Flixton House Limited

# Flixton Manor

## Inspection report

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## Ratings

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

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

# Summary of findings

## Overall summary

This inspection took place on the 6 and 7 September 2016 and was unannounced.

Flixton Manor is registered to provide accommodation with personal care with nursing for up to 38 older people. At the time of our inspection there were 33 people living at the home, the majority of whom were living with dementia. Accommodation is provided over three floors, including a basement level, ground floor and first floor. All bedrooms are single occupancy. Newer bedrooms have an en-suite toilet. There are two communal lounges and a small dining area on the ground floor.

The previous inspection took place in September 2014. We found four of the standards we looked at were met; however we found care plans did not include written assessments of people's capacity to consent to their care and treatment at Flixton Manor. Following the inspection in September 2014 the provider wrote to us to tell us the action they intended to take to ensure they met all the relevant regulations. Part of this inspection was undertaken to check whether the required improvements had been made. We found improvements had been made in relation to undertaking capacity assessments for people living at Flixton Manor.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was due to retire shortly after our inspection. A senior carer who had worked at the home for many years had been appointed as the new manager and was applying to be registered with the CQC.

During this inspection visit we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, relating to recruitment processes, training and staff supervision, lack of staff interaction with people who used the service, assessments and reviews of care, managing complaints, meeting people's social needs and quality assurance and auditing systems. We also found breaches of the Care Quality Commission (Registration) Regulations 2009 relating to not submitting the required notifications to the CQC. A notification is information about important events which the service is required to send us by law.

Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

Everyone we spoke with said they felt safe living at Flixton Manor. They said the staff were kind and caring. Staff had received training in safeguarding adults and knew the correct action to take if they witnessed or suspected abuse. Staff were confident that the registered manager would act on any concerns raised.

Assessments of people's needs had been completed. However there were duplicated assessments and different assessment tools used for the same area of need resulted in different outcomes. Care plans and

risk plans were identified from the assessments. People's personal life history was not recorded. Staff did not have access to the care plans and relied on verbal information and their memory to know people's needs and preferences. People and relatives were not involved in the formulation or review of the care plans.

All the people living at the home required two staff to support them to mobilise and with personal care. The staff on duty were busy throughout the day. They did not have time to sit and talk to people. Some staff did not talk to people when providing support for example when supporting a person to have a cup of tea.

The home did not have an activities organiser in place. The staff did not have time to arrange activities for people to be involved in. Appropriate music or films were not played, the television being on low volume throughout our inspection. Reminiscence books were not seen. People were seen to be asleep or withdrawn throughout the inspection.

The staff recruitment process was not robust in ensuring suitable people were employed. Full employment histories were not recorded and two references were not obtained for each applicant. Staff did not receive supervisions and staff meetings were not held. The senior care worker had started to undertake staff appraisals and aimed to do these annually. Staff had received training in mandatory subjects such as manual handling and fire safety. Staff had not received any training in supporting people living with dementia.

We saw the first floor corridor was uneven and presented a trip hazard. The carpets were also rumpled. We saw items stored in the basement corridor outside one person's bedroom. There was only one shower available for people to use. The en-suite toilets were not large enough for people who needed to use mobility aids to access, therefore there was sometimes a queue to use the shared accessible toilets. The home was not decorated in a way to aid people living with dementia. Signage was not in place in the home. We have made recommendations about seeking best practice for facilities and decoration of the home.

Relatives and people said they were able to raise any issues with the staff or registered manager and were confident the issues would be dealt with. However one relative had asked for more activities for their loved one and this had not been actioned. We also saw the provider had not responded to complaints contained in the minutes of a safeguarding case conference.

The service had audit systems in place however they had not been robust enough to identify the shortfalls found during this inspection. The registered manager did not recognise the need for staff to be able to have sight of the care plans or for relatives to be involved in writing or agreeing them.

Medicines were administered and stored safely. People received their medication as prescribed. Guidelines were required for when 'as required' medicines needed to be administered where a person was not able to verbally inform staff themselves.

Systems were in place to help ensure people's health and nutritional needs were met. Records we reviewed showed that staff contacted relevant health professionals to help ensure people received the care and treatment they required.

We found the service was working within the principles of the Mental Capacity Act (2005). Capacity assessments were completed and applications for Deprivation of Liberty Safeguards (DoLS) were appropriately made.

All areas of the home looked clean. Procedures were in place to prevent and control the spread of infection. An infection control audit in June 2016 had identified areas for improvement and these were being implemented.

Contact details in case of utility failure were available. We have recommended best practice guidance is sought for formulating a written business continuity plan to deal with any emergency that could affect the provision of care. Regular checks were in place for fire systems and equipment.

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

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve.

This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

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

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

The recruitment process was not robust enough to ensure only suitable people were employed. Staffing levels meant the staff were task orientated and had little time to interact with people who used the service.

Risk assessments had been completed; however duplicate assessments with differing outcomes were seen.

People received their medicines as prescribed. Guidelines were needed as to when 'as required' medicines needed to be administered.

There were trip hazards due to the uneven floor on the first floor and rumpled carpets.

We have recommended best practice guidance is sought for formulating a written business continuity plan.

### Is the service effective?

**Requires Improvement**

The service was not always effective.

Staff received on-going mandatory training. New staff had not received training in a timely manner to equip them to undertake their role. Staff did not receive training in dementia care. Regular staff supervisions were not completed.

There were not enough available facilities for the number of people living at the home and the decoration of the home was not 'dementia friendly.'

Systems were in place to assess people's capacity to consent to their care and treatment.

People received the support they needed to help ensure their health and nutritional needs were met.

### Is the service caring?

**Requires Improvement**

The service was not always caring.

There was little or no interaction between staff and people being supported.

People's wishes for their care at the end of their lives were sought. Staff were trained in providing sensitive end of life care.

People and relatives said the staff were kind and caring.

## Is the service responsive?

**Inadequate**

The service was not responsive.

Multiple assessments were seen. Not all were fully completed and some were duplicated.

Staff did not have access to the care plans. All information was verbally given to staff.

Relatives were not formally involved in agreeing and reviewing care plans.

Few activities were arranged for people who used the service. They were seen to be asleep and withdrawn.

People and relatives said they were confident to raise any issues they had with staff or the registered manager. However complaints made through a case conference had not been responded to.

## Is the service well-led?

**Inadequate**

The service was not well-led.

Although some auditing systems were in place they were not robust enough to identify the issues seen during the inspection.

The Care Quality Commission had not been notified of incidents and deaths as required.

Staff said the registered manager was approachable and they enjoyed working at the home.

# Flixton Manor

**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 6 and 7 September 2016 and was unannounced. The inspection team consisted of one adult social care inspector and an expert-by-experience on the first day of the inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert had experience of services for older people. The adult social care inspector returned for the second day of the inspection.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law. We contacted the local authority commissioning and safeguarding teams as well as the local Healthwatch board.

We spoke with two people living in the home, three relatives, the registered manager (who was due to retire shortly), the clinical lead nurse, one registered nurse, a senior carer who was applying to become the registered manager and eight care staff. We also spoke with the chef, the head housekeeper and a visiting health professional. We observed the way people were supported in communal areas and looked at records relating to the service. These included seven care records, five staff recruitment files, daily record notes, medication administration records (MAR), maintenance records, audits on health and safety, accidents and incidents, policies and procedures and quality assurance records.

Requires Improvement

# Is the service safe?

## Our findings

Everyone we spoke with said they felt safe living at Flixton Manor. One person said, "It's alright here". A relative told us, "I believe this is a very safe place. All the residents are checked every two hours; day and night" and another said, "I am delighted with the quality of care [name] receives here."

We received mixed feedback about the number of staff on duty each day. One person said, "I don't think there is a shortage of staff, but they could always benefit from more." However a relative told us, "Most of the time there is not enough staff. [Name] has to wait over 30 minutes to be taken to the toilet." A resident we spoke with told us they also had to wait to be supported to go to the toilet as the staff were busy. Our observations throughout the inspection were that staff were very busy attending to people's needs. They were task orientated and had little time to engage with people and talk with them. 29 people living at Flixton Manor required two staff to support them to mobilise, go to toilet, shower or get dressed. One staff said, "We don't get much time to sit and talk with service users; we talk with them as we are passing." One person said, "Some of the staff take the time to sit and chat with me, but not very often."

We looked at the rotas for a two week period for the home and found staffing levels to be inconsistent. On ten days there were five care staff, a nurse and the clinical lead nurse on the rota each morning. Four days had six care staff on the rota to work in the morning. On ten days in the afternoon there were five care staff rota'd to work, a nurse and the clinical lead nurse. However on four days there were four staff on the rota. At night there were two care staff and a nurse on duty. We were told that one staff member was always present in the lounge area of the home. However throughout the inspection we observed this was not the case. All staff were supporting people or administering medication and so were passing through the lounge but were not present to support people or engage with them. One staff member said, "We need six care staff as we are now getting full." We saw the care staff respond to the call bells in a timely manner.

On the first day of our inspection there were five care staff and the clinical lead nurse on duty. The staff were busy supporting people to get up in the morning. The clinical lead nurse was administering medication and so was in and out of the lounge area and also taking medicines to people's rooms. This meant breakfast was not served until after 10am. Some people had got up before 7am and had been provided with one cup of tea before their breakfast was served. On the second day of our inspection there were six care staff, a nurse and the clinical lead on duty and breakfast was served at 9am.

This meant that people sometimes had to wait for support as the staff were busy supporting other people. Staff were also very task orientated as they did not have the time to sit and talk with people. The senior carer told us when they had been appointed to be the new registered manager they had requested that there were six care staff on the rota each morning and five staff in the afternoon and the provider had agreed. The senior carer was in the process of recruiting more staff to enable this to happen. We will check to ensure this has happened at our next inspection. The service did not use a dependency tool to determine the number of staff required based on the needs of the people living at the home.

We found the current staffing levels to be a breach of Regulation 18 (1) of The Health and Social Care Act

2008 (Regulated Activities) Regulations 2014.

We looked at the procedures in place to help ensure staff were safely recruited. We looked at five staff personnel files. We saw a completed application form was in place. However the form did not detail the applicant's full employment history. It asked for the most recent employer and one other employer. In one case the applicant entered an employer from five years previously and not the employer immediately before their current employer. One application form only gave one employer from 2013. However the interview notes detailed they had moved to this country in 2003. No details of any previous employment or what they had been doing between 2003 and 2013 was available. Two staff files did not contain any references. One person had not worked for a long period; however good practice would be to obtain character references. The other three files only contained one reference. This did not follow the service's recruitment policy which stated 'references would be sought'. I was told by the registered manager two references should be obtained. We saw proof of identity documents, including a photograph and work permit where applicable, and a criminal records check from the Disclosure and Barring Service (DBS). The DBS identifies people barred from working with vulnerable people and informs the service provider of relevant criminal convictions or cautions noted against the applicant. We saw the registration PIN numbers for the qualified nursing staff had been checked with the nursing and midwifery council.

We found the lack of references and full employment history to be a breach of Regulation 19 (2) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were able to explain how they safeguarded people living at Flixton Manor and who they would report any concerns they had to. We saw staff had received training in safeguarding vulnerable adults; this was confirmed by the staff we spoke with. One staff member said, "I would report it to the nurse." A nurse we spoke with explained how they would look into the concern, record it and talk with the clinical lead nurse or registered manager and appropriate action would be taken. This should help ensure that the people who used the service were protected from abuse.

As part of our inspection we looked at whether medicines were being administered, stored and disposed of safely. We saw an up to date medicines policy was in place. Training records showed, and we were told, that the nursing staff had received training in the administration of medicines. The clinical lead nurse told us they observed the nurses administrating medicines; (although this had not been recorded.) This meant the nurse staff were provided with the skills and knowledge to administer medicines safely.

We looked at the medication administration records (MAR) for seven people as well as checking their medicines. We saw the MAR were correctly completed and where controlled drugs had been administered they had been checked and signed for by two staff members as they are required to do. We observed staff administering people's medicines and saw staff explain what the medicines were for and sit with people until they had taken all of their prescribed medicines. People told us that they received their medicines when they should do. We saw there were guidelines for each person as to how they preferred to take their medicines and for one person who had their medicines administered via a percutaneous endoscopic gastrostomy (PEG) tube. We saw one person had regularly refused their medicines. We saw one person was administered their medicines covertly. We saw their GP had been involved in agreeing that this was in the person's best interest.

However we did not see any guidelines for when any prescribed 'as required' medicines should be administered. Some people using the service were not able to verbally communicate if they needed an 'as required' medicine such as pain relief. Guidelines for nurses and care staff as to how people would communicate non-verbally their need for an 'as required' medication were required. The clinical lead nurse

said that they and the nurse team knew people well and knew if an 'as required' medicine was needed. However new staff, nurses or agency nursing staff would not know. The registered manager told us they would add this to each person's medicines file.

We saw the care staff signed a separate sheet when they had applied any topical creams. One person had been prescribed creams to be applied four times a day. Staff had only been applying it twice a day. This meant the person had not received the prescribed creams as directed by their GP. The clinical lead nurse told me they would talk with the staff team and ensure the prescribing instructions were followed. This was the only cream we saw that was required to be applied four times a day. All other creams were applied as prescribed.

The computerised care records we looked at identified risks to people's health and wellbeing including falls, manual handling, poor nutrition, bed side rails and the risk of developing pressure ulcers. The manual handling assessments gave clear guidance for staff as to the equipment to be used to support people to mobilise safely. We saw records were kept of the regular checks made by staff when people were in bed, including re-positioning records to reduce the risk of developing pressure ulcers.

However we saw the same risk had been assessed using different tools. For example one person had three different assessments for the risk of developing pressure ulcers. One stated there was a low risk, one that there was a high risk and the third that there was a very high risk of developing pressure ulcers. This meant it was not possible to see what the actual risk to the person was. Risk management plans had been written for people at risk of falls and pressure ulcers, including those with multiple assessments. Staff told us the clinical lead nurse and the other nursing staff informed them verbally of the risk management plans.

Accidents and incidents were recorded in an accident book. Details were recorded in the daily notes of the person involved. The accident book was given to the registered manager to review. We saw these were summarised by the registered manager and logged on the computer system. The registered manager monitored these for any trends, such as multiple falls by the same person.

We reviewed the systems in place to help ensure people were protected by the prevention and control of infection. We looked around the home and saw the bedrooms, dining room, lounges, bathrooms and toilets were visibly clean. People and relatives told us they thought the home was kept clean, one relative saying, "I am very pleased with the cleanliness here." We saw the latest infection control audit by the local authority had rated the home as 65% in June 2016. An action plan had been put in place and we saw work being undertaken to address some of the issues raised by the audit; for example installing a sluice room on the first floor. The registered manager explained that at the time of the audit the home had been one domestic staff short. They had since recruited another domestic staff. The head housekeeper told us when domestic staff were on annual leave they were not covered so the remaining domestic staff concentrated on ensuring the bedrooms and lounges were clean. This meant other tasks, such as shampooing the carpets were not completed at these times.

Staff had access to personal protective equipment such as gloves and aprons. We observed staff using these appropriately.

On our tour of the building we noted that items were being stored in the basement corridor outside a person's bedroom. We also saw the first floor corridor was uneven where two buildings had been knocked through into one. This was a trip hazard. A notice had been placed on the wall by the uneven corridor to highlight the potential risk. We noted the carpets on the first floor corridors were rumpled and could present a trip hazard.

We found the trip hazard of the uneven floor and the rumpled carpets to be a breach of Regulation 15(1) e of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had a personal emergency evacuation plan (PEEP) in place. This gave details of the support a person would need in order to evacuate the building if they were in the communal lounge or in their bedroom.

Records we reviewed showed that the equipment within the home was serviced and maintained in accordance with the manufacturers' instructions. This included the fire alarm, call bell, emergency lighting systems and manual handling equipment. Records we looked at showed regular checks were carried out on gas and electrical items and the water system. This helped to ensure that people were kept safe.

We saw contact details were kept in the home's office for utility companies in case of an emergency such as a gas or water leak. There were no formal plans in place to set out the action staff had to take in the event of an emergency or if the building, or part of it, needed to be evacuated for any period of time. We recommend the provider uses current best practice guidance to formulate a written business continuity plan for such eventualities.

Requires Improvement

# Is the service effective?

## Our findings

At the last inspection in September 2014 we found the home was not compliant with the Mental Capacity Act 2005 (MCA). This was because capacity assessments were not being completed. The 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA.

At this inspection we found capacity assessments were being completed when people moved to the home. Where required appropriate DoLS applications were then made.

Staff we spoke with were aware of the importance of providing people with day to day choices; such as what to eat and which clothes to wear. We observed staff asking people what they wanted and waiting for their answer before providing care. However we also observed some staff putting aprons on people before lunch without asking if they wanted one or not.

People we spoke with said the staff had the skills to meet their needs. One person said, "I think the staff are well trained and professional in the way they meet my needs." A relative told us, "They (the staff) know how to support [Name] really well."

New staff told us they shadowed experienced staff when they first started so they could get to know the people living at the home. They were also registered on a nationally recognised qualification in health and social care at level two. One staff said, "My assessor visits me every three weeks to observe me and give me my next work books." The senior carer told us the home did not use the care certificate for staff new to care, instead using the level two qualification.

Staff told us they received training including health and safety, manual handling, fire safety, infection control and diabetes in elderly people. Training records confirmed this. Nursing staff had received training in supporting people who required PEG (percutaneous endoscopic gastrostomy) feeding. We also saw refresher training was planned for the week after our inspection in safeguarding vulnerable adults and manual handling. We observed staff using safe manual handling techniques throughout our inspection. However we noted none of the staff team had received training in dementia care. The majority of the people living at Flixton Manor were living with dementia. We saw one nurse, who had been employed over 18 months on a part time basis, did not have training in catheter care and a staff member who had started work at the home in March 2016 had only received formal training in MCA / DoLS. They had been enrolled on the nationally recognised level two course in health and social care. We also saw that a recently employed nurse

was not on the training matrix at all so it was not possible to see what training they had received.

All the care staff we spoke with said they did not have regular supervisions. The clinical lead nurse had completed a supervision with nursing staff six months ago, however they told us these were not undertaken regularly. A nurse told us they had informal discussions with the clinical lead nurse. We discussed staff supervisions with the registered manager who acknowledged staff did not have formal supervisions, but went on to say she was always available and provided support to staff whenever needed. We were told staff meetings were not held. The clinical lead nurse and registered manager said they spoke to staff as they needed to, either individually or at handovers at the start of shifts, rather than have a formal supervision or staff meeting.

The senior carer said they had started to complete staff appraisals and would continue to do so. They aimed to complete an appraisal on an annual basis.

All staff we spoke with said they felt well supported and were able to speak to the senior carers, nurse on duty or registered manager if they needed to.

We found the lack of training for new staff, specialised dementia training, supervisions and staff meetings means that the provider is not able to ensure that people using the service are supported by suitably qualified, competent and skilled staff. This was a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We observed a morning handover meeting between the night shift and the incoming day shift. The handover was used to inform staff of people's wellbeing and any changes that had been noted. Staff told us if they had been off work for a period, for example annual leave, they would ask for an extended handover from the clinical lead nurse or senior care worker so they were aware of any changes in people's needs whilst they had been off.

We looked at the systems in place to ensure people's nutritional needs were met. The care records we looked at all contained a risk assessment regarding people's nutritional intake. We saw that people were weighed weekly if they were considered at risk of malnutrition. We saw evidence of referrals to the dietician and the speech and language team (SALT) where people were at risk of malnutrition.

Food and fluid intake was recorded for people assessed as being at risk of not eating or drinking enough. However we saw some records recorded the food and fluid offered to people and not the actual quantity consumed. The charts did not give staff advice on the recommended intake of food or fluid for the person. This meant whilst people's nutritional needs were being met, accurate records were not available for monitoring purposes and when the person's nutritional needs were reviewed by the dietician or SALT team.

People told us they enjoyed the food at Flixton Manor. One said, "I love my bacon and eggs in the morning and the staff get me my favourite cheese on toast for tea." A relative told us, "[Name] has gained weight since living here."

Menus were planned in advance and rotated on a two week basis. People were offered a choice and could ask for alternatives if they preferred. The chef had a good understanding of people's dietary needs and was informed whenever advice from the SALT team or dietician changed. People's cultural needs were catered for as required. We saw the kitchen was clean and well stocked. The most recent inspection from the environmental health department had awarded the service a 5 (Very Good) rating for food hygiene.

We observed the lunchtime meal at the home. There were table places for only nine people. Other people ate their meals at small tables in their chairs. We were told by the registered manager people could choose to sit at the tables if they wanted to, however this would not be possible if everyone chose to do this. We observed a relative inform staff they thought their relative might eat better at a dining table rather than in their chair. This was responded to straight away by staff. People were encouraged and supported to eat in an appropriate way, with many people able to eat independently.

Each person was registered with a GP. We saw referrals had been made to other medical professionals when required. The health professional we spoke with said the home would ring for advice or to make an appointment when needed and would then follow any advice given. They said the staff were always helpful and knew the people they supported well. They said there were always staff available to support the person they had come to see. People and their relatives told us the service contacted the GP in a timely manner if they were not feeling well. This helped ensure people's health needs were being met.

On our tour of the building we noted there was only one shower room available for people to use. The shower room in the basement was not used and the bathroom on the first floor was old and again not used. We saw there were en-suite toilets in the newer bedrooms. However these were not accessible for people who needed to use a hoist and needed staff to support them with their mobility. This included the majority of people living at Flixton Manor. The registered manager told us these facilities were therefore not used. This meant everyone was using the shared accessible toilets and the one shower room available. People were not able to have a bath. This meant there was a queue to use the toilet at times. People told us they had one shower a week. Staff said they offered people additional showers when they could. However one person said they would like more showers but hadn't asked as they thought they would not be able to because the staff did not have time. The registered manager told us they were planning to upgrade the first floor bathroom.

Flixton Manor supports people who are living with dementia. However the décor of the home was not 'dementia friendly.' Doors were not painted in a colour to clearly differentiate them from the surrounding walls. People did not have pictures or memory items on their bedroom doors so they could identify their own room. Signage was not available to assist people to know where they were in the home.

We found the lack of bathing facilities and the environment not helping to promote the well-being of people living with dementia to be a breach of Regulation 15 (1) c of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

# Is the service caring?

## Our findings

Everyone we spoke with said the staff were kind and caring. One person said, "I think this is a very friendly place in terms of the staff and residents." A relative commented, "There is a nice rapport between the staff and residents; there is a relaxed atmosphere." Another said, "They (the staff) are very thoughtful and caring."

Most people living at Flixton Manor were living with dementia and might talk about things they did many years ago. Understanding about people's lives and histories can help staff understand about why people behave in a particular way. Staff can then provide appropriate support and assurances to people who may be distressed, confused or afraid. We saw the computer care files did not contain any information about people's personal history or likes and dislikes. This meant the staff did not have the background information to talk with people or support them if they had some memory loss, especially when they first moved to the home.

In discussions with staff they were able to explain the different needs of people and how they were supported. For example who required thickeners in their drinks and which hoist and sling each person used. A relative told us the staff had a good understanding of their loved one's care needs. Another said, "The staff manage the PEG (percutaneous endoscopic gastrostomy) really well."

Staff were able to describe how they maintained people's privacy and dignity when providing personal care.

Throughout the inspection, as noted previously in this report, the staff were very busy supporting people with their needs. We noted there was very little interaction between the staff and the people who used the service as staff walked through the lounge areas, especially on the first day of our inspection.

We saw that some staff did not talk with people when supporting them. For example we saw one new staff member support someone drink a thickened cup of tea. They did not speak to the person whilst supporting them. On the first day of our inspection two staff supported several people to go to the toilet after lunch. However they did not interact with the people they were supporting or the other people who were sat in the lounge. We also saw some staff serve people's lunches in the small lounge area without speaking to them. We noted other staff interacted more with people when providing support. Staff completed the required tasks in a caring and gentle manner. People had to wait to access the toilet or shower due to staff being busy and the few facilities being available for them to use.

This meant people sat for long periods with no interaction with staff and people were not always engaged or re-assured when support was provided. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home is registered with the Six Steps end of life programme. This is a recognised system for supporting people at the end of their lives. We saw people or their relatives were involved in discussions about the care people wanted at the end of their lives and their wishes after their deaths. The senior carer explained how the GP was involved in any decisions about possible resuscitation and anticipatory medicines were

obtained to ensure the person was comfortable and pain free. The staff supported people and their relatives at this time, including ensuring a relative or staff member was with the person when they passed away.

We noted that all care records were held securely; this helped to ensure that the confidentiality of people who used the service was maintained.

We were told that the service has an open door policy and visitors are welcomed. During our inspection we saw a number of visitors coming and going. People we spoke with said they could visit whenever they wanted.

Inadequate

# Is the service responsive?

## Our findings

We reviewed seven care plans. The care plans were written and stored on a computer system called Care Sys. We found that people had multiple assessments for different areas of their care. We also saw the same assessment had been duplicated, in one case six times; each duplicate assessment had a different section of the assessment completed. Therefore to see the entire assessment you had to look at six different files. As noted previously, where there were duplicate assessments the outcomes were conflicting. One person had 23 assessments saved in their care file. Six were duplicates of the same assessment and other assessments covered the same areas; for example pressure ulcers, a separate assessment for continence when this was also included in another, larger, assessment.

Not all assessments had been fully completed; for example a mini mental state examination (MMSE) tool was used to assess people's cognitive abilities. For two people only one question of the assessment had been completed. For three people the same comment had been made about the support they required for making decisions and with their memory.

This meant the assessment information was not easily accessible and was in some cases contradictory. The assessments were not completed in a person centred way, with the same comments seen in different people's assessments.

From the comments made in the assessments the Care Sys created care plans of people's needs. These contained details about the support people required; for example the type of hoist and sling required for all manual handling, whether they used a hearing aid and guidance on the personal care a person needed.

All the care staff members we spoke with said they did not access the Care Sys. The care plans were not printed out. This meant the care staff were not able to read people's care plans or risk assessments. All care staff said they were told any information they needed by the clinical lead nurse. This meant they had to ask the clinical lead nurse for any details they could not remember as they were unable to refer to the care plans or risk assessments themselves. They also had to remember all the care details for each person. Being able to refer to these plans is especially important for new staff or agency staff who did not regularly work at the home. We spoke with the registered manager who said the Care Sys was for the nurses to use and did not recognise that the care staff would benefit from being able to access the care plan information. They told us the verbal information provided by the clinical lead nurse and other nurses was sufficient.

We saw the nurses and clinical lead nurse wrote the daily notes for each person on the Care Sys. They also reviewed people's care plans and risk management plans monthly. However we saw that not all areas of the Care Sys were kept up to date. For example the record of professional visitors was not regularly completed. We saw details of a GP visit recorded in the daily logs for one person and not in the professional visitors' record. This meant it was difficult to track any ongoing professional visits without going through all the daily notes.

People and relatives we spoke with told us they had not formally been involved in completing or regularly

reviewing the assessments and care plans. One relative said they had given a lot of information to the service when their loved one had moved to the home, however they had not seen any care plans subsequently written. The registered manager said relatives could ask to see the care plans if they wanted to do so. Relatives had signed a form stating they could ask to access their loved ones care plans if they wished to do so. However, the relatives we spoke with seemed to be unaware of this. The registered manager also told us the plans were for the use of the nurses and so relatives were not involved in developing the care plans or reviewing them. We were told the relevant social worker would arrange formal reviews of people's needs and care and they would invite family members to attend. The clinical lead nurse said the review was held with the nurses and did not include senior care staff. The care staff were informed of any changes in a person's care plans following the review.

The clinical lead nurse said they or the nurses contacted relatives to keep them informed of any changes affecting their loved one.

We found the incomplete and contradictory assessments, lack of access to the care plans for care staff, incomplete recording and the lack of involvement of people or their relatives in the care plans to be a breach of Regulation 9 (1) with reference to 9 (3) a, b, c and d of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw the Care Sys had the facility to record personal details, likes and dislikes and life history. A one page profile template was in place which would record these details. We discussed with the senior carer about how this information would be beneficial to the care staff and agency staff to refer to.

The clinical lead nurse completed initial assessments before people moved to Flixton Manor. They visited the person and spoke to relevant people such as family members and nurses on the hospital ward. We saw one person who had recently moved to the home had been referred back to social services as the home felt they could not meet their needs. The clinical lead nurse explained the information given to them at the assessment had not been correct and the needs of the person were greater than they had been told. They said that this was not the first time this had occurred and they were now going to enquire more thoroughly into any changes in, and issues regarding, medication or behaviour during the initial assessment.

We saw the home organised for an external entertainer to visit the home four times a month, which we were told by relatives was enjoyed by the people who used the service. A masseur visited monthly and a hairdresser every week. However these were the only activities organised by the home. The home's activities organiser had retired in January 2016 and had not been replaced. As previously noted the care staff were very busy supporting people and therefore did not have time to sit with people or organise any games or activities. Throughout our inspection the television was on in both lounges. The volume was low and so could not be heard by the people who used the service. Music or films appropriate to people's interests were not offered. We did not see any games or reminiscence aids available for people to use. One person had a newspaper and another read magazines, however most people sat with little interaction with staff or each other. We observed many people to be asleep or withdrawn. A relative told us they had asked about more activities as their loved one was bored but none had been arranged.

The registered manager told us people did not want to get involved in activities, stating the activities officer had struggled when they had been in post. Therefore this was not seen as a priority area for the home.

This meant people's need for stimulation and activity was not being met. We found this to be a breach of Regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw a complaints policy was in place. The registered manager told us there had not been any formal complaints received by the service in the past year. People and relatives we spoke with said they would raise any concerns with the care staff, clinical lead nurse or registered manager. They said they were confident any concerns raised would be addressed. One person told us they had told the registered manager their bed had not been made and this was quickly resolved. However one relative told us they had asked for their loved one to be able to sit outside and for more activities to be arranged but this had not happened, however they had not made a formal complaint.

Before the inspection we were aware of a safeguarding case conference that had taken place in March 2016. We asked what action the provider had taken following the case conference. The registered manager was not conversant with the outcomes of the case conference, saying the provider had not spoken to her about it. We spoke with the provider by telephone. We were told they had not responded to the outcomes of the case conference as they were waiting for the family involved to make their concerns known to them in writing. However, in the case conference minutes it is recorded on three occasions that the provider will respond to the issues raised during the safeguarding investigation. One of the recommendations from the case conference was that it was 'stated during the meeting that [provider] would arrange for the family to receive answers to their complaints.' After the inspection we confirmed with the lead social worker in the case conference that the outcome of the conference was that the provider would respond to the issues raised by the family.

This meant the provider had not responded to the complaints raised by the family and had not discussed the outcomes of the case conference with the registered manager. This was a breach of Regulation 17 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

# Is the service well-led?

## Our findings

The service had a registered manager in post as required by their registration with the Care Quality Commission (CQC). The registered manager was due to retire shortly after our inspection. A senior carer with many years of experience at the home had been appointed as the new manager. They were in the process of applying to be registered with the CQC.

All the people and staff said the registered manager and senior staff were approachable and supportive. The clinical lead nurse was visible within the home throughout our inspection. All the staff we spoke with were positive about working at Flixton Manor. One staff member we spoke with had joined the staff team after working at the home as an agency worker.

The registered manager showed us how the Care Sys computer system prompted them to undertake various audits of the service such as bed rails, mattresses, incidents, medicines and care plans. We saw any actions required following the audits were noted.

However the audits had not identified the shortfalls found during our inspection, especially with regard to staff recruitment and the duplication and quality of assessments and care plans. The registered manager did not think the care staff needed to be able to access and view the care plans and risk management plans, relying on all the required information to be communicated verbally. They also told us families are asked for information about their relatives as part of the assessment when they move to the home, but the care plans were for the nurses' use and so the families were not involved in writing or agreeing them. There was a lack of staff supervisions, the service was task orientated in nature and the there was a lack of stimulation for the people who used the service

The shortfalls in the auditing systems, staff not being able to view the care plans and the lack of involvement of relatives in writing and reviewing care plans was a breach of Regulation 17(1) with reference to 2a, b and e of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told there were no staff meetings held; staff would speak with the clinical lead nurse at handover or individually when required. We were also told relative meetings were not held. We saw a relatives' survey had been issued in January 2016, with five surveys being returned. These were positive; however we saw one comment about agency staff members not interacting with people. We observed that this was still the case during our inspection for one agency staff member. This meant the registered manager sought some views of relatives, however did not provide relatives a formal opportunity to meet with the manager to discuss the service.

Services providing regulated activities have a statutory duty to report certain incidents and accidents to the Care Quality Commission (CQC). Before the inspection we found CQC had not received any notifications from the service since July 2014. The registered manager told us they had tried to notify CQC of the deaths of people who used the service, however the emails they had sent to CQC had been returned as undeliverable. When we looked into this we found the registered manager had mistyped the email address for CQC. This

meant the registered manager had not carefully looked in to why the emails had been undeliverable in order to resolve the issue.

We were shown a file of completed notification forms that they had tried to send to CQC. This contained some, but not all, notifications concerning people who had passed away. There were no forms for any other notifiable events.

We noted that the service had contacted the CQC in writing via post to inform us the registered manager was retiring and so needed to be de-registered.

The failure to notify the CQC appropriately was a breach of Regulation 16 (1) and Regulation 18 (1) of the Care Quality Commission (Registration) Regulations 2009.

We found multiple breaches of the Health and Social Care Act 2008 during this inspection. These included the staffing levels required to support the needs of the people living at the home, the lack of a robust system for recruiting staff suitable for working with vulnerable adults and no supervision for staff or specialised dementia awareness training. There was little interaction between staff and people who used the service, few activities for people to be involved with, multiple and contradictory assessments of people's needs, care staff did not have access to people's care plans and there was a lack of involvement of people and their relatives in developing and reviewing their care plans. The provider had not responded to a complaint following a case conference, there were issues with the environment, a lack of facilities to meet people's needs and shortfalls in the auditing systems used to monitor the quality of the service.

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<br><br>Treatment of disease, disorder or injury | Regulation 16 Registration Regulations 2009 Notification of death of a person who uses services<br><br>The failure to notify the CQC of people who used the service's death appropriately was a breach of Regulation 16 (1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 Registration Regulations 2009 Notifications of other incidents<br><br>The failure to notify the CQC appropriately of any incidents was a breach of Regulation 18 (1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 9 HSCA RA Regulations 2014 Person-centred care<br><br>We found the incomplete and contradictory assessments, lack of access to the care plans for care staff, incomplete recording and the lack of involvement of people or their relatives in the care plans to be a breach of Regulation 9 (1) with reference to 9 (3) a, b, c and d<br><br>This meant people's need for stimulation and activity was not being met. We found this to be a breach of Regulation 9 (1) |

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 10 HSCA RA Regulations 2014 Dignity and respect<br><br>This meant people sat for long periods with no |

interaction with staff and people were not always engaged or re-assured when support was provided. This was a breach of Regulation 10

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed<br><br>We found the lack of references and full employment history to be a breach of Regulation 19 (2) |

| Regulated activity | Regulation |
| --- | --- |
| Accommodation for persons who require nursing or personal care<br><br>Treatment of disease, disorder or injury | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>Current staffing levels not sufficient to meet the needs of the people using the service. Regulation 18 (1)<br><br>We found the lack of training for new staff, specialised dementia training, supervisions and staff meetings means that the provider is not able to ensure that people using the service are supported by suitably qualified, competent and skilled staff. This was a breach of Regulation 18 (2) (a) |

This section is primarily information for the provider

# Enforcement actions

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

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 15 HSCA RA Regulations 2014 Premises and equipment |
| Treatment of disease, disorder or injury | We found the lack of bathing facilities and the environment not helping to promote the well-being of people living with dementia to be a breach of Regulation 15 (1) c<br><br>We found the trip hazard of the uneven floor and the rumpled carpets to be a breach of Regulation 15(1) e |

**The enforcement action we took:**

Warning Notice issued

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 17 HSCA RA Regulations 2014 Good governance |
| Treatment of disease, disorder or injury | The shortfalls in the auditing systems, staff not being able to view the care plans and the lack of involvement of relatives in writing and reviewing care plans was a breach of Regulation 17(1) with reference to 2a, b and e |

**The enforcement action we took:**

Warning Notice issued