main door but they were on leave. We noted that there was better safety monitoring on our subsequent two visits.

Risks, such as those related to moving and handling, prevention of pressure sores, choking and a person's risk of falling, had been assessed and recorded in care plans. However we found that some assessments did not contain sufficient information and measures put in place to reduce the risk were not always robust. For example, one person's pressure area care plan stated that they should be moved 'regular' and that the pressure area should be checked 'regular'. This person had a grade three pressure sore, which is a significant wound and requires the service to notify CQC.

The care plan did not identify how often the person should be repositioned, which area of the skin should be checked, what equipment to use or what setting the pressure mattress should be on. We could not be assured that the provider had considered all actions needed to reduce the risk of this person's pressure sore deteriorating further.

We found similar issues with three people's pressure care plans. Where care plans and risk assessments clearly identified the risks relating to pressure care we saw that staff did not always provide care according to the assessed needs. For example one person required repositioning every two hours and another every three or four hours. We saw that this was not happening and there were periods when each person was left up to six hours without a change of position. Records for another person who required repositioning every two hours recorded that they remained in the same position for nearly five hours. The manager was not able to confirm if this was a matter of poor recording or of a lack of care.

Risks from the environment had been assessed and measures put in place to reduce most risks. However we had multiple concerns about the management of these risks as procedures were not followed and action was not always taken to reduce a known risk. For example there was a procedure in place to test the water temperatures to ensure people were not at risk of scalding. These tests were carried out monthly rather than weekly. We saw that temperatures of up to 50 degrees centigrade had been recorded with no follow up action. The manager told us that water temperatures should be no more than 43 degrees. One person's basin had been consistently recorded as being 49 or 50 degrees for the last four months with no action taken to remedy it. We spoke to the person who used the service and they told us, "It's hot in the morning. I have to be careful". We tested the basin and found it could easily scald a person, especially if their skin was very frail. We asked the manager to address this matter urgently.

We noted that window restrictors were in place to reduce the risk of people falling from height. However we also noted that a door was open which led to the roof space and noted open cupboards which stated that they should remain locked. The tea trolley was left unattended on several occasions and a metal teapot posed a significant risk to people especially to one person who drove past in their electric wheelchair. The laundry room door did not have any lock and the room was accessible to all. We were concerned that chemicals stored in this room and the iron posed a potential risk to the people who used the service and the manager told us they would fit a keycode lock as a matter of priority.

We found that some potential risks had not been fully considered. One staff member was seen to have long acrylic nails which could easily tear frail skin. We raised this as a concern with the staff member but noted they had not been removed when we visited for our third day of inspection. On day one of our inspection we found that the main doors to the service were accessible to all. We also noted a second set of doors were accessible. We found that the potential risk of the main road directly outside the property had not been fully assessed. The manager confirmed to us that some of the independently mobile people who use the service were sometimes confused.

There was a clear procedure set up for the regular testing of the fire detecting and firefighting equipment. However tests were not being carried out according to this procedure and action had not been taken to address issues found. Weekly tests of the fire call points had been carried out twice in July, one in August and once in September by the time of our inspection visit on 19 September. We also noted that there was no record of what action was taken regarding one person who propped their door open which is a fire risk.

On 14 August 2017 it had been noted that 'still having problems with the fire panel'. We saw that the fire panel was signifying a fault present. The manager confirmed that they had not called out an engineer but were certain that the fault did not mean the system was unsafe. We asked to see confirmation of this from an engineer from the maintenance company. This was not provided to us but on 19 September 2017 the provider confirmed that the system was safe and a new part had been ordered. We could not be totally assured that the fire detection system had been fully operational during the four week period.

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

There were measures in place to help protect people from the risk of harm or abuse. Some staff files showed that staff had received training in safeguarding people from abuse but this was not the case for most staff. Staff were able to tell us what they would do if they suspected or witnessed abuse. One staff member told us, " I would tell a colleague or a senior. I am not sure if they do body maps here. I would record it". Another staff member was equally clear saying, "I would go straight to management or straight to safeguarding. If I saw poor practice I would go to [the provider or the manager]. They would listen".

Some staff were not clear how they would raise concerns outside of the organisation by reporting directly to the local authority or CQC for example. The service had reported safeguarding concerns appropriately to the local authority and had notified CQC of any safeguarding concerns they were dealing with.

Medicines were managed well and people told us they mostly received their medicines on time. We found this to be the case on the first two inspection visits but on the third we saw a member of staff giving time sensitive medicines 90 minutes after the prescribed time.

There were systems in place for the ordering, storage, administration and disposal of medicines including controlled drugs. Information about people's medicines was available to guide staff. We observed two drugs rounds, including one carried out by an agency nurse who was new to the service. They told us that they felt they had the information they needed to give people their medicines safely. We saw that one person had their medicines using percutaneous enteral gastronomy (PEG). There was a notice in this person's room reminding staff that all medicines needed to be given via PEG. This helped reduce the risk of the person being given medicines orally which might place them at risk of choking. Staff took their time and made sure people had any pain relief they needed.

We checked the stocks of medicines, including controlled drugs and blood thinning medicines which have to be very carefully managed, and found that records tallied with the stocks we counted. The medicines room was well organised and staff were confident they had the knowledge and skills they needed to administer medicines. We saw that staff had received training in administering medicines and their competence was checked by senior staff.

We saw that some people had syringe drivers in place to deliver medicines directly under the skin. These are used when people are not well enough to be able to take medicines by mouth. Nurses told us they felt confident to deliver medicines this way, although refresher training had not been provided to ensure staff skills and knowledge was current.

Requires Improvement

Is the service effective?

Our findings

We received both positive and negative feedback about the skills and expertise of the staff. One person who used the service said, "I'm very happy with the carers who look after me". A relative commented, "[My relative] is always well presented…They keep me informed" and another said, "Staff have been so helpful…I pick the charts up and check they've been in. I can't fault the place". Others commented more negatively with one relative saying, "The carers do their best but I don't feel the level of training is very good".

We reviewed the service's induction of new staff and staff training records. We saw that new staff received a structured induction. One staff member who had previously worked in the care sector told us, "These are the best people who have ever trained me". Before staff carried out their duties unsupervised they spent a period of time shadowing experienced staff. New staff told us they felt supported to learn the skills they needed to carry out their roles with one saying, "If I have a question I'll ask. The door is open. I've got tremendous support".

When first employed staff undertook a comprehensive two day induction which was designed to ensure they had the required skills and competences to carry out their roles. New staff shadowed more experienced staff as part of the induction process. One person's induction had been completed in one day which meant that they had been required to absorb a great deal of information in a very short space of time. We spoke with a new laundry assistant who had not yet received their induction but who was being closely supervised by their line manager. They told us, "I am working with my supervisor who shows me things I should and shouldn't be doing". Formal supervisions were held regularly and an annual appraisal system was in operation.

Care staff received relevant training including training in nutrition, first aid, moving and handling people, fire safety and food hygiene. One staff member commented, "The training has all been updated since the new providers came". However staff were yet to receive some specific training which would benefit them. For example, nursing staff had no record of any additional training, such as catheter or syringe driver management. Staff had not received training in supporting people with diabetes, caring for people at the end of their life or caring for those living with dementia, although dementia training was planned. Recently senior care staff had begun to administer medicines to people and each person had been provided with additional training. They told us that this training equipped them to carry out this task. We observed that there was a commitment from the new owners to improve staff training and this process had already begun.

We spoke with a healthcare professional who was visiting the service on the day of the inspection. They told us, "This is one of the better [care homes] in the area. They don't call us out very much and [people] are looked after quite well". Although this was positive feedback we found that there were some concerns about the day to day management of people's healthcare needs. Care plans did not always give staff enough detailed guidance and the management of wounds was poor.

Records relating to people's wound care were not detailed and were often contradictory, with little clear guidance for staff. One person was described as having a pressure sore on their sacrum in one part of the

care plan while in another a different site was mentioned. There was no clear plan for how often to re-dress this person's wound and practice varied. There were minimal photographs taken to record the progress or deterioration of this significant wound and no referral to a specialist tissue viability nurse (TVN) had been made. Information about equipment to be used, mattress settings and pain relief were all absent from the care plan.

Another person had a record of a necrotic grade three pressure sore. This was dated 4 August 2017. The care plan stated that the wound should be redressed in four days but there were no other details in the care plan documenting how to manage this person's wound. The service did not refer this person to the TVN until 23 August 2017.

Another person had a pressure sore to their sacrum. The initial assessment of this wound did not have an accompanying photograph, the wound was not graded and there was no care plan in place to manage this wound. A fourth person was found to have their air mattress switched off which meant that it was not protecting them from further deterioration of their moisture lesion. Although the person was very happy with the care they got we noted that the issue with the air mattress, alongside a lack of repositioning, meant they were at risk of a deterioration of their health rather than an improvement.

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

Records showed that people had access to a variety of healthcare services including GPs, district nurses, falls team, psychiatrists, opticians, occupational therapists, dieticians and chiropodists. We received positive feedback from a community diabetic nurse who came to visit some of the people who used the service. The service was signed up for the GP matron service which ensured fast access to healthcare support and worked well.

People who used the service were happy with the food and the choice available. One typical comment was, "They feed us very well". Another person commented, "It's very good. I've put on weight". People chose their meal the day before. We noted that there were no menus on the tables and plated options were not shown to people to help them make a choice. Food was placed in front of people, sometimes without explanation. There was no choice of drink and the dining room was not ideally suited to the number of people who were wheelchair users. Most people had a tray on their laps rather than having their meal on the table as their wheelchairs did not fit underneath. Several people mentioned to us that the dining room was quite cold. People were not all served at the same time which did not help make the meal a sociable occasion. Some people struggled to eat independently and we noted that there were no plate guards being used which might have been of help to them.

However we observed good and caring interactions from staff who were trying to support people to eat their meals. One staff member offered to cook another dish which was the person's favourite as they did not fancy the meal they had chosen. This was much appreciated. Although staff were kind and caring in their interactions there were not enough staff to provide the support needed. We saw one staff member assisting three people which required them to lean over people. On one day the meal experience was poor for people and a staff member commented, "It's chaos. The carers don't know what people have".

Kitchen staff confirmed that the new owners had provided a good budget so that they purchased good quality food. Stocks confirmed this. People's likes and dislikes were clearly displayed and surveys were carried out to see what people thought of the meals provided. Food people could eat with their fingers was available as were low sugar options for people with diabetes, although a separate diabetic pudding was no longer made. The cook told us their aim was to provide low sugar, healthy puddings for everyone and this

mirrored the feedback from the diabetic nurse who felt the service was managing diabetes well. The kitchen staff demonstrated a good knowledge of people's dietary needs.

We found that food and fluid charts were not completed accurately. We could not determine if people being nursed and supported in their rooms, were receiving the food and fluids they needed to stay well. One person was noted to have a drink in their room but told us, "I can't reach it". Their care plan stated that their food and fluid intake should be monitored as they were at high risk of not eating and drinking enough but there was no food and fluid chart in the person's room. Staff told us the person's eating and drinking was recorded in an evaluation folder but there was no record in the folder. The manager confirmed that the person was not on a food and fluid chart but were on weekly weights. Records were therefore contradictory and left the person at risk. We noted that their weight had reduced by over a kilo between 2 July 2017 and 27 August 2017. Weekly weights were not being recorded as the last recorded weight was 27 August.

Where fluid charts had recorded a very low fluid intake we saw that this information was not handed over or any action taken to promote fluids. For example one person's recent fluid intake was recorded as 100 mls for a whole day, 150mls the following day, 250 mls the day after and 120mls on the day before our inspection. Daily notes did not correspond with these figures and stated 'fair diet and fluid intake' and 'good fluid intake'. This meant records were not reliable. Where a daily note confirmed 'no fluid intake' no action was recorded in response to this. The manager agreed that although a fluid recording procedure was in place it did not highlight to staff if and when a person's fluid intake was reducing and making them unwell.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) 2014

We observed staff asking for people's consent before providing them with care and treatment. People told us that staff were good at asking their permission before helping and supporting them. People's capacity to consent to aspects of their care and treatment was documented in care plans but some information was confusing and records contradicted each other. We found that the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were not well understood by carers and senior staff. The MCA states that where a specific decision is required to be made it must be established if a person can consent and if they cannot the decision needs to be taken in their best interests and involve relevant people, often the family but also other professionals. DoLS applications are required to be submitted to the local authority when a person's liberty needs to be restricted in order to keep them safe.

People's capacity to consent had been assessed by a senior member of staff or nurse in most records that we viewed. It was not evident that the person making the judgement had the necessary skills to do so, other relevant people were not involved and records were confusing.

For example, one person's care plan stated that the person 'can consent to care on [their] own but with major decisions would like [their relative] to support'. However we saw that a bedrails assessment had not included input from the person themselves or their relatives and a Best Interests decision had been signed by a senior member of staff. The record simply stated that the person was 'unable to make the decision and that the provision of bedrails was in their best interest'. This meant that the legal process had not been properly followed to ensure that this person was not at risk of being unlawfully deprived of their liberty.

The information about this person's capacity to give informed consent was contradictory with some parts of the care plan stating '[Person] is able to understand the information given' and others stating 'unable to give consent'. Decisions about this person's consent to taking medicines, having personal care and transferring safely had all been completed by a senior member of staff with no recorded involvement of anyone else, including the person themselves. This confusion meant there was a risk that the person's consent to aspects

of their care and treatment was not being effectively established.

We found other examples of contradictory records and confusion on the part of the staff carrying out MCA assessments. We saw a capacity assessment for one person which had been completed by a nurse which stated that the person was 'under a DoLS – unable to make decisions'. The assessment related to the provision of bedrails and permission to use restraint. No next of kin or other professional person had been involved in the decision. Another person, who was said to be 'able to verbalise my needs to staff' also had bedrails in place but their consent to this was not recorded.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) 2014

Some care plans had assessments which did not relate to specific decisions. For example an assessment had been completed relating to the person's ability to transfer safely and another related to maintaining the person's right to vote. Whilst these were welcome additions to the care plan they did not need an assessment of the person's capacity and did not fit the criteria of the MCA. The provider had recognised that, when they took over the service in April, there had been very few MCA assessments and the status of DoLS applications was not clear. We noted that they had begun to remedy this and this was to be commended but further work was required to ensure the service was working fully in accordance with MCA and DoLS.

Requires Improvement

Is the service caring?

Our findings

People who used the service, and their relatives, all commented on how lovely the staff were. Staff were familiar with people's needs and demonstrated their patience and care throughout our inspection visits. One person commented, "The staff are kind". A relative told us, "They do little things like putting music on for [my relative]….They just look after you too – they treat you like you're the patient!" We observed staff taking time to communicate with people and making sure they understood their wishes. We saw that one person who used the service was very concerned about another asking, "Is she ok?" Staff went to check and reassured the person in a very kind way saying, "She is just tired. She has had a bit of a cough but she really is ok". The person was reassured by this. One relative told us, "Certain staff [my relative] is very fond of and knows all about their family. The majority of the staff are gentle and kind".

Some people were not willing to share their concerns. One person seemed very low when we went to visit them in their room. They told us they were not comfortable and we asked if staff were gentle when they helped them move position. They replied, "No, not always" but they did not feel able to tell us more. They told us that sometimes staff left the door open when they are not fully covered up but gave us no further details.

We noted that sometimes interactions with people were very brief but this was often at times when staff were very busy. We found the staffing levels could impact on how staff spent their time with people and led to some people's dignity being compromised. For example one person was observed to be waiting for staff to assist them to get up. They were still in bed at 12.30. They had the remnants of their liquid medicine still on their chin from the 8am drugs round, crumbs from their breakfast all over their bedclothes and a strong smell of urine in their bedroom. Another person did not have their glasses on and their hearing aids did not work. They were upset by this.

We also observed some language from staff which, while not intentionally disrespectful, treated people like children. One person who used the service liked port and lemon. We asked how often they were able to have one. Staff told us they pretended the blackcurrant squash they had with their tablets was port and lemon. They said, "It's the only way we can get it down her!" We also heard a staff member telling someone, "You won't like me in a minute – I'm coming back to do your bottom!" These comments were made affectionately but showed that staff did not fully consider the feelings of the adult person they had in front of them. Staff had not undertaken any equality and diversity training but this was due to be arranged.

We noted around the home that a notice was placed on a person's bedroom door when staff were helping someone with their personal care. This made it clear where staff could be found but also ensured that people knew not to attempt to enter the room. The notice stated 'We care about dignity and privacy'. Despite this notice, we occasionally saw staff entering rooms without knocking and again felt this was a lapse due to staff being so busy rather than the accepted culture of the service.

We observed a member of the agency staff, treating people with patience, kindness and sharing a joke with them which we saw was greatly welcomed. We saw that the person who used the service was often very

resistant to staff support and care and the staff member used their undoubted people skills to build a relationship quickly through their humour and kindness.

Information in care plans was person centred. Plans documented what was important to the person and how best to successfully support them. We saw that families advocated for their relatives and an advocacy service could be arranged for those who needed this. People's wishes and preferences regarding the end of their life were recorded. When people's health was declining significantly, preparatory medicines were made available to ensure pain was relieved as much as possible and people were kept as comfortable. One relative was very anxious that their family member's specific wishes had been recorded in their care plan and we saw that they were and staff were aware of them.

One family had very high praise for the support they had been given as their relative approached the end of their life. They were every appreciative of the staff and felt that their relative's care could not be improved. They had confidence in the staff during this most difficult time.

Requires Improvement

Is the service responsive?

Our findings

We saw that the manager assessed people's care and support needs before admission to the service to ensure the service could meet their needs. A care plan was written once people had moved in and we saw that care plans were person centred and included important information about the person's likes, dislikes and preferences as well as their previous life history. However plans did not always show how people and their families had been involved in planning and reviewing their care needs. One family told us they had been invited to a care review but had received too little notice to be able to attend.

Care plans documented people's care and support with regard to a variety of needs including mobility, eating and drinking, social needs, bathing and hygiene, mouth care, continence, sleep sexuality and general wellbeing. Plans were comprehensive but some could have benefitted from some more specific detail to guide staff. The manager and new providers have worked hard since April to review all the paperwork at the service and this was an on-going task which was well underway.

We saw evidence that plans were reviewed and were updated when people's needs changed. However, due to some information being recorded in different places, some confusion about people's current needs was present. For example one person complained to us that they could not find their call bell. We observed them feeling around on the bed for it. Staff told us the person could not use their call bell but their care plan did not make this clear. New and agency staff might find this a confusing picture. There was a risk that staff might not check on the person frequently enough if they thought they could use their call bell, when in fact they could not.

Where people's likes and dislikes were identified we saw that their preferences were not always respected. It was not clear if this was a staffing issue or if staff were not fully aware of people's preferences. Most people did not receive a regular bath even though everybody was asked about their preferences in this area. Mostly people had bed baths or strip washes. One person told us, "We're supposed to get one [bath] but it doesn't always happen". One person had received one bath in July and one in August. We asked if they liked a bath and they replied, "Ooh yes".

Care plans noted if people were happy to receive care from a staff member of the opposite gender. One person told us, "I have [a male member of staff] and they asked me if that was ok and I said fine". Other people also confirmed this was the case. Staff demonstrated an awareness of people's need for companionship from people of the same gender and we saw staff encouraging people to sit together as they thought they would enjoy a chat together, which they did. People told us this could be further improved and some gentlemen at the service asked for a club for themselves and opportunities to watch sport on television.

People were supported to follow their own interests, hobbies and spiritual beliefs. A local priest visited the service regularly. We spoke with one person whose faith was central to their life and they were very happy with the way the service supported them with this. Other people chose to spend their time in a variety of ways and a new activities co-ordinator had recently been appointed. We observed several craft sessions

which those participating in absolutely loved. The sessions were inclusive and people with different abilities and skills were supported to produce arts and crafts which were displayed around the service. One person said, "Those flags up there – they were really fun to do". Another said, "We've been doing stone art pictures to hang up …we do quite a lot of interesting activities".

The activities co-ordinator had plans to expand their role and provide more individual sessions. One relative told us that they would welcome this as their family member never had anything like a manicure or a one to one session in their room. They said, "They would love that". They had already noted down people's preferences for various pastimes and were very enthusiastic about their key role in the service. They only worked four days a week which meant that on some days there was little or no stimulation for people.

A resident committee had been formed and there were plans in place to start up a residents' newsletter. These were designed to be forums where people who used the service could raise issues which were important to them. Surveys had not yet been sent out to gauge people's views on their care and treatment as it was too little time since the new provider took over but this was planned.

The service had a complaints policy and procedure in place and complaints were audited on a monthly basis. We reviewed one formal complaint which had been made since the new provider took over. We found that each point raised had been investigated and responded to in writing by the manager. The person raising the complaint had accepted the outcome of the investigation. We found the response to be appropriate for the issues raised.

We found however that although people were aware of their right to complain, some people did not feel able to exercise this right. Both staff and some people expressed that they would hesitate to raise any concerns with one of the directors who was often at the service. People told us that they had not received a sympathetic response always. We asked one relative if they thought people who used the service would be able to raise concerns or make complaints. They said, "I'm not sure – I think they'd be too frightened". This was a typical comment and led us to be concerned about the culture of the service. Before our inspection the CQC had received a number of complaints which had not been raised directly with the provider or the manager. Many of these could not be fully substantiated but it was a concern that some people did not feel they could raise an issue and expect a reasonable response from the provider.

Requires Improvement

Is the service well-led?

Our findings

Archers Healthcare Limited bought the service in May 2017. Our methodology dictates that usually we would give any new provider enough time to begin to make the required improvements to the service and put their own stamp on things. However we took the decision to inspect this service quite soon after the new providers had acquired the service. This was because we received a high number of complaints about the service and a significant amount of staff contacted us as whistleblowers. Due to the level and nature of the concerns we decided to inspect and establish the current picture.

We found that, although a number of concerns remained, it was clear that the manager and new provider had worked hard to try to address the issues raised at the last inspection. New procedures had been introduced, care plans had been re-written, training reviewed and various initiatives put in place to begin to address the poor quality care people had been receiving. We appreciated that both the provider and the manager understood that they still had a lot of changes to make and a new culture to embed and that this would take time.

The registered manager had worked for the previous provider for a few months and was very positive about the support and guidance she received from the new provider. She told us, "I get very active support". Feedback was positive about the manager and we found her competent, professional and willing to listen. Staff also gave us positive feedback about the new provider with one person saying, "There's been a lot of changes but I have to say it needed it". Another staff member told us, "If it hadn't been for [the new provider] we would have gone under". A third member of staff also commented, "Some of the staff were unhappy before. It's now so much better". People who used the service and some relatives also gave us positive feedback about the changes they had already seen. One relative said, "It's been much better the last few months".

However, we also found that the process of bringing about the changes that were needed had made some people fearful and we found that the culture was not open and people, especially staff, were afraid to speak out and voice their views. This feedback related to one of the directors who was often at the service and occasionally worked on shift themselves. One staff member said, "I don't agree with the way [the director] shouts at some of them [staff]". Some staff were reluctant to speak with us with two asking to speak 'off the record'. We received comments such as, "I want to keep my job" and "I want to keep working here". One person said, "Nothing's been said that's ever upset me. I like it here and I want to stay. I've got to be careful here".

We discussed this concerning feedback with the manager who confirmed that staff had been shouted at by the provider. They explained, "I'm not going to say [they] haven't shouted because [they] have…. [They] shout to get things done". We appreciated that the provider had challenged poor practice and had tackled an unhealthy staff culture and this will always be difficult. However, in dealing with staff in this way a fearful culture had grown and people did not feel they could be open and honest. The provider needed to ensure that the service was more inclusive with staff and those using the service being consulted about changes in a more effective way. Staff needed to be enthused to take on the new values the provider was seeking to

instil in the service. Both the directors of the business were very passionate about the service and we did not doubt their sincere intention to bring about improvements to benefit the people who used the service. We did however question their methods.

We saw that the manager had implemented a new system of audits and checklists to ensure the quality and safety of the service. We found that the audits themselves were comprehensive. The manager was clear about which areas of the service to focus on but issues had not always been followed up. The faults with the fire alarm system and the very hot water had been identified but no action taken The routine maintenance checks had not always been carried out and the lack of an effective audit meant that people were placed at risk. The poor management of food and fluid recording meant some people could be placed at risk of not eating or drinking enough. Pressure care checks had not been carried out regularly. Audits had not identified these threats to people's health and wellbeing.

We appreciated that the manager and new provider had a very large task ahead of them when they started to make improvements to the business. We had confidence that the issues we raised would be responded to appropriately. Some new reporting systems had been introduced such as a monthly report highlighting anybody who had had a weight loss of more than 2kg. The manager admitted that recordkeeping needed to be further improved. Duplication and contradictory information made it difficult for staff to ensure they had all the current information they needed to support and care for people. We could not always be assured that reports, such as the monthly weight loss report, reflected accurate information.

The new provider was clearly dedicated to improving the lives of the people who lived at Lower Farm. Investment had already been made to improve the physical environment and this change, and others, were recognised and appreciated by the people who used the service, relatives and staff.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider did not ensure that care and treatment met people's needs. Regulation 9.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider did not ensure that people had given their consent to care and treatment. Regulation 11.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not ensure that risks to health and safety has been assessed and action taken to mitigate these risks. Regulation 12.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The provider did not ensure that people's nutritional and hydration needs were met. Regulation 14.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider did not ensure there were

Treatment of disease, disorder or injury	sufficient numbers of suitably qualified, competent, skilled and experienced staff. Regulation 18.