

Mills Family Limited

# Fairlight & Fallowfield

## Inspection report

Ashfield Lane  
Chislehurst  
Kent  
BR7 6LQ

Tel: 02084672781  
Website: [www.millscaregroup.co.uk](http://www.millscaregroup.co.uk)

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### Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

**Requires Improvement** 

Is the service effective?

**Good** 

Is the service caring?

**Good** 

Is the service responsive?

**Requires Improvement** 

Is the service well-led?

**Requires Improvement** 

# Summary of findings

## Overall summary

This inspection took place on 8 and 9 January 2019 and was unannounced. Fairlight and Fallowfield 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. The care home accommodates up to 55 people, across two joined buildings or units with adapted facilities, one of which focuses on residential care, and the other on nursing care. There were 52 people living at the home at the time of our inspection

At the last inspection on 22, 23 and 24 November 2017 we had found some improvement was required because sufficient staff were not always deployed to ensure people received prompt support when required. We also found that some environmental risks were not consistently managed safely at the service, call bell response times were not monitored effectively and notifications were not consistently submitted to CQC, where required. The home was again rated Requires Improvement overall for the fifth successive occasion since 2015. As part of our methodology for services repeatedly rated Requires Improvement we met with the provider on 26 January 2018 to discuss their improvement action plan to discuss what they would do to improve the key question safe and well led to good.

At the last inspection in November 2017 there was no registered manager in post. At this inspection there was an experienced registered manager who had registered as manager at the home since May 2018. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At this inspection we found all the areas we had identified as requiring improvement at the last inspection had been addressed. However, we found the quality of other aspects of care and support was not effectively monitored and managed to ensure other specific risks to people's health and safety were identified and assessed. We found two breaches of regulation as the systems to ensure oversight of risks in relation to the premises and people's dietary needs was not always effectively managed to reduce possible risks to people. The issues we found had also not been identified by the provider's own quality assurance systems.

You can see what action we have asked the provider to take in respect of one breach of regulation at the back of the full version of this report. However, full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded

Other aspects of the governance of the home also required some improvement. There were no regular infection control audits or checks carried out on the care provided at night. Some issues identified were not always addressed promptly. While there was informal discussion and regular handovers between shifts; there was an absence of visible processes such as meetings to aid communication and oversight of the

home. People's views about changes to the service were not always consistently sought. The service has again been rated Requires Improvement for the sixth time.

Improvements were required as although there were systems in place for the monitoring and investigating of accidents, incidents and safeguarding; there was no clear system to ensure trends or learning was consistently identified. We also found some improvements were needed to ensure people's diverse rights were identified, respected and supported and to evidence people and their relatives' involvement in the care review process.

People and their relatives told us they felt safe at the home. Staff understood how to safeguard people and where to report any concerns to. Some risks to people were identified and assessed appropriately. There were arrangements to deal with emergencies. People were protected from the risk of infection and the environment was clean. Medicines were managed safely. There were enough staff to support people and meet their needs. Effective recruitment practices were in place to reduce the risk of unsuitable staff.

People's needs were assessed before they went to stay at the home to ensure these could be met. People were supported to have enough to eat and drink and to have access to a range of health professionals when required.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. People gave consent to the care and support they received. There were systems in place which ensured the service complied with the Mental Capacity Act 2005. (MCA 2005). This provides protection for people who do not have capacity to make decisions for themselves.

Staff received suitable training and support. People and their relatives were positive about the home. They told us staff were kind, respectful, caring and treated them with dignity. People were consulted about their care and support needs and provided with information about the service.

People had a care plan that recorded their current care and support needs. People's needs for stimulation and social interaction were recognised with a range of activities provided. People's needs at the end of their lives were recognised and planned for. People and their relatives were aware of how to raise a complaint and we saw these were responded to appropriately.

People relatives and staff were positive about the way the home was run. Some aspects of the quality monitoring of the services did work to identify and address issues. Staff liaised with other organisations to communicate about people's care and support needs.

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

We always ask the following five questions of services.

### Is the service safe?

The home was not consistently safe.

Some risks to people were identified and assessed but risks in relation to the use of the stairs had not been assessed or identified.

There were systems in place to manage emergencies and to identify and monitor other risks in relation to premises and equipment.

There were systems in place for the monitoring and investigating of accidents, incidents and safeguarding. However, there was no clear system to ensure trends or learning was consistently identified.

Staff understood how to safeguard people from possible harm or abuse and understood the action to take if they had any concerns.

There were enough staff to meet people's needs and staff recruitment practices complied with the regulations.

Medicines were stored, managed and administered safely.

Staff understood how to reduce the risk of infection.

**Requires Improvement** 

### Is the service effective?

The home was effective.

People's physical, mental and social needs were assessed before they moved into the home.

Staff were supported to do their job and received regular training, supervision and annual appraisals of their work performance.

People told us they enjoyed the food and were supported to eat a well-balanced diet.

People were supported to maintain their health and well-being

**Good** 

and were referred to health professionals when needed.

There were arrangements in place which ensured the service complied with the Mental Capacity Act 2005 (MCA 2005).

Overall the home environment was suitably maintained and adapted to meet people's needs.

### **Is the service caring?**

**Good** ●

The home was caring

People and their relatives told us staff knew them well and were kind and caring.

People told us they were consulted about their care and support. They were encouraged to be as independent as possible and supported to maintain important relationships.

People and their relatives told us their privacy and dignity was respected.

### **Is the service responsive?**

**Requires Improvement** ●

The home was not always responsive.

People's diverse needs were not always consistently identified or met.

People were involved in making decisions about their care, although this was not always clearly recorded.

There were a range of activities available to meet people's interests and needs.

The home had achieved the highest award for end of life care from a recognised scheme and provided care and support to people at the end of their lives.

People and their relatives knew how to make a complaint and these were responded to in line with the complaints policy.

### **Is the service well-led?**

**Requires Improvement** ●

The service was not consistently well led.

There was now an experienced registered manager in place. They had addressed the issues found at the last inspection.

However, we found other concerns that were not identified by the provider's quality monitoring.

The system of oversight of some risks in relation to an aspect of the premises and people's dietary needs was not effectively managed and there was a risk of inappropriate care.

Some area of quality monitoring required improvement to work effectively or not regularly carried out.

People's views about the home were sought through surveys and meetings. They told us these were acted on. However, it was not clear that they were consulted about some changes that took place within the home.

There were regular handovers but otherwise there were limited arrangements for the monitoring of risk and sharing of information across the home.

Staff spoke positively about the leadership at the home and the provider and changes they had introduced.

# Fairlight & Fallowfield

## 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 the 8 and 9 January 2019 and was unannounced. On the first day, the inspection was carried out by one inspector, a nurse specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. On the second day of the inspection the inspection team consisted of two inspectors.

Prior to our inspection we reviewed the information we held about the service. This included their previous action plan following the last inspection and notifications we received. A notification is information about important events that the provider is required to send us by law. We reviewed the information the provider sent us in the Provider Information Return as part of our inspection planning. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We also contacted the local authority safeguarding and commissioning teams to obtain their views. We used this information to help inform our inspection planning.

During our inspection we used a range of different methods to help us better understand people's experiences of the support and care they received within the home. People living at the home had varying levels of communication so we used our Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us. We spent time observing the support provided to people in communal areas, at meal times and the interactions between people and staff. We tracked the care people were given to see that it matched with their care plan. We spoke with ten people using the service, seven relatives, three visitors and two visiting health professionals.

We spoke with the registered manager, both unit managers, the provider's representative and a representative from the catering company. We also spoke with two senior care workers, one agency care worker, four care workers, an activity coordinator, the housekeeper, a domestic staff member and the

maintenance person. We looked at aspects of twelve people's electronic care records and paper records, staff recruitment, training and supervision records and records relating to the management of the service such as audits, meeting minutes and maintenance reports. We also looked around the building.

# Is the service safe?

## Our findings

At the last inspection of the home in November 2017 we had found some improvement as needed to the deployment of staff as call bells were not always promptly answered. At this inspection we found these concerns had been addressed. However, we found while some risks to people were identified and assessed a specific risk in relation to the premises had not been identified or assessed. Risk assessments were not completed for people who liked to use the stairs, to reduce the possible risks of falls and injury. There was no guidance in place for staff to reduce this risk and there was therefore a risk of inappropriate or unsafe care.

Staff also told us about a person living with dementia for whom there was possible risks if they tried to use the stairs. We checked their care plan and there was no record of this identified risk or guidance for staff. The unit manager told us that this person had a pressure mat to alert staff at night if they mobilised. However, their care plan recorded them as likely to wander in the communal areas downstairs during the evening. Their falls risk assessment stated there were no environmental risks in relation to them falling; this failed to identify or assess this risk or provide suitable guidance to staff.

Generic guidance was available in relation to health conditions. Risks in relation to health needs such as diabetes were clearly identified and assessed in the nursing unit, but we found one person on the residential unit had no care plan to guide staff on their individual health needs in respect of their diabetes or any warning signs or actions to take if they had concerns which posed a risk to their health.

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

Accidents, incidents and safeguarding were monitored at the home; however, some improvements were needed to ensure robustness. Accident and incident records had not always been signed off by senior staff to evidence they had reviewed them or considered action to reduce future risks. The analysis of accident and incidents we saw was limited to the number of incidents rather than an analysis of other factors such as place or time, to identify trends, learning and minimise reoccurrence.

We discussed this with the registered manager, provider and their representative and they advised that the new electronic system would enable a more detailed analysis to take place which the provider and managers could monitor.

Some learning was identified. The registered manager discussed an area of learning being considered from a recent safeguarding matter. The provider's representative also advised how they had implemented some changes following a small number of thefts of people's possessions earlier in the year and now photographed people's jewellery when they admitted to the home. No further issues had arisen and this change was implemented across all the provider's homes. However, there was no clear process to show how learning from other previous safeguarding was identified and shared across all the homes.

Other risks to people in relation to falls were assessed and guidance was in place to reduce these risks. Where it was appropriate some people had additional staff support or pendant alarms to enable them to call for staff support as they mobilised around the home. A relative said, "They seem to understand [my family member] fairly well. The staff always help them with mobility." We found risks in relation to skin integrity and health conditions were assessed and guidance was in place to minimise risks.

Other risks in relation to the premises and equipment were managed effectively through a process of regular internal checks and audits and external servicing and maintenance. This included risks in relation to water temperatures, window restrictors, hoists and slings, fire safety, gas and electrical equipment and installation. The provider arranged for regular fire safety and legionella risk assessments to ensure any risks were minimised. Care staff checked pressure mattresses to ensure these were maintained at the right setting.

There were arrangements to respond to emergencies. Staff including night staff had received fire safety training and took part in fire drills; they said they had been shown how to use the evacuation equipment, should this be required. People had personal emergency evacuation plans in place to guide staff and emergency services.

People and their relatives told us they felt safe from harm and discrimination at the home. One person told us, "I feel perfectly safe here. I am very well looked after" Another person remarked, "I feel very safe, very much so. The care assistants, and the general atmosphere, make me feel safe." A relative said, "I think they are very safe here. I cannot fault the care here at all."

Staff understood how to protect people from harm or abuse and how to report safeguarding concerns. They were aware of where they could report any concerns to externally if needed. Staff told us they received regular training on safeguarding to refresh their knowledge. Records showed safeguarding concerns were reported appropriately and that the registered manager worked with the local authority to raise and investigate any concerns and take any necessary action.

At this inspection we found there were sufficient staff deployed to meet people's needs. People and their relatives confirmed that call bells were responded to in a timely way. One person told us, "They come quickly if I ring for them day or night. There is no problem." A relative said, "The staff are very good they do respond quickly." We observed for people nursed in bed their call bells were placed for ease of use.

We looked at the call bell monitoring records which evidenced there had been a considerable improvement in call bell response times since the end of October 2018. The registered manager had oversight to ensure calls in the day and at night were promptly responded to. We saw that they were monitoring this effectively and all call bells were now responded to within four minutes. The registered manager told us if there was any significant delay in a response they would be individually investigated to establish the reasons for this.

People and most of their relatives told us there were enough staff to support their needs. Our observations on both days were that people were supported in a timely way throughout the day and were not left waiting for support to mobilise or at meal times. Staff were available in the communal areas in both units throughout the day. Staff told us they thought there were enough of them to support people safely but the need to rely on agency staff for some shifts could make things difficult. Health professionals we spoke with told us there were always staff available when they visited to communicate with them and they had not noticed any issues with staffing levels.

The registered manager told us they adapted staffing levels to meet people's needs. They had increased

staffing levels during the day since working at the home. We saw where they had identified concerns about a person's safe mobilisation due to a health condition they provided individual staff support throughout the day.

Recruitment processes included evidence of the range of required checks. Proof of identification was recorded with copies of photographic identification and proof of address and we also saw evidence of checking candidate's legal right to work. Disclosure and Barring (DBS) checks were carried out prior to staff commencing employment. Nursing staff were subject to checks of their registration with the Nursing and Midwifery Council. A log was maintained and current registrations were checked to ensure that registrations were up to date. The provider received information about agency staff recruitment checks and training to reduce the risk of unsuitable staff.

Medicines were safely managed. People and their relatives told us they received their medicines as prescribed. One person said, "They are reliable with the medicines. I get mine when I should." A relative commented, "There has not been any issues with my [family member's] medicines." We observed that medicines were administered in a personalised way and staff were knowledgeable about the way people preferred to take their medicines.

Prescribed medicines were administered, stored and disposed of safely. Controlled drugs were stored appropriately and checked regularly. Medicine administration records (MAR's) we checked had been consistently signed with no gaps. Medicines including creams and drink thickeners were stored securely and temperature checks were completed to ensure they were stored at safe temperatures. Medicines were disposed of appropriately. High-risk medicines such as warfarin and time specific medicines were managed appropriately and in line with guidance.

Staff had received medicines training and competency assessments before they administered medicines to ensure they understood their roles. However, we found some improvements needed as there were no competency checks for nurses new to the home in the last few months or for agency nurses to ensure their competency to administer medicines at the home. We discussed this with the provider who told us this was part of their policy and would be addressed following the inspection.

Staff worked effectively to reduce the risk of infection. People and their relatives told us the home was clean. One person said, "My room is cleaned thoroughly. No problems there." A relative said, "I have never noticed any smells and the place is always very clean when I visit."

We observed the home was clean and free from odours. We observed staff used personal protective equipment appropriately such as gloves and aprons and told us these were available when needed. Hand washing reminders were displayed in bathrooms and hand sanitizer was available throughout the home to promote good infection control standards. We observed domestic staff were cleaning the home during our inspection. The kitchen was awarded a rating of five by the food standards agency in September 2017, which is the highest possible rating.

## Is the service effective?

### Our findings

People's needs were assessed before they started to use the service to ensure these could be planned for and met. The service used risk assessment tools that followed practice guidance. People, their relatives where appropriate and other professionals were involved in these assessments. The service offered a respite care service and assessments were completed in these circumstances to ensure people's needs could be safely met.

People and their relatives told us they thought staff were competent and knowledgeable about their roles. One person said, "The staff are good. They know what they are doing." A relative said, "From what I see, they are very good. I know they get lots of training." Staff new to health and social care followed the Care Certificate, the recognised training for staff entering this area of work. They told us this also included a period of shadowing experienced staff. Agency staff confirmed they received an induction which included information about people's needs and what to do in the event of a fire.

Staff told us had access to online and face to face training, to ensure they had enough knowledge and competence to meet people's needs. One staff member told us, "We get lots of training here, which is good. If we don't do it then we can't work." Training included aspects of safety such as fire safety and first aid as well as safeguarding and moving and positioning people, dementia and diabetes. We viewed a training matrix and saw that completion of training was high. Poor attendance at training was addressed with a system of warnings and staff being invited for a formal discussion if the non-completion of training became an ongoing issue.

Staff told us they had access to supervision and regular appraisals of their performance. Records confirmed this and there was evidence of continuing professional development discussions.

People confirmed that staff sought their consent and respected their wishes. One person commented, "Staff always tell me what they have come to do and ask me if I am happy." Staff we spoke with understood the importance of obtaining consent and told us they sought consent from people when offering support and respected their wishes.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures 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 had the appropriate legal authority and were being met. We saw paper care records contained information about people's capacity to make decisions; these had yet to be transferred to the electronic care plan. The registered manager told us they were in the process of working with the IT company to ensure that this could be recorded in a decision specific way in the electronic care plan.

Staff demonstrated awareness of the MCA and DoLS including people's right to make informed decisions independently, but, where required to act in someone's best interests. The registered manager showed a good understanding of MCA and DoLS. Where applications had been made to local authorities to deprive people of their liberty for their safety, this was assessed appropriately. Where these applications had been authorised, the appropriate documentation was in place and the manager had an oversight of DoLS with their date of expiry. The electronic system included alerts so that staff were notified when an application was due.

People were supported to eat a balanced diet. The provider used an external catering company that provided meals for people living at the home. We had positive feedback about the quality of the food and the choices available. One person commented; "The food is excellent here, very tasty." Another person said, "The food is good, I really enjoy it. There is plenty of it too." We spoke with a catering representative who told us they attended residents' meetings to get feedback on people's preferences. They used this information to repeat or change meals. We observed the lunchtime experience across the service and saw people chose where to eat their meals. There were enough staff to support people promptly when required and people were assisted appropriately to eat at their pace. Coloured crockery and other assistive equipment such as plate guards were provided to enable people living with dementia to eat as independently as possible. A range of drinks were available and offered at meal times and throughout the day to try and ensure people were sufficiently hydrated.

People's weight was monitored to ensure any sudden weight loss or gain was identified. People's diets were fortified where appropriate to reduce the risk of malnutrition. Diabetic needs were addressed through a range of low sugar alternatives.

Staff worked across the organisation to deliver care and support. There were a series of staff handover meetings between shifts. This increased staff awareness of any changing needs or factors in relation to the running of the service. Staff were allocated particular areas of care and support so that they were clear about their role and if any issues arose the management team could identify where the problem arose.

People were supported to maintain their health and well-being. People told us they saw the GP dentist or chiropodist when needed. One person said, "I see the doctor and the optician when I need to." We checked the records for a person with diabetes that confirmed they had regular eye and foot checks. There was a visiting GP for each unit who visited on a weekly basis or when needed. They told us staff referred people appropriately and followed their guidance. Information and guidance from visiting health and social care professionals was retained in people's care plans to ensure staff were aware of people's needs. We saw health professionals recorded in the new electronic care plan.

The home environment had been suitably adapted to meet people's needs. There were accessible toilets and bathrooms throughout the home and equipment was available for people who required it such as wheel chairs, hand rails and lift access to all floors. People had access to a large and well-maintained garden. However, we noted the lift was too small for a stretcher and difficult to access because of the way the door opened. We discussed this with the provider and their representative, they told us this had not been raised as a concern but they would review to see if there was a way of changing the doors to make

access easier.

## Is the service caring?

### Our findings

People and their relatives were complimentary about the care and support provided by staff across the home. One person told us, "I am really well looked after here. I cannot fault the staff they are kind and gentle and brighten up my day." Another person commented, "The staff look after me very well." A relative said, "We are so pleased we chose this home, the staff are amazing, nothing is too much trouble. It really is a lovely place." Another relative remarked, "There are wonderful caring staff here. I can relax and know [my family member] is well looked after. We observed some very caring interactions on both units during the inspection. Staff were patient and did not rush people as they provided care; they chatted with people and shared a joke, where this was appropriate. Where people were unable to communicate we saw they relaxed in the company of staff, who we saw reassured people who appeared disorientated. Staff were knowledgeable about people's preferences for their routines or interests, for example who liked to use the library or spend time in their rooms as well as their past life experiences to enable them to engage with people in a meaningful way.

People told us they were involved in making decisions about their care and support as much as possible. For example, people's personal care plans included preferences about their care needs and their back grounds, this enabled staff to understand the people they supported and what influenced their preferences or choices they made. We saw staff consulted with people throughout the day, for example, about where they wanted to sit, or have their meals and if they wanted to take part in an activity. People were also provided with a service user guide that provided information about the home, what people could expect and what they could do if they were not happy with anything. There was also a newsletter to inform people about upcoming events at the home. The registered manager told us they had introduced a resident of the day system in which each person's needs were fully reviewed with them by the staff team to ensure all their needs were being met.

Staff enabled people to be as independent as possible. People's independence was promoted using dementia friendly coloured crockery and equipment was available to meet people's needs to mobilise. Care plans identified which aspects of their care and support people could manage and which they required assistance with. For example, where people had been assessed as able to use the lift independently they were encouraged to do so. People's links with families and friends were encouraged. A staff member told us how they used to skype to support people to maintain contact with relatives in other countries. Relatives and friends told us they felt welcomed at the home. One relative remarked, "The minute we walked in we are welcomed and met with smiling faces".

People and their relatives told us they were treated with respect and dignity. One person told us, "They are respectful, the staff knock on my door to check I am happy for them to enter." One relative said, "From what I have seen. The staff are discreet and respectful." Staff gave examples of how they tried to ensure people's privacy and dignity was respected and that personal information remained confidential.

## Is the service responsive?

### Our findings

People had a plan of care to meet their individual support needs. Since the last inspection the provider had introduced an electronic care record system to record people's support needs and care delivery. The home was in the process of transferring over from the paper care plans to the electronic records. We viewed the electronic care plans and some paper records.

Care plans were up to date and reflected people's current needs and recorded their preferences in areas such as to their health, personal care and communication. People and their relatives told us this was the case but this was not always clearly recorded. The registered manager told us they would be using more frequent resident of the day meetings to ensure people's care needs were regularly reviewed in the future. However, these were not established at the time of the inspection and the minutes of a staff meeting on 27 November 2018 gave no reference to the involvement of people or relatives in this review.

Some improvements were needed to ensure that people's diverse rights were identified or supported and that training provided to staff was understood. The electronic care plan template included a section for cultural and religious needs but not sexuality and it was not evident that this area of possible need was explored with people or their relatives. People's cultural needs were not always identified. For two people with cultural dietary requirements these were not identified, assessed or recorded in their care plan. The menu for the home did not regularly reflect the food preferences that they told inspectors about.

Staff told us they completed training on equality and diversity, which we confirmed from records and there was a strong focus on person centred care and being led by the needs of the individual. For example, one care worker told us, "We get to know people well and would always give them choice and ask them about their preferences. However, staff told us they had not had a particularly diverse group of people and when asked they struggled to give examples of where different cultural, religious or lifestyle needs might need consideration; despite the fact there were people with cultural needs living at the home. The registered manager had advised us in the provider information return that they were sourcing additional equalities training for staff in relation to sexuality.

People's religious needs were recorded and we saw there was a religious service at the home that people attended. The registered manager was in the process of reviewing to check if there were any unmet religious needs through the activities coordinators.

There were arrangements in place to follow the accessible information standard. This standard requires services to identify, record, share and meet people's information and communication needs. The registered manager told us they could access information in different formats for people who needed it. Resources could be accessed in braille if needed; however, this was not appropriate for anyone currently using the service. The registered manager said that staff knew they needed to spend time with some people to help them communicate verbally in a way that suited them. We saw staff used pictorial guides used to communicate with people where appropriate. Staff could also use online translation to communicate with anyone who had language difficulties.

People told us their needs for stimulation and socialisation were met. One person said, "There is plenty for me to do here." Another person commented, "There are activities if you want to join them. I don't always want to and prefer to sit and rest and they respect that." A relative commented, "There always seem to be things going on when I visit." Another relative remarked, "Staff always make sure residents from both wings of the home attend events when there is a visiting performer."

Some people could follow their interests such as knitting or reading books from the home's library. The home had activities coordinators who ran a planned activities programme that was displayed for people to see. This included group activities within the home such as pampering sessions, skittles, balloon tennis, bingo and quizzes. Visiting entertainment was provided on a regular basis including creative talks, music and animal therapy. For example, the home had regular visits from a 'second chance' local farm where animals would be brought in to visit. People were able to go on trips on occasions shopping or theatre trips as observed at the inspection. Staff told us that they worked to ensure that everyone who wanted to go on trips had the opportunity to do so.

The home had a sensory room that had been developed as a quiet space and relaxing environment for people to use. This included relaxing lighting and music and the use of a foot spa. Reminiscence boxes were available for staff to use when communicating with people. The boxes included items such as clothing and magazines.

Individual activities were also provided for people who preferred to stay in their rooms or were nursed in bed. The type of activity provided was based on their individual needs and could include conversations, jigsaws, quizzes, reading and arts and crafts.

People and their relatives told us they understood the provider's complaints process which was displayed in the home. Most people said they had not needed to make a complaint but they were confident if they made a complaint it would be addressed. One relative said they had complained and "It was dealt with very satisfactorily, in a transparent and reasonable manner."

We looked at the registered managers complaints folder and saw that complaints received were acknowledged, investigated and responded to in line with the provider's policy.

There were arrangements to meet people's needs at the end of their lives. Staff received training in end of life care and worked with a local hospice. The home continued to hold beacon status, the highest level for end of life care from the nationally recognised Gold Standards framework.

## Is the service well-led?

### Our findings

At the last inspection of the home in November 2017, there was no registered manager and we found some improvement was needed to the systems to monitor quality and safety as staff response time to call bells were not being effectively monitored and oversight in relation to some risks in relation to the premises and the sending of notifications of reportable events such as safeguarding or injury to CQC as required improvement.

At this inspection there was an experienced registered manager in post. He understood his responsibilities as a registered manager and had submitted notifications to CQC in line with the regulations and we saw the home's rating was also displayed as required.

People and their relatives were positive about the management of the home. One person said, "It's pretty good here, you can tell it is well organised. The staff know what they are doing." Another person commented, "Nobody would choose to be in a home, but if I have to be in one then I would choose here." A relative remarked; "Well led? Very much so. The manager is very approachable. The staff always tell me if anything changes. Overall, this place is brilliant. In particular, it is immaculately clean." Another relative stated, "The manager is very helpful. This place has got a lot going for it."

We found improvements had been made to address the areas previously identified. However, we found other areas of concern in relation to the way the home was monitored for risks to people's health and safety. While external and internal environmental checks were carried out monthly, these had not identified or assessed the potential risk of falls in relation to the staircases in the home. The system for monitoring people's care records had not identified that for people using the stairs individual risks in relation to their mobility or possible falls were not recorded or guidance available to staff. The system for monitoring safety had not identified the possible risk that some people at the home lived with dementia and may lack the capacity to understand and decide if they can use the stairs safely.

The oversight of people's dietary needs was not effective and did not reassure us that all risks had been identified and action taken to reduce these risks. The catering company the provider had contracted to provide meals at the home had an out of date list of the dietary requirements for 23 people, out of 52 people living at the home. This list also included people no longer living at the home. We observed one person whose care plan stated they required a modified texture diet was recorded on this list as requiring a normal but fortified diet. This person was provided with the correct diet but the list held by the catering company was inaccurate and there was a risk that unfamiliar staff would not be aware of people's required diets as their records were out of date and inaccurate.

Guidance from the speech and language team (SALT) for this person was not available to catering staff, or, in the care records when we asked to see it and so was not easily accessible to staff. It was sent to us two days after the inspection. We saw the guidance included information about other risks; for example, about the pace of eating that were not recorded in this person's care plan to guide staff. Other people's care records we looked at also did not contain guidance on the specific level of diet or additional instructions provided

by SALT to reduce risks. A health professional told us that some recommendations they gave on the phone in relation to types of cups to aid easier or safer drinking had not always been put in place when they then visited.

The catering staff told us they had no recorded dietary levels or stages for people's needs in line with the guidance from the British dietary association. When asked by inspectors the catering representative said they were not aware of different levels of diet but made a 'wet puree' or 'puree' texture. Care workers received training on food safety but also appeared unfamiliar with specific levels of diets. The clinical lead told us there were regular meetings with the catering staff about people's needs; but, these were not recorded so we were unable to verify how the arrangements were managed. There was no choking risk template to guide staff on the assessment of any choking risk. None of these issues which posed possible risks to people's health and safety had been identified by the provider's quality monitoring systems or systems to audit and check people's records to ensure they were accurate and up to date.

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

Other aspects of the governance of the home required improvement to ensure they were effective. The provider carried out their own checks on the service we found that some issues were acted on, but, issues were identified in consecutive visits. For example, in relation to the business continuity plan. This was identified as an area of action in the provider visits of September and November 2018 and January 2019. An internal cleaning audit had identified concerns about the carpet in one bedroom over several weeks and we were told an alternative flooring had been considered. However, no action had been taken to address this issue.

The registered manager told us they had not conducted a night check visits since they started work at the service in March 2018 and he was unaware of when the last check was done.

The registered manager told us that they were looking to introduce a regular infection control audit, but, at the time of the inspection regular infection control audits were not carried out to monitor for the risk of infection. We were shown two audits for the residential unit for 2018 and the registered manager showed us an external audit for one unit in August 2018. The registered manager told us some changes had been introduced following the audit such as the installation of hand gel dispensers. However, there was no infection control action plan to address any areas of concern identified and no follow up audit had taken place. There were action plans created in relation to issues identified by external monitoring visits for example from the local authority, fire risk assessment and from staff and resident meetings but these were not combined in an overall service improvement plan to enable full over sight of areas to improve, learning identified and that actions taken to address these issues was being promptly taken.

People's views about the service were sought through surveys and resident meetings. People told us they felt listened to. However, some improvement was needed to ensure that the meetings worked effectively to consult with people and gain their views about the running of the service. It was not clear if these meetings were advertised, so that relatives would have advanced notice and be able to attend to represent their family member if appropriate. Relatives did not appear on the attendance lists for the minutes of four meetings we looked at. The registered manager told us they were not but the provider's representative informed us they were. Minutes we looked at discussed the menus regularly, maintenance issues and outings. We found a request by someone who wanted to go for fish and chips in July 2018 had not been added to the action plan. There was also an absence of recorded discussion with people seeking their views about the new electronic care records.

The service worked with other organisations and professionals such as the local authority and health professionals. District nurses visited to support people's needs on the residential unit. The registered manager attended the local authority provider forum to keep informed and up to date. We had found issues about the way some recommendations about people's diets were recorded and communicated in the home. Health professionals we spoke with were mostly positive about the way the home communicated with them.

There were handover meetings for staff to share information about people's changing needs and to ensure people were aware of their roles and responsibilities. While there was informal discussion, there was an absence of arrangements to aid effective management oversight of people's needs. This had not impacted on people's care but the absence of robust arrangements of communication and oversight meant it was possible information could be missed. For example, the manager met with nursing staff to discuss areas of practice and accreditation. There were no regular clinical meetings to ensure there was oversight of people's complex health needs or areas of risk to aid timely identification of any deterioration or consideration of referrals to health professionals. There were no heads of department meetings to share oversight of different aspects of the service.

Some systems were effective in identifying actions to improve the quality and safety of the service provided. Some audits and checks were effective in identifying issues and making improvements such as the call bell audit. We tracked to see that a maintenance report had identified a piece of equipment as faulty and saw this had been taken out of use.

The registered manager told us he was working to address the culture of the home to deliver more personalised care to people and for staff to work together across the home, he was confident changes were happening. He said he felt well supported and listened to by the provider to carry out his role. Staff told us the provider had aimed to provide good person-centred care which reflected people's needs and preferences. One staff member said, the provider, "Has three priorities, the residents, the residents and the residents." Staff we spoke with told us the registered manager was supportive and approachable and had made a difference since starting to work at the home. One staff member said, "You can talk to the manager and he listens. He has improved the way the home works."

Staff said they worked well together and understood their responsibilities. Regular staff meetings were held although we saw these were not always well attended. These discussed changes that were implemented such as the electronic care records and proposed changes to inform staff and seek their views.

This section is primarily information for the provider

## Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	Care and treatment as not always provided in a safe way as some risks to people's safety were not identified or assessed. Reg. 12(1)(2)(a)(b)

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 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Systems to identify monitor and mitigate risks to people's health and safety and to improve the quality and safety of the service were not effectively operated. Reg. 17(1)(2)(a)(b)

### **The enforcement action we took:**

We served a Warning Notice against the provider.