Ms Catherine Blyth

Feng Shui House (Blackburn)

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This comprehensive inspection took place on 1, 2 and 3 August 2018. The first day of the inspection was unannounced. At the last comprehensive inspection on 19 February 2018, we found the provider was meeting all the regulations we reviewed.

Following the inspection in February 2018 we received concerns regarding the management of risks. The team therefore inspected the service on 14 May 2018 against two of the five questions we ask about services: is the service safe and is the service well–led? The inspection revealed that improvements needed to be made to the processes in place when people were unable to consent to taking their prescribed medicines and in pre-recruitment checks the provider made for care staff.

At the May 2018 inspection the rating for the key question - is the service safe? had deteriorated to 'Requires improvement' but the overall rating for the service remained 'Good'.

This inspection on 1 August 2018 was undertaken to check on concerns we had received about the service in relation to people's safety and moving and handling practices and inappropriate care planning. We conducted a comprehensive inspection so that we could ensure that people were safe and to re-inspect the service and provide a new rating.

Feng Shui House (Blackburn) is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided and both were looked at during this inspection. Feng Shui House accommodates up to 16 people. On the day of our inspection there were 12 people using the service.

The registered provider was an individual who also managed the home on a day-to-day basis. Registered providers 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. As the registered provider was also responsible for managing another care home, they were supported in the day-to-day running of the home by a deputy manager.

During this inspection we found that the service was in breach of regulations under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The breaches were in relation to care planning and risk assessing and a series of other safety issues; including poor moving and handling practices and poor medicine's control. This meant that people were at risk from injury. We also found that the service to be in breach of five other regulations These breaches were in respect of a lack of person centred care, failure to obtain consent, inappropriate supervision and support of staff, the employment of fit and proper persons and failures to demonstrate oversight and compliance with the regulations by the registered provider. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals are concluded.

Care plans did not always accurately reflect people's current needs and had not been sufficiently reviewed. Assessments of people's needs did not direct staff on how to manage potential risk or how best to support people. Advice and input from external healthcare professionals had not been included in care plans or passed on to staff and had not been followed. Risks or hazards within the environment had also not been considered.

A bedroom shared by two people was dirty and required immediate attention and a thorough clean to prevent the risk of infection.

Medicines were not always stored safely and there was concern over the absence of policies around the use of covert medicines and medicines that were provided on an 'as required' basis (PRN).

Inspectors had to intervene with one person who was being helped to eat unsafely and not consistent with the direction from health care professionals.

People had access to harmful substances in an open room and the kitchen was left open with a hot pan on the stove.

Clinical waste was stored in bags and not in bins in an area outside of the home that meant that it was unsafe for people to access that area.

A communal upstairs bathroom window was not restricted and could allow someone to fall and injure themselves and the hot tap water temperature was too hot and presented as a risk of scalding to vulnerable people.

Recruitment systems and processes were not sufficiently robust to ensure appropriate staff were employed to work with vulnerable people. When employing people, we noted that the registered provider had not undertaken sufficient enquiry of previous employers in health and social care.

Consent had not been sought for CCTV monitoring and recording within the home and some elements of the care and support that was being provided was not person centred. People's consent was not always obtained, and management and staff had misunderstood legislation around this.

Some members of the care staff team were unaware of safe moving and handling techniques and, on occasions, inspectors and external specialists had to intervene to prevent unsafe practices from continuing. Staff training around these matters was poor and some staff hadn't been trained at all. Records showed and staff confirmed, that they did not have access to regular training organised by the registered provider. Most staff had commenced their national vocational qualification (NVQ) and this was the only training some staff had accessed. Staff did not have access to regular formal supervisions and appraisals.

Although all the people we spoke with told us staff members respected their privacy, we noted some practices that did not respect privacy and dignity especially when personal care was being provided in a shared room setting. The registered provider purchased some screens during the inspection but these were not in use before the inspection. We did observe staff knocking on people's doors before entering.

We had concerns during this inspection in relation to the day to day running of the service and governance provided by the registered provider. Records that should have been in place did not exist and the registered provider lacked an understanding of the regulations and their responsibility to meet them. There was a lack of monitoring of the service and issues and concerns we raised during our inspection had been missed by

the registered provider and senior management staff.

All the people we spoke with told us they felt safe living at Feng Shui House (Blackburn). Relatives were happy with the care and support their family members received.

People we spoke with made some positive comments about the staff team and the care and support they received. We also observed good interactions with people from staff members.

People had access to regular activities to prevent them from becoming bored and in order to stimulate them. Although there was no activities programme, we saw staff engaging with people with meaningful activities throughout the inspection by playing games and quizzes. We also saw photographs of celebrations in the home and special occasions.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measure will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe and there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months. This service will continue to be kept under review and, if needed, action could be escalated to incorporate urgent enforcement to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

Some aspects of the service were not safe.

Action had not always been taken to support people where risks to them had been identified.

People were receiving their medicines as prescribed by health care professionals but their medicines were not always stored safely.

Appropriate recruitment checks did not always take place before staff started work.

The registered provider had not assessed and considered the risks to people within the environment, such as falls and scalding from access to the kitchen.

Individual risk assessments for people, such as falls, had been completed but these had not been updated when risks changed.

There was a lack of suitably trained, competent and skilled staff on duty.

There were arrangements in place to deal with foreseeable emergencies.

Is the service effective?

Requires Improvement

Some aspects of the service were not always effective.

The lack of training for staff in important areas placed people using the service at risk of poor care and support.

The registered provider had an understanding of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) but did not always act according to this legislation when dealing with issues of consent. They did not always follow guidance in the MCA Code of Practice.

People were not always protected against the risks of inadequate nutrition. Where people were losing weight, arrangements such as monitoring were not always followed.

People had access to a GP and other health care professionals when they needed them.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy was not always respected. Some people were not always shielded from others when receiving personal care.

CCTV monitoring and recording was in place in a part of the home that should have received the consent of people using that area.

Confidential documents were left in communal areas and inspectors had to ask for these to be moved during the inspection.

People using the service and their relatives were provided with appropriate information about the home before they moved in.

Staff were seen to knock on people's doors before entering.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans did not included details of people's up to date health conditions.

On occasions there was a lack of a person-centred approach to care and support.

We observed that activities were available to people throughout the three days of our inspection.

The service supported the use of technology to assist and support people.

Is the service well-led?

Inadequate

The service was not well-led.

Whilst the registered provider was knowledgeable about the people who used the service and their needs, we found they lacked understanding around the regulations and their responsibilities to ensure these were met.

The registered provider had failed to send a notification to the

CQC that was a legal requirement.

The audits and checks that were in place were not picking up the issues seen at the inspection.

People and staff were not involved in providing feedback so that the registered provider could monitor the service and make improvements.

Feng Shui House (Blackburn)

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 1, 2 and 3 August 2018 and the first day was unannounced. On the second and third days, the service was aware we would be returning.

The inspection team consisted of two adult social care inspectors and an assistant inspector.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give us some key information about the service, what the service does well and improvements they plan to make.

Before the inspection we received notification information of concerns around moving and handling practices at the home. We also reviewed the information we held about the service such as notifications, complaints and safeguarding information. We obtained the views of safeguarding and contract monitoring team and local commissioning teams.

During the inspection, we used a number of different methods to help us understand the experiences of people who lived in the home. We carried out observations in the communal areas of the service and undertook a Short Observational Framework for Inspection (SOFI) during the lunchtime period. A SOFI is a specific way of observing care to help us understand the experience of people who used the service who could not talk with us.

We spoke with five people who used the service, four relatives and three external professionals. We also

spoke with the registered provider, area manager, deputy manager, four care staff and a cook.
We looked at a sample of records including six people's care plans and other associated documentation, three staff recruitment and induction records, staff rotas, training and supervision records, minutes from meetings, complaint's and compliment's records, medication records, maintenance certificates, policies and procedures and quality assurance audits.

Inadequate

Is the service safe?

Our findings

During our focussed inspection of 14 May 2018, we had concerns about processes when people were unable to consent to taking their medicines and the pre-recruitment checks the registered provider was making for care staff before they were employed. We looked at this again during our inspection and found improvements had not been made.

During our inspection, some people's medicinal creams were not in their own rooms but in other bedrooms. In one bedroom we noted on all three days the cream remained in the wrong room despite each day informing the area manager. There were no body maps in place in people's rooms to show staff where to administer creams. Some creams required storage below a certain temperature and were in bedrooms. This meant the service could not be sure they were stored safely.

Other medicines were not always managed safely. Staff administered medicines to some people hidden in food or drink. However, instructions from a local pharmacy for staff on how to give medicines covertly had only been provided in the week before the inspection. Although the practices around covert medicine's administration were safe at the time of the inspection, practices before then were without guidance and there had been no policy in place to assist staff.

Staff recorded the temperature of the room where controlled medicines were stored to ensure that they were within a safe range. However, most medicines were stored in a trolley in the main hallway of the home. Temperatures were not being monitored in this area and during the course of the inspection the temperature in this area was seen to exceed 27°C. We noted that most of the medicines contained in the trolley required to be stored below 25°C. We brought this to the attention of the area manager who immediately arranged for an air conditioner to be placed in the hallway and for temperatures in the area to be monitored and recorded. A failure to ensure that medicines were kept within a safe range of temperatures may mean that they lose their efficacy.

We looked at the medicines administration records (MAR's) of four people using the service. These included the person's photograph, details of their GP and any allergies they had. Staff had signed the MAR's confirming that they administered medicines to people using the service. The MAR's also recorded when staff had applied prescribed creams.

During the inspection we sat in the lounge to observe the moving and handling techniques being used by staff. We observed a staff member attempting to support someone to move in an unsafe way and had to ask them to stop. During the observations we also saw one person that used a walking frame when mobilising. We noted that the frame was moved away from the person and put in the corridor and on a separate occasion we found the frame in the person's bedroom whilst the person was elsewhere in the home. We had to ask for this to be given to the person to maintain their safety should they wish to mobilise. We looked at this person's care records and found they had sustained a total of 13 falls since 6 December 2017. One of the falls resulted in a fractured hip that required an operation and a stay in hospital. Since returning from hospital in February 2018 the person had a further nine falls. There was a risk assessment in place which

highlighted falls as a risk but this had not been reviewed since March 2018 and did not direct staff as to the action needed to mitigate the risks of further falls. The mobility care plan did not direct staff on the level of support staff needed, how to support or when aids such as sensor mats were to be used. The care plan had not been reviewed since February 2018 and did not reflect the further falls the person had sustained.

During consideration of this person's care file, we saw reference to a 'bleed on the brain'. There was no further reference to this condition. We enquired of senior staff about this and was told that the service had no further information as the person's family had dealt with the matter. We enquired of the person's relatives who told us that the home had dealt with the matter and staff from the home had taken their family member for a scan at a local hospital when the injury had been diagnosed. We discussed this with local authority safeguarding team and they established information at the home that supported that the home was involved in the diagnosis. They were satisfied that care plan documentation had been adjusted to reflect the home's involvement and the person's injury was detailed. This ensured that staff were aware of the matter and could support the person safely and effectively.

During our observations at the inspection, we noted one person was sliding out of their chair. A staff member approached them and the person requested to use the bathroom. The staff member brought a stand hoist to assist the person out of the chair. It was evident that the staff member did not know how to correctly use the equipment. For example, the staff member attempted to put the sling hooks on the wrong way around. A moving and handling assessor from the local authority intervened to ensure safe use of the equipment. The person became resistant and refused to use the hoist so the manoeuvre had to be stopped. The staff could not explain how they were going to support the person to access the bathroom. The person remained in the chair for in excess of three hours until moving and handling techniques were successful; this was through the support of the moving and handling assessor and new equipment they provided.

We also observed the same person had slippers where the sole was coming loose, and their foot was not fitting safely. This person had a walking frame which staff took out of the lounge and placed in a corridor, despite care records alerting staff that the person would attempt to get up and mobilise unaided. Care records we looked at showed that this person was mobile with walking frame. However, the person needed the use of a hoist for personal care and assisting into bed. None of the care records we looked at showed the need for this or the type of hoist and sling to be used. The moving and handling assessor told us the hoist was previously unable to go under the bed due to the bed design; they had brought this to the attention of the registered provider who arranged for a replacement bed. The moving and handling assessor also showed us that the hoist could not be positioned into the shower area and staff had informed them they were using a commode in the shower area to undertake personal care. This meant the person did not have suitable access to a shower.

Care records for another person showed they were able to walk short distances with a walking frame and staff were assisting them into bed with a turn table and handling belt. However, during our inspection it was necessary for the moving and handling assessor to recommend that a specific hoist and sling were used as the person was unable to weight bear. Care plans we looked at in this case had not been updated or reviewed since 21 December 2017 they did not refer to any specialist input in moving and handling and there were no referrals to specialists around these concerns. This placed the person and staff members at risk of inappropriate and unsafe moving and handling procedures.

We looked at how people were supported with their dietary and nutritional needs. During our inspection we noted one person was titled back in a chair whilst being supported to eat their breakfast. We asked two staff members why they were supporting them to eat in such a compromising position and they were unable to clarify why. We spoke with the area manager who stated it was due to the person's posture and it was easier

to support them in that position. We asked the area manager to ensure this practice ceased with immediate effect due to the risk of choking. We checked records that were in place from the speech and language therapist, these clearly stated that the person must be supported to eat and drink as upright as possible. This meant the practices the service were using was against specialist advice and exacerbating the risk of choking.

We saw that some people were weighed on a monthly basis. However, one person's weight records showed they had been gradually losing weight over a period from 14 April 2017 to 17 July 2018. On the 22 December 2017 it was documented the person required weighing on a weekly basis; records showed this did not occur and monthly weighing continued. On 4 June 2018 and 17 July 2018, it was documented to 'monitor' the person's weight. There was no explanation of how this was to be done. Another person's weight record showed they had lost 4kg in a month. Again, it was documented to 'monitor' weight with no explanation of how and when to do this. On a third person's weight records these again showed the person was losing weight. However, in this case the service had involved the GP and dietician. Care plans and risk assessments in relation to all of these people had not been reviewed and did not evidence any action being taken to address weight loss. This meant people were at risk through malnutrition.

We looked at how accident and incidents were being managed within the service. We saw accident forms were not always completed when a person had sustained an injury or when an incident had occurred. For example, one person had sustained a total of 13 falls since admission to the service. The accident book had not been completed for these. Accident forms that had been completed for other people did not evidence any learning from these or actions taken to mitigate further risks.

There were environmental safety concerns at the home. Materials that should have been regarded as those that required precautions consistent with 'Control of Substances Hazardous to Health' Regulations (COSHH) were left accessible to people. The room used by the hairdresser was open to people when it was not in use and chemical products such as peroxide were left on a shelf accessible to people. We raised this with the registered provider who arranged for the materials to be locked away.

We noticed that there were a large number of clinical waste bags stored against plastic bins making the outside area unsuitable for use. The issue of inappropriate storage of clinical waste was raised on the first day of the inspection. The area manager told us that this waste was removed every four weeks by external contractors and this would be increased to every two weeks. On the last day of the inspection clinical waste was still located at the side of the bin and this was accessible to people who used the service and visiting children who had attended the home for a function.

During the inspection an inspector visited a shared bedroom and observed that parts of the room were unclean and presented a substantial infection risk. This was immediately brought to the attention of the area manager who arranged for the room to be thoroughly cleaned. We were told that there was a daily 'room cleanliness check' and outside of that check, it was up to staff to bring issues, such as that seen in the shared bedroom, to the attention of management.

There were other environmental safety concerns around the home. A communal toilet on the first floor was not fitted with a window restrictor. This could allow people to fall and injure themselves. In the same communal toilet, the hot water was too hot and not regulated so that it was safe for use by vulnerable people. During the inspection a window restrictor was fitted and the hot water to the bathroom was disconnected. Other water temperatures around the home were noted to be within in a safe range but there were no monitoring of water temperatures taking place in the home.

The kitchen of the home was a short distance away from the main lounge area and on the ground floor. It had recently been awarded a five-star rating for hygiene and cleanliness form the local authority. However, on occasions, during the inspection, we noted that the cook left the kitchen for short breaks. During these times the kitchen was accessible to vulnerable people without supervision. On one occasion we noted that the kitchen was left unattended with boiling pans on the stove. An inspector stayed in the kitchen until the cook returned and brought the issue to the attention of the area manager who immediately arranged for a lock to be fitted to the kitchen door.

Fire safety audits such as fire alarm emergency lighting and firefighting equipment checks were taking place every month. The alarm system and panel should have been serviced annually and this had expired in April 2018. The area manager assured us that this would be serviced within a few weeks of the inspection. Lancashire Fire and Rescue had inspected the home in June 2018 and had made a recommendation around enhancements to fire doors within the home. These improvements had been made at the time of our inspection.

People's Personal Emergency Evacuation Plans (PEEPs) were out of date and not reflective of people's mobility changes. Three people's plans were kept in a folder containing all the resident's plans who were no longer present at the home. Other PEEP's suggested a person was in a room they no longer occupied and on another floor and, in another, provided contradictory information about the physical support a person required in the event of an emergency. This meant that people were at risk in the event of a fire and the issues could cause confusion and delay in the event of an emergency. During the inspection the area manager reviewed PEEP's for every resident at the home. We considered these and were satisfied that they accurately reflected people's whereabouts and support needs in the event of an emergency.

These series of safety issues are a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the recruitment systems and processes in place to check these were sufficiently robust. There had been an issue at the last inspection in May 2018 around pre-recruitment checks. We looked at three staff personnel files who had been recruited since the last inspection in May 2018. Although we saw that everyone had been asked to complete an application form and the provider had requested enhanced disclosure and barring checks (DBS), the provider had not made sufficient enquiries of previous employers before employment in two of the three cases. This meant that insufficient checks had been made of previous employers in health and social care roles and the provider had not ensured they were employing staff suitable to care and support vulnerable people.

This issue is a breach of Regulation 19 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All the people who used the service we spoke with told us they felt safe. Comments we received included, "I am really safe here. There is always someone about day and night." One relative said, "Yes I think my relative is safe. They are in good hands as the staff are dedicated and very caring."

The home had a policy for safeguarding adults from abuse. The registered provider was the safeguarding lead for the home. Most of the staff we spoke with demonstrated a clear understanding of the types of abuse that could occur. They told us about the signs they would look for, what they would do if they thought someone was at risk of abuse and whom they would report any safeguarding concerns to. One member of staff told us, "I would report any concerns I had to the deputy manager or provider. They are always available." Staff were also sure of the correct reporting procedures. All the of the six members of staff we

spoke with told us they had received safeguarding training and said that they would have no hesitation about reporting concerns. They all said they would not know how to escalate any safeguarding concerns they had outside of the home.

At the time of this inspection there were two safeguarding concerns being investigated by the local authority. We could not report on these at the time of this inspection. The CQC will monitor the outcome of the safeguarding investigations and actions the provider takes to keep people safe.

At the inspection we considered records relating to the maintenance of equipment in the service. We noted that there were annual records of maintenance for moving and handling equipment such as hoists. We physically checked this equipment at the service and noted that they had all been examined or serviced in line with the Lifting Operations and Lifting Equipment Regulations 1998 and the associated Code of Practice.

We observed a good staff presence at the inspection and asked people who used the service if they felt there were enough staff on duty to meet their needs. Comments we received included, "There always appears to be enough staff." One relative said, "I've never known them to be short staffed and there always seems to be staff around to deal with the residents." We considered the staffing rota for the week of the inspection and the preceding week and were satisfied that there were sufficient staff on duty over the two week period.

There were contingence plans in place to deal with issues such as a loss of power. Contingency arrangements were in place to utilise sub-contractors and their details were available for staff to contact in the event of an emergency. We were told that if some people had to leave the home in an emergency, accommodation for some residents could be provided at a care home in the Blackpool area that was owned by the registered provider.

Requires Improvement

Is the service effective?

Our findings

One person using the service told us, "It's really nice here, the staff work very hard and they are always helpful. The food is great, whatever is on the menu is always lovely." A relative said, "The staff seem to know what they are doing. My relative is well looked after." Despite these positive comments our findings did not indicate that the service was effective.

We have already commented in the 'Safe' section of this report around our concerns on the unsafe moving and handling practices at the home at the time of the inspection. During the inspection we spoke with two members of staff about this. They both told us that they did not feel confident around the use of moving and handling equipment and would prefer more information and practical training on the use of equipment such as hoists and slings. One member of staff described the moving and handling training they had received as 'poor'. Another said, "I would prefer more information about the use of hoists and slings." We looked at the training matrix provided by the area manager and noted that nine staff out of the 16 employed at the service had been formally trained around moving and handling but this training was not practically based.

We looked at other areas of training and noted that there were significant gaps around essential training for care staff. Eight out of 16 had been trained in dementia care. Three out of 16 had been trained in assisting people with eating and drinking, hydration and nutrition. Four out of 16 in falls prevention and one out of 16 in the completion of risk assessments. One member of staff who had been employed in the service for a significant period of time expressed a concern about their understanding and implications of the Mental Capacity Act 2005 and said that they had not received any training around this. We considered the training matrix and noted that seven out of 16 staff had received mental capacity training and nine out of 16 training on Deprivation of Liberty Safeguards (DoLS).

Supervision and appraisal records we considered showed staff were not in receipt of regular supervisions or appraisals. Supervision contracts that some staff had signed, stated they would receive supervision three times a year. However, we looked at the supervision records for 10 staff members and found three staff had not had any supervisions and four staff had only had one supervision session in over 12 months. One member of staff was not sure about whether they had had an annual appraisal of their work performance and the documents we saw supported that appraisals were not being completed. The lack of regular supervisions and appraisals does not support or encourage staff in their roles. There were also substantial risks that management were unaware of the limitations of staff, as concerns around safe practice and lack of knowledge were not being discussed.

Staff were not working within their scope of training and experience. There was also a lack of formal supervision. These issues are a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

At the time of the inspection, local authority specialists in moving and handling were present, and we observed staff engaging meaningfully with them in the use of equipment such as hoists and slings and in

safe techniques in supporting people around these issues.

Staff said they had completed an induction when they started working at the home. One member of staff told us they were shadowed by experienced staff as part of their induction before they were permitted to work alone. Four care staff we spoke with all said that the registered provider encouraged and supported them to complete nationally recognised health and social care qualifications such as NVQ's.

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. The registered provider and area manager demonstrated an understanding of the MCA and DoLS. They said that there was a mix of people who used the service with some people who had capacity to make some decisions about their own care and treatment and others who had either no capacity or fluctuating levels of capacity to make decisions. Although we noted that DoLS applications had been properly made and any authorisations were being correctly adhered to, some practices in the home were not consistent with the MCA and the associated Code of Practice.

There was CCTV coverage in and outside the home. We noted that there was a sign near the front door warning of this and that generally the cameras' coverage was of entrances and exits to the home. However, there was an area of the home that was being monitored by CCTV and recordings were being made without the appropriate consent. The hairdressing room was monitored and neither the hairdresser nor people using the facility were aware of this practice. The registered provider said that the system was in operation because of thefts of hairdressing products and that everyone involved had consented to the process. We spoke with people and their relatives during and after the inspection and established that this was not the case and no one other than management were aware of the monitoring. One relative approached us during the inspection and said that they had spoken with the registered provider and had just been told of the monitoring and recording and had no concerns and had provided 'consent' to the process during the inspection. We established that the person who used the service had capacity to make a decision and that they had not been consulted about the process. The monitoring and recording of the hairdresser's room was stopped during the inspection.

We noted that one person had capacity to make decisions but that their care plan noted that all aspects of their care and support had to be consented to by a designated relative. This included the taking of photographs and other specific care and support issues. This practice was inconsistent with the MCA and Codes of Practice. These concerns were brought to the attention of the registered provider during the inspection and the care plan was amended to reflect that the person insisted that their relative was contacted about 'every aspect of care'. Even though the care plan was amended so that staff were aware of the need to consult the person they were supporting, there were other issues relating to authority and consent that demonstrated that there was a misunderstanding in the service around consent and the implications of the MCA.

We saw that mental capacity assessments were completed and contained in people's care plans. These

were general assessments and were not relevant to specific decisions. During the inspection the area manager accepted that the assessments needed to be decision specific and that some people in the home who had capacity issues, could make decisions about some matters but needed assistance with other more complex questions. They said that they would review all of the capacity assessments to reflect individual's personal circumstances and to ensure that staff were aware of the specific abilities of people they cared for and supported. We saw an example of a revised assessment completed by the area manager and noted that it specified the person's ability to make specific decisions, what assistance they required and how staff should consult with them and their relatives, if appropriate, and the relevant health and social care professionals in making decisions for them in their 'best interests' in line with the MCA.

The concerns over people's consent to processes are a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We saw Do Not Attempt Cardio-pulmonary Resuscitation (DNAR) forms in some of the care files we looked at. A DNACPR decision form in itself is not legally binding. The form should be regarded as an advance clinical assessment and decision, recorded to guide immediate clinical decision-making in the event of a patient's cardiorespiratory arrest or death. However the process for completion must be correct otherwise the form can be deemed invalid. The final decision regarding whether or not attempting CPR is clinically appropriate and lawful rests with the healthcare professionals responsible for the patient's immediate care at that time. These had been fully completed, involving people using the service, and their relatives, where appropriate, and signed by their GP.

We found there was clear and frequent communication between care staff and the kitchen regarding people's dietary preferences and requirements. We spoke with the cook. They showed us documents which alerted kitchen staff to people's dietary risks, personal preferences and cultural and medical needs. The cook said they accommodated people's personal preferences by offering range of choices each meal time. For example, they cooked separate meals if people requested one that was not on the day's menu. We also noted that the kitchen was clean and well-kept and had been awarded a five-star hygiene rating from the local authority.

We observed how people were being supported and cared for at lunchtime. A daily menu was available for people to make their choices from. One person using the service told us, "The food is great. Nice meals." Another person told us, "The food is like home cooking. You can ask for what you want to eat." Some people required support with eating and some ate independently. The atmosphere in the dining room was relaxed and not rushed and there were enough staff to assist people when required. During the inspection we saw that they received hot meals and drinks in a timely manner. We saw that people were also provided with drinks and snacks throughout the day.

People were supported to maintain good health and had access to health care support. Where there were concerns, most people were referred to appropriate health professionals. A GP told us they visited the home regularly to attend to people's needs. They told us the home was supporting people properly and meeting people's needs. They said that staff followed people's care plans and actively sought advice from health care professionals when they needed it.

Requires Improvement

Is the service caring?

Our findings

One person using the service told us, "The staff are definitely caring. I can't say anything bad about them." Another person said, "I cannot knock the staff but they are always very busy." A relative told us, "This is a lovely place. We are always made to feel welcome. My relative is really well looked after." However, we saw some instances of undignified care. Throughout our inspection we were concerned about people's privacy and dignity. En-suite bathrooms in shared rooms, including some toilets and showers, were exposed and did not promote the privacy or dignity of people. People who were sharing bedrooms did not have access to any form of screen to separate the room when personal care was being undertaken. There was an absence of any consideration towards consultation with people and their relatives when people were sharing bedrooms. A member of staff said, "At the moment the sharing of rooms doesn't work."

During the first day of the inspection we observed that people's confidential health records had been left open and on display in a communal area. There was also an unlocked container that contained people's private records. We raised this with the deputy manager straight away and the documents were moved to a secure location in the main office.

We did witness examples of good care from staff and saw that in most cases people were treated with understanding, compassion and dignity. For example, we heard a member of staff in the lounge area supporting a person using the service who was crying. They stayed with the person, showed a very caring comforting attitude and asked them if they wanted a drink. We also observed other staff actively listening to people and encouraging them to communicate their needs.

Information contained in the care files indicated that people using the service, their relatives and appropriate healthcare professionals had been involved in the care planning process. A relative told us, "This is a very good care home. We looked at lots of places before we decided on Feng Shui." A visiting health care professional told us they had no concerns about how staff were supporting people using the service and said, "The staff are caring, this is one of the better care homes I have been to."

People using the service and their relatives were provided with appropriate information about the home in the form of a user's guide. This included the complaint's procedure and the services they provided and ensured people were aware of the standard of care they should expect. The area manager told us this was given to people and their relatives when they started using the service.

We reviewed how the service ensured that people were treated with kindness, respect and compassion and that they were given emotional support when needed. People spoken with made some positive comments about the staff team and the care and support they received. People who used the service told us that staff were kind and caring. Comments we received included, "Very nice" and, "Yes they are kind." One relative we spoke with told us, "Yes they are definitely kind and caring." Relatives spoken with also confirmed there were no restrictions placed on visiting and they were made welcome in the home.

If people could not express their view the home ensured that the person's relative was involved. We noted

that on the occasions when relatives or other supporters were unavailable, people had access to a professional representative who acted as an advocate. An advocate is a specially trained person such as an Independent Mental Capacity Advocate who can help if a person does not have capacity to make particular decisions and would benefit from having an independent 'voice'.

Requires Improvement

Is the service responsive?

Our findings

People using the service and their relatives told us the service met their care and support needs. One person who used the service told us, "I receive good care from staff. If I need anything I just ask. There is always something going on." A relative told us, "My relative is happy here. They are happy with the staff." Despite these positive comments we found that some aspects of the service were not always responsive.

The registered provider said that people's needs were assessed and care and support was planned. We also saw that care and health assessments were undertaken to identify people's support needs before they moved into the home. The registered provider and area manager told us that care plans and risk assessments were developed using the assessment information. However, care plans did not always include information and guidance to staff about how people's needs should be met and care was not always delivered in line with their individual care plans. The plans should have been regularly reviewed but in three of the care plans we looked at, they had not been reviewed at all and in one file the last review was in February 2018. That review did not reflect changes to the person's care and support needs as a result of a number of falls. In addition, related risk assessments had not been reviewed or updated.

Some people shared bedrooms in the home. We noted that two people with limited mental capacity shared a room and there was no documented consideration towards the propriety of these people having a room together. Neither person knew the other before they started to use the service. When we spoke with relatives about this, they said they were not consulted about the safety and social aspects of the proposal to share a room. They were told that a room was available without any thought or consideration towards best interests of either service users. Staff told inspectors that one of the people in the room rarely slept and was up most nights. We were told that the other person was less mobile and needed support of a walking aid. There appeared to be an incompatibility in conditions and characters between the two 'room-mates'. Neither of their care plans or risk or support assessments supported that any consideration had been given towards putting the two together in their best interests and in accordance with person centred considerations.

There was an absence of privacy and dignity when people shared a room with another service user. Some toileting facilities were 'open plan' and exposed and there was no privacy screen to shield service users when care staff were performing personal care. When we raised this with the area manager, privacy screens were brought into the service during the inspection.

We noted one person was struggling to communicate with staff due to being unable to hear. We looked at their care records and found they had a hearing impairment. The area manager told us the use of hearing aids had been unsuccessful. We enquired how the service was actively engaging and communicating with the person as it did not appear anything was in place. We were informed a journal was used that staff used so they could communicate with the person. This was not in place and we were not provided with the journal during our inspection. We explained the importance of being able to communicate with people to the area manager who told us they would ensure a journal was put in place.

These issues demonstrate a lack of a person-centred approach to care and support and are a breach of

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

People using the service and staff told us the home had had a series of parties to commemorate a Royal Wedding and a special occasion for a resident. We saw records that included photographs of people from the home partaking enthusiastically in the activities. There were balloons, sandwiches and cakes on tables. One person said, "We have parties and had one last week. We all enjoy getting together and talking about the past." The deputy manager said, "We get good support from the provider to plan activities. This is one of the things that I am particularly proud of."

Although the home did not employ a designated activity co-ordinator, during the inspection we saw an activities program for people using the service that included bingo, pampering sessions and a sing-song. We saw staff engaging with people and saw them reading a book to one person and engage them in a conversation about their life history. We also saw staff visiting people in their rooms when they were bed-bound.

We observed people using the service and local students partaking in reminiscing sessions. The students also built an outside bench for residents to use and the deputy manager told us that they had been visiting regularly and had been involved with various planned activities. One person said, "I love that the children come to the home and show an interest." Another person said, "There are a few things going on and I can do them if I want to."

People using the service and relatives said they knew about the service's complaints procedure and they would tell staff or the provider if they were unhappy or wanted to make a complaint. They said they were confident they would be listened to and their complaints would be fully investigated and action taken if necessary. We saw copies of the complaint's procedure displayed in the home. One person using the service said, "I would raise my concerns with the provider if I had any. I am confident they would deal with them properly." We saw a complaint's file that included a copy of the provider's complaint's procedure and forms for recording and responding to complaints. Complaints' records showed that the home had not received any complaints since the last comprehensive inspection in February 2018.

The service supported and encouraged the use of technology to assist and support people. During the inspection we saw the use of technological aids to assist staff to support people such as the use of monition sensors to assist in the prevention of falls. We also noted that staff had access to walkie-talkies and one staff member said, "These help us to deal with people quickly and make sure that the right number of staff are available to support people."

The provider had an accessible information policy covering the requirements of the Accessible Information Standard. The Accessible Information Standard was introduced by the government in 2016 to make sure that people with a disability or sensory loss are given information in a way they can understand. NHS and adult social care services are legally required to follow this standard.

In line with this standard, the provider had ensured that most policies relevant to people who used the service such as the complaints' policy, had been provided in accessible way. This was often through a person's relative. The area manager said, "We would always ensure that any individual who had any form of communication barrier or difficulty would be provided with as many alternate methods of communication as is possible to ensure clear understanding of all aspects of their care, promoting involvement continually."

Inadequate

Is the service well-led?

Our findings

People and their relatives spoke positively about the registered provider and staff. One person told us, "I can access the provider anytime I want to." A relative said, "The provider and deputy manager are excellent and know what is required. However, despite this positive feedback we found that aspects of the service were not well led.

The provider's systems for assessing, monitoring and improving the quality and safety of the services that people were receiving were not always effective. Some audits were carried out of people's care files but none of these audits had identified shortfalls in recording, assessments or planning that we found at the inspection. For example, the failure to correctly monitor people's weight and take appropriate action was an issue that effective monitoring should have established and action could have been taken to resolve the matter before the inspection. There was an absence of safety checks relating to temperature monitoring with medicines and management oversight of the concerning condition of people's rooms was absent. There was also an absence of environmental checks that could have established the environmental safety concerns that we saw at the inspection such as the COSHH materials. These were available to people in the open hairdresser's room and the kitchen.

The home's documented policy suggested that infection control checks should have been taking place on a weekly basis. The document had been altered to show that monthly checks were taking place but we noted that a check hadn't taken place since March 2018.

Significant lapses in training of staff had been allowed to continue and there was a concern that some staff may have been employed inappropriately and without the required regulatory checks to ensure that they were safe to deal with vulnerable people. There was a complete absence of any checks or reviews around these areas of concern.

Whilst the registered provider was knowledgeable about the people who used the service and their needs, we found they lacked understanding around the regulations and their responsibilities to ensure these were met. For example, a person sustained a significant injury in the home in January 2018 that required to be reported to the CQC. This legal notification had not been made and the registered provider had not fulfilled their regulatory obligations around this significant incident. We found that the registered provider had notified CQC of other accidents, serious incidents and safeguarding allegations, as they are required to do. This meant that in those cases we were able to see if appropriate action had been taken to ensure people were kept safe.

The registered provider had allowed their staff to support people inappropriately around moving and handling and had not provided effective and practical training to ensure that people were supported safely consistent with best practice. Although, generally, staff praised the registered provider, some said that they weren't confident around some areas of practice and that they hadn't received formal supervisions and appraisals where these issues could be discussed.

Staff told inspectors that there wasn't a routine of regular staff meetings and in the last meeting before the inspection in May 2018, the registered provider only discussed postings on social media. There was no recorded discussion around any concerns or needs staff had and any issues with people who they were supporting. Significantly, there was an absence of any records supporting that incidents and accidents involving people in their care were discussed with staff.

Staff said that they had raised issues with the registered provider in relation to people's privacy and dignity that is reported in the 'Caring' section of this report but action had not been taken. With regard to the privacy issue with showers, one member of staff said, "They have been raised as issues for a while but its only after all this with you (the CQC inspection) that they are doing something."

We saw that residents' meetings were held in February and June 2018. The meetings involved discussion about future activities at the home. However, the registered provider did not use the gatherings as an opportunity to seek input from people about facilities at the home, meal preferences, improvements, staffing issues or other concerns. We asked for records of the service seeking formal feedback from people, their relatives and visitors to the home such as surveys. However, there was an absence of any records of the registered provider seeking any feedback or views of people on what actions to take to improve quality. The absence of people's views and feedback meant that the registered provider was not evaluating ways to improve the service.

This series of governance issues were a breach of Regulation 17 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The failure to notify the CQC of a person's significant injury at the home in January 2018 is a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We spoke with the cook on most days of the inspection who said that when a new person started to use the service, they met with them to discuss their preferences and needs as far as food and hydration was concerned. They said that they were supported by the registered provider to provide high quality food and meals with a good range of choice and variation. The meals we saw supported this and people using the service were particularly complimentary about the meals at the home.

We asked staff how well they thought the registered provider communicated with them in relation to what was happening within the service. Comments we received included, "We usually have a regular talk in the morning and at night as a handover", "Everyday we get a handover from the night staff" and, "We have handover in the morning and they will tell us if there is anything going on." We asked staff how they would know what had happened in the service when they returned from annual leave; one person told us they would not know how to find out if another staff member did not tell them. We saw a number of policies and procedures were in place that had been developed by an external company. These were tailored to meet the needs of the service. However, three out of two staff members we spoke with told us they had not seen any policies and procedures or read them. Records should be available to staff members so they are up to date with necessary information about people at all times.

We noted that the service had received some compliments via an online service. We saw people had commented, ""Happy with everything. Lovely staff. Good food. Fantastic Care." And, "This is my second time in here. Happy with staff and food. Would not hesitate to come back." And, "My relative came to you for respite care in December. What a beautiful place you have the love and care my mother received was outstanding. You made their stay enjoyable. The room was tastefully decorated and the food was top class. We would not hesitate to contact you again should we need to. Thank you for everything you did for my

relative."