Mosaic Community Care Limited

Fresh Fields Nursing Home

Inspection report

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Date of inspection visit:
22 August 2016
23 August 2016
30 August 2016
12 September 2016

Date of publication:
31 October 2016

Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The home was last inspected in April 2016 where we found continued breaches of the regulations in relation to person centred care, consent, good governance, staffing, notifications and medicine management. Notifications are things providers must tell us about which affect people using the service. The service was placed into special measures. The provider sent us an action plan outlining improvements they said they had made, or planned to make to become compliant with the regulations.

This inspection was a follow up inspection done on 22 and 23 August to check the progress and improvements the provider had said they had made, and as a consequence of the findings additional safety and welfare checks were carried out on the 30 August 2016 and the 12 September 2016 to ensure people were safe. We found some improvement in relation to complaints and notifications but sufficient improvements had not been made in all other areas. For example in relation to medicines and staffing we found that there had been further deterioration and the risks posed to people had increased. We also found further breaches of the regulations in relation to nutrition and hydration, dignity and respect and premises and equipment.

Fresh Fields Nursing Home is a purpose built home set in the grounds of Wythenshawe Hospital but the hospital has no association to the service. The home provides nursing and residential care for up to 41 people. At the time of the inspection there were 23 people living in the home. Due to the level of risk identified at the inspection in April 2016 we asked the home to agree not to admit anybody further, until the required improvements had been achieved. The provider agreed and sent us an action plan outlining improvements they had made. We met with the provider in June 2016 to check progress and found the staffing levels were still not adequate to support any further admissions. The provider then sent a further action plan which we looked at during this inspection.

The home still did not have a manager registered with the Care Quality Commission. The home had been without a registered manager since 2014. A manager had been recruited but had not registered with the commission. This was the sixth Manager to be recruited to the service during this time and we found on the safety and welfare check done on 12 September 2016 that they had also left the service. The service is required to have a registered manager and was therefore still in breach of this regulation. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. At the last inspection we found, 'the lack of a registered manager over the last twelve months had significantly impacted on the quality of the service provided at Fresh Fields Nursing Home'. At this inspection we found there was not enough autonomy, support or resource available to enable the manager to make the positive changes needed.

We had been made aware of a number of people who had been recently recruited into the service such as the human resource manager and the head of quality and compliance. We were able to speak to both these

people during the inspection to ascertain their position and commitment to the home. Unfortunately the head of quality and was not available to speak with during all of our visit as we were made aware on 5/9/2016 that they had also left the service. The provider told us they were currently on sick leave which we were unable to corroborate.

At the last inspection in April 2016 we found there were not enough qualified skilled or experienced staff to meet the needs of the people using the service. After that inspection we were made aware that only two nurses had been recruited. The provider had agreed to block book agency nurses to ensure all nursing needs were met, aid communication and provide continuity whilst permanent nurses were recruited. We checked and found that the provider had still not ensured there were enough suitably trained or qualified staff deployed to meet the needs of people who used the service. We found the home was still in breach of the regulation relating to staffing.

Due to the level of risk we found during the inspection we made Manchester City Council aware of the concerns we had which included the staffing levels at the home. The Council liaised with the provider and ensured there was an extra nurse available on shift to support the home over the bank holiday weekend. This was funded by the Local Authority. We also asked the provider to send us an emergency action plan outlining what they were doing to safeguard the people at the home along with some additional information. We carried out a safety and welfare check on 30 August 2016 and because the situation at the home was changing on a daily basis we carried out a further care and welfare check on the 12 September 2016 also to ensure that people were kept safe.

At the last inspection in April 2016 we reviewed people's care files and found, 'improvements had been made since the last inspection'. At this inspection we noted that information contained within the care plans was not passed onto staff and some people were receiving care and treatment which was not in line with their assessed needs. We looked at risk assessments and saw there was comprehensive information to identify what the risks were to some people but not all staff we spoke with knew what some of the risks were. We therefore found the home was still in breach of the regulation in relation to safeguarding and improper treatment.

We found some people who were nursed in bed were deprived of their liberty. Suitable arrangements had not been made to protect their rights in line with the Mental Capacity Act and Deprivation of Liberty Safeguards.

At the last inspection in April 2016 we found a number of concerns in relation to medicine management. These included, 'people running out of medicines and staff not keeping a record of when, where or why they were administering creams'. At this inspection we found a significant number of people were not receiving their prescribed medicine safely or at all. We asked the home to raise two safeguarding alerts to the local authority as a result of what we found. We found the home continued to be in breach of the regulation in relation to medicine management.

At the last inspection in April 2016 we saw the home was in need of new carpets and redecoration in some areas. The provider told us they were going to make a significant investment to ensure this was done. At this inspection we found no evidence this investment had occurred. We saw areas of the home and garden in a state of disrepair with some areas of the garden being unsafe. The provider again told us this was still something they planned to do. We asked the provider to send us the design plans and improvement plan. We did not receive this.

At the last inspection we reviewed the information and support available to ensure people received enough

nutrition and hydration. We found, 'Records kept to monitor people's intake of food and fluids were poorly completed, inaccurate and did not outline why people were being monitored. We asked the provider to review their current system of recording and monitoring the food and fluid intake to ensure it was done correctly for those people who needed it.' We followed up on information of concern we had received regarding people's food and fluid intake. We found the provider had not reviewed the systems and there had been no improvement since the last inspection which meant people were placed at risk. We found there were breaches in relation to this regulation.

At the last inspection we found there was, 'no system in place to assess people's capacity to consent to care and consideration was not given to the principles of the Mental Capacity Act 2005.' At this inspection we saw that the manager had begun the process of assessing the capacity of people who were most at risk but found evidence of people receiving care and treatment without their consent. This meant the provider was still in breach of this regulation.

At the last inspection we,' saw examples of staff interacting with people in positive and caring ways but it was clear that at times they were simply too busy and some interactions were rushed or missed. We therefore found improvement was needed in relation to how some staff carried out interventions.' We found the same thing occurred at the inspection in August 2016 which meant some people received poor care and treatment. We found this to be a breach of regulation regarding dignity and respect.

At the last inspection in April 2016 people we spoke with were not happy with how complaints they had made had been managed. We found this had improved since the last inspection because the manager ensured all complaints were dealt with in a timely manner. People told us they were now confident the manager would sort things out. Therefore at the time of our visit we found the provider was no longer in breach of this regulation.

At the last inspection in April 2016 we found breaches in relation to good governance. This was because, 'there was a lack of leadership and management within the home which meant quality audits were not being completed and the quality of care being delivered was compromised as a result'. At this inspection we found little or no improvement because systems already established were not being used to monitor or manage the quality of service provided either at service or provider level. This was a continued breach of this regulation.

At the inspection in April 2016 we placed the service into special measures. We did not consider enough improvement had been made at the inspection in August 2016 and the service will remain 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, 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.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Medicines were not managed safely.

Improvements had not been made in relation to the safety of the premises.

There were not enough suitably trained or qualified staff to meet people's needs.

Is the service effective?

Inadequate

The service was not effective.

The service did not support people in line with the principles of the Mental Capacity Act 2005.

Staff's skills and knowledge were not up to date and there were no permanent nurses present at the home during the day. Communication at all levels was poor resulting in some people receiving inappropriate care and treatment.

Is the service caring?

Requires Improvement

The service was not always caring.

The provider did not provide people with explanations or involve them in things which may affect their health and well-being.

Care provision was not consistent and not all people were treated with respect.

Staff morale was low which impacted on the quality of care people received

Is the service responsive?

Inadequate

The service was not responsive.

People did not receive person-centred care.

Care plans and risk assessments were not used to support people with their assessed needs.

People had limited access to activities within the home.

Is the service well-led?

Inadequate

The service was not well-led

Leadership was lacking which impacted on the quality of service delivered.

The manager did not have sufficient support or resources to manage the service effectively.

The provider did not monitor the quality of the service despite introducing new systems.

There was still mistrust between the people who used the service, their families and the provider. There was not a culture promoting openness and transparency and staff morale was low.

Fresh Fields Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.
This inspection took place on the 22, 23 August and was unannounced. We carried out further safety and welfare checks on the 30 August and the 12 September 2016 to ensure people remained safe as we had found some serious concerns on the first two days of inspection which we were not assured the provider had remedied. The care and welfare checks were to ensure that people were kept safe and follow up on the action(s) the provider had taken to improve the service.

On the first day the inspection team included two adult social care inspectors, a pharmacy inspector 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. The expert by experience had experience of older people's services. The second day was carried out by two adult care inspectors, the third day by two adult social care inspectors and a pharmacy inspector and the fourth day by two adult social care inspectors and a specialist advisor. A specialist advisor is a person with specialist skills and knowledge in a particular area. The specialist advisor we used was a specialist in medicine management.

Before our inspection, we reviewed the information we held about the home, requested information from Manchester City Council, the Clinical Commissioning Group (CCG) and the Nursing Home team. We looked at notifications we had received from the service and reviewed action plans sent to us by the provider after the last inspection with the improvements they said they were going to make.

During the inspection and safety and welfare check we spoke with 12 staff including the provider, the human resource manager, the head of quality and compliance , the acting manager, nurses and carers. In addition we spoke with the kitchen staff and two visiting healthcare professionals. We spoke with 16 people who used the service and eight visiting relatives.

We observed how staff and people living in the home interacted and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the

experience of people who could not talk with us. We observed support provided to people in the communal areas, including the dining room and lounges during lunch, during the medication round and when people were in their own rooms.

We reviewed 14 people's care files, including medicine records and looked at care monitoring records for personal and nursing care. We also looked at the recruitment records of the two newest staff.

We also reviewed the additional information received after the inspection which we had requested due to the serious concerns identified during our initial two days.

Inadequate

Is the service safe?

Our findings

At the inspection in April 2016 we rated the home as requiring improvement in this domain. This was because we had seen some improvement since the inspection in July 2015 in relation to medicine management although further improvement was needed. At this inspection we found the risk to people had increased due to the lack of permanent nursing staff and medication errors which had occurred as a result and had placed people at a serious risk of harm. The risk to people was extreme and we asked the provider to make two safeguarding referrals. We ensured people were safe before we left the inspection.

At the inspection in April 2016 there were two permanent day time nurses employed at the home who knew people well. This meant that when medicine errors occurred they were able to rectify them quickly which reduced the risk of harm to people who used the service. We found there were breaches in relation to medicine management but at that time the risk to people who used the service was not extreme.

At the inspection in August 2016 we found the permanent nurses had left and had not yet been replaced. The provider had told us at a meeting in June 2016 that they would block book agency staff in the interim period whilst permanent nurses were being recruited. At the inspection we spoke to the nurse on duty who told us they were from the agency and had been asked to work up until 01/09/2016. They told us they thought they were part of a block booking but had only commenced work 10 days previously. We spoke with the agency who confirmed they were reluctant to block book as they feared they would not be paid. During the inspection we were made aware from the agency that one of the nurses identified to work from the agency had decided they no longer wanted to work at the home because "they were worried they may loose their PIN." This meant that the home had not had permanent nursing staff for over two months. We checked to see what impact this had had on the people who used the service. We found it was extreme.

We found a number of people were not receiving the correct amount of medicine at the correct time. For example, one person was prescribed anti-Parkinson's medicines, where symptom control can be significantly reduced by omitted or delayed doses. On the 22 August the morning medicine round did not finish until 14.30 which meant this person received their medicine later than they should and was not in line with the prescribing instructions.

During the first day of the inspection we observed that the nursing home team had been called in to review the high blood sugars of one of the people living at the home. However on arrival the care home staff could not provide any history of the blood sugar results and records were not up to date. The registered nurse told us that they had taken a blood sugar in the morning for this person. This had not been recorded. Also, we found the test strips used had expired on 31August 2014. Using test strips that are out of date could give an inaccurate reading which meant people were at risk of inappropriate care and treatment.

We also noted one person was prescribed warfarin to thin their blood. An assessment from the anticoagulant clinic on the 28 July and 5 August 2016 stated that this person should have 2mg on three days of the week and 3mg on the other four days. The Medicine Administration Record Sheet (MARS) dated from 25 July to 21 August 2016 shows that 2mg was administered four times in a seven-day period between 4 and

10 August. This increased the risk of this developing a clot in the leg or the lung or a stroke.

Another person was also prescribed warfarin to thin their blood. The anticoagulant clinic prescribed a dose of 2mg on Tuesdays and Thursdays and 3mg to be administered on the
other days. On the Monday 1 August 2016, a 3mg tablet and 2x1mg tablets had been signed as being administered. On the 2 August, no warfarin had been signed as being given. There was no record that the discrepancy from the 1 and 2 August had been raised with the anticoagulant team or doctor. We asked the home to raise this as a safeguarding alert to the local authority as this person was at significant risk of harm.

We also found some people did not receive their medicine at all which increased the level of risk of harm to them. For example, we saw one person was prescribed amoxicillin 250mg/5ml liquid to be taken three times daily. At the morning handover on 22 August, we noted that staff said that a dose had not been administered the night of 21 August 2016. They said this was because staff could not find the Medication Administration Record sheet (MARS). The morning dose on the 22 August was also omitted, as the MARS could not be located. Missing antibiotics may reduce the effectiveness of the antibiotic in treating the infection and could increase the risk of antibiotic resistance.

We also noted that one person was prescribed a controlled drug (buprenorphine patches) for the relief of pain. The patch should have been changed on the 7 August 2016; however, the MARS and controlled drugs register stated that it had been applied on the 8 August 2016. This person was prescribed a controlled drug (butrans 5mcg patch) which should have been changed on the 5 August 2016; however, it was applied on the 6 August 2016. Having a patch applied a day late may affect the effectiveness of pain control.
We therefore found the home was still in breach of Regulation 12 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 with reference to 2(f)(g).

At the last inspection in April 2016 people told us, "They are terribly short staffed; they are run off their feet.I've been quite happy with the care but the atmosphere at the home is a bit down, there is no continuity of staff. There is poor communication between staff and management."
Staff we spoke with at this inspection told us morale had improved because of the manager. They said, "yes we can talk to [manager], she understands our concerns but the provider still doesn't listen and there is not enough staff."

We spoke with the nurse on duty who told us they felt there were not enough nurses. They said, "things get missed, systems don't work, two nurses are needed here to ensure patient safety." We had previously spoken with the provider at a meeting in April 2016 and through numerous email exchanges about the need to ensure the core staff team was stable. The provider had maintained there were enough nurses to support the 23 residents.

We spoke with the manager who confirmed they thought two nurses were needed. They said that because of the lower occupancy at the home the provider had not wanted to increase the nursing provision. This was corroborated by email exchanges between the provider, Manchester City Council and the Commission. A visiting professional told us that they "had not seen a regular nurse on duty for months which means information is not passed over. The nurses don't know the residents well and records are not current."

On the first day of the inspection we asked the provider what they had done to ensure there were enough nurses on duty. They told us they were working with an agency to block book staff for a 12 week period. We asked to see rotas to corroborate this but were unable to as the rotas were only done weekly. We spoke with one of the nurses from the agency who said they had worked at the home for a week and a half previously and was only booked until 1/09. The provider also said that the other agency nurse had agreed to take a

permanent contract. On the third day of the inspection we were able to speak with the manager as they had returned from holiday. They told us they were not aware that the agency nurse was becoming a permanent member of staff. We also spoke with the agency who confirmed the agency nurse did not want to work at the Home permanently.

The provider also told us they had recruited a clinical lead, as the clinical lead recruited after the last inspection in April had since left, and that they would be starting at the home 29/08/2016. They also told us that week commencing the 29/08 there would be two nurses on duty. When we arrived for the third day of inspection the manager told us the clinical lead was actually starting on 31/08. They confirmed that this role was supernumerary with only 12.5 hours being operational as a nurse. There was only one nurse on duty on the 30/08 and there had only been one the previous day. The manager told us they were not aware the provider had agreed to two nurses and this had not been organised in her absence.

We asked the manager to break down how many nursing hours still needed to be covered at this time. They told us it was 87.5 hours per week. The agency confirmed this was the number of hours they had been asked to provide cover for. This meant that consideration had not been given to having two nurses on duty which the provider had told us was happening. We spoke to the manager who then covered the rota for the next week with the agency nurse who had agreed to do extra shifts.

We had received information of concern that the provider was completing and updating nursing care plans and they were not qualified to do so. We checked seven nursing care plans. We found four had been updated by the provider and three by the head of quality and compliance who was a former nurse but did not hold a current PIN number.

For one person we found there was some confusion about how they should receive liquids. We saw thickeners were available in the kitchen area for this person with instructions to remind staff that this person was at high risk of choking and required thickened fluids.
We asked staff about this person. Two staff told us they had normal fluids and one staff said there was a note in the communication book from the provider telling them to thicken the drinks. We checked the care plan which said, '[name] is high risk with intake of foods and fluids. Risk feed due to risk of aspiration as documented in the pro formas available.' We asked to see the pro formas but the registered nurse was unable to locate it although they said they did recall seeing it. We checked through the most recent assessments from the speech and language team (SALT) done on 29 June 2016 which stated, normal fluids and a pureed diet.'

We then checked the communication book and saw an entry made on 26/8/2016 which read," Also [name of provider] said [name of resident] is on thicken fluids in all his drinks."
We asked the manager how the provider would have made that decision and if they were qualified to do so. They told us the provider was not qualified and the manager was not aware that the instruction had been made. The manager then rang the provider who denied asking staff to write the message in the communications book. We spoke with the staff member who was able to recall what was said, they told us,"[the provider] said to thicken the drinks which left us confused. They are not qualified to make this decision so we raised it with the nurse." The nurse told us they had instructed the staff to continue supporting the person in line with their SALT assessment. The manager told us they would ensure all staff knew to do this and would disregard the instructions from the provider.

After the last inspection we said we would closely monitor the position of the management team within the home and report on progress at the next inspection.

The home had recruited a manager but they had not yet applied to the Commission for their registration. The manager had written a statement outlining their hesitancy to register as the manager for the home as they wanted to protect their reputation. A clinical lead was also recruited but they had since left and a new clinical lead had been appointed. This person had worked at the home previously as had the head of quality and compliance. It is a concern that the service cannot retain key staff and this had been an issue since the registered manager left in 2014. We also had no assurances that key staff would stay because the manager was not registered and the head of quality and compliance was not on the payroll but worked as a consultant to the company. At our visit on the 12 September 2016 both the manager and the head of quality and compliance had left.

We considered that there were not sufficient numbers of suitably qualified, competent, skilled and experienced persons deployed in order to meet the needs of people who used the service. This was a breach of Regulation 18 (1) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we saw areas of the home needed new carpets and redecoration. The provider told us they were going to invest some of their own money into the home and were consulting with a designer to improve the environment for people living with dementia. We said we would check this at the next inspection. The provider sent us a plan outlining the improvements they said they had made. This was dated 24 June 2016 and it said, 'Refurbishments of the home are underway many now complete'.

We found one carpet had been replaced as we had instructed at the last inspection but no further remedial work had been done. There were a number of trip hazards as a result of the carpet edges lifting at joints or bunching up. We again brought this to the attention of the provider who said the carpets were being replaced next week. We asked them to send us confirmation that this had been ordered but we did not receive this. On the third day of the inspection we spoke to the manager about plans to refurbish the home which the provider had mentioned to us previously. They told us they were not aware of any plans and no refurbishment was taking place to their knowledge. We did not see any evidence of refurbishments having been done or taking place.

We looked around the garden and noted that the doorway to the small garden to the right of the building was open and not alarmed. The gate leaving the garden, which led to the refuse bin area, was in a poor state of repair allowing access to and from the main car park and onto the public road. We had been made aware of a previous incident in which one person had been found wandering outside the home. We did not see any action taken as a result of this incident and so the risk remained the same.

We noted that the hand rails in the Pergola in the garden were rotten and would not have taken the weight of anyone using the rail and we saw the wooden floor of the shelter in this garden was rotten and had collapsed. The main garden had a tent type shelter over the main decking area; the wooden decking was wet and slippery. We saw no evidence that a non-slip treatment had been applied which we considered to be a hazard.

There were no improvements in relation to the decor to support people who were living with dementia. There was a distinct lack of dementia friendly signage throughout the home and some rooms had no names on and others the wrong names. We did not see people moving around the home independently or being encouraged to do so. We considered this to be a breach of 15 (a,b,c,d,e) of The Health and Social Care Act 2008 (Regulated)Activities Regulations 2014

Inadequate

Is the service effective?

Our findings

At the inspection in April 2016 we found improvements were needed to ensure people had access to, and were offered snacks and drinks throughout the day and night if required. This was because there were a number of people who were at high risk of dehydration and malnutrition and care records did not accurately reflect what some people had consumed. The provider did not provide us with any update regarding how this had improved so we spoke to the staff and checked records.

We found some people did not receive their food supplements in the correct way and some records did not accurately reflect what people had consumed.

For example, one person was prescribed a food supplement (complan shakes) to be taken twice a day. Complan shakes had been withheld on 25, 26, and 29 July 2016 and on the 9 and 10 August 2016 due to 'loose stools'. There was no record that a doctor had advised the food supplement to be withheld. Not having food supplements as prescribed may increase the risk of not meeting a person's nutritional needs.

We spoke with the nurse about the issues the home had about the recording of food and fluids and they told us, "I've repeatedly told the management about recording fluid intake, they [the staff] record fluid provided but don't record the amount taken. They need to sit and watch them drink. I regularly find residents showing signs of dehydration when I do the meds."

We saw one person's nutrition care plan stated "poor oral intake of 300 – 500ml per day", however there was no documentation or correspondence to indicate their daily fluid intake requirements. The daily notes we looked at indicated that their fluid and food intake was small, for example, "6 spoons of food along with 100ml tea" and "200ml of thickened tea – sips taken only". The fluid intake was recorded as what was put into a cup or beaker before it was given to the person. It did not indicate the exact volume of liquid consumed by the person and was therefore difficult to obtain an accurate fluid balance record.

We checked the care plan for this person again on 30 August 2016 and saw an entry made by a care worker in the daily notes on 23/08/2016. The entry said, 'weight 33.4 – critical decrease'. We asked the nurse whether this had been escalated and appropriate action taken. They told us the care worker had not made them aware and it had not flagged up on the daily handover report. This meant people at risk of weight loss and malnutrition were placed at higher risk because critical information was not passed on. The nurse told us an urgent referral would be made to the nursing home team to ensure this person was reassessed. We found there to be breaches of Regulation 14 (1, a,b 4,d). of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not protected from the risk of malnourishment and dehydration.

At the last inspection we found there was a breach of regulation relating to the skills and knowledge of some of the staff. We checked to see if improvements had been made.

We found that some improvements had been made with a number of staff telling us they had recently

attended safeguarding training. However one of the bank nurses employed by the home told us they had not received any training at Fresh Fields.

We asked night staff about their understanding of safeguarding and although they had awareness of what safeguarding meant they were unable to locate the safeguarding policy as it was not in the policy filing cabinet. We asked the staff if there was a safeguarding incident who they would report it to. They told us there was a telephone number they would ring and that it was on the notice board in the kitchen. On looking this could not be found. This meant that the night staff would not be able to make a safeguarding referral because the nurse in charge was neither aware of the referral process or the telephone numbers to ring.

Another member of staff told us that they had not seen or read care plans/risk assessments and would not know how to access them. They told us they had not been shown how to use the care doc system and so could not update any care plans. They told us they had not received an induction but other staff showed them what to do.

We asked the staff if they had received supervisions. All staff said they had had one in July with the clinical lead who had now left. Some staff also said they received supervision with a nurse who had also left. Staff were asked how they were able to raise any issues they had. One said, "Managers just go; we don't know why, we are kept in the dark, I may go to [head of quality and compliance but not to [provider]. Happy to talk with [manager]."

We wanted to check how well the staff knew the care needs of the people they were supporting. We found the majority of the care staff knew people well, but the nurses, because they were new to the home and not permanent did not. We found this impacted on the quality of care provided and put people at risk.

We asked to see the training matrix and were told it would be sent on after the inspection. We did not receive this.

We found the ongoing lack of support for staff and the lack of staff insight of the impact their lack of knowledge may have on the individuals they supported was a continued breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At the last inspection we found that staff working at the home, including nurses, had no understanding of the Mental Capacity Act 2005 or the process which should be followed if someone needed to be deprived of their liberty.

We saw the manager had begun the process of assessing the capacity of people who we were told by the

provider were at the highest risk. We were then shown applications which had been made to the authorising body in line with the MCA. We asked to see the capacity assessments for two people because we believed, through conversations and observations, that they did have capacity when they had been assessed as having no capacity. The provider told us the nursing home team had done the assessments for one of these people and they were in the process of challenging the outcome as they also believed the person had capacity. We asked the provider to send us a copy of this assessment but they did not. We saw improvements had been made in relation to the application of the principles of the act but this process had not been completed for all people and it was a concern to us because the acting manager had left.

We saw examples of where service users' rights were not upheld and the home was not working in accordance with the MCA. One person was being prescribed medication covertly. There was no care plan or risk assessment to support this and the person had not given their consent. Other people were being nursed in bed because there were no suitable chairs for them to sit in. Again they had not given their consent and was a deprivation of their liberty. We brought this to the attention of the manager who spoke to staff to ask them about suitable chairs. One member of staff said that there was a chair at the person's house and that it had supposed to have been brought into the home in February 2016 but this "just hadn't happened". The manager then instructed the staff to ensure the chair was brought in. We found unnecessary restrictions were being placed on people and this was a continued breach of Regulation 11 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the inspection in April 2016 we found improvements were needed to ensure people had access to, and were offered snacks and drinks throughout the day and night if required. This was because there were a number of people who were at high risk of dehydration and malnutrition and care records did not accurately reflect what some people had consumed. The provider did not provide us with any update regarding how this had improved so we spoke to the staff and checked records.

We found some people did not receive their food supplements in the correct way and some records did not accurately reflect what people had consumed.

For example, one person was prescribed a food supplement (complan shakes) to be taken twice a day. Complan shakes had been withheld on 25, 26, and 29 July 2016 and on the 9 and 10 August 2016 due to 'loose stools'. There was no record that a doctor had advised the food supplement to be withheld. Not having food supplements as prescribed may increase the risk of not meeting a person's nutritional needs.

We spoke with the nurse about the issues the home had about the recording of food and fluids and they told us, "I've repeatedly told the management about recording fluid intake, they [the staff] record fluid provided but don't record the amount taken. They need to sit and watch them drink. I regularly find residents showing signs of dehydration when I do the meds."

We saw one person's nutrition care plan stated "poor oral intake of 300 – 500ml per day", however there was no documentation or correspondence to indicate their daily fluid intake requirements. The daily notes we looked at indicated that their fluid and food intake was small, for example, "6 spoons of food along with 100ml tea" and "200ml of thickened tea – sips taken only". The fluid intake was recorded as what was put into a cup or beaker before it was given to the person. It did not indicate the exact volume of liquid consumed by the person and was therefore difficult to obtain an accurate fluid balance record.

We checked the care plan for this person again on 30 August 2016 and saw an entry made by a care worker in the daily notes on 23/08/2016. The entry said, 'weight 33.4 – critical decrease'. We asked the nurse

whether this had been escalated and appropriate action taken. They told us the care worker had not made them aware and it had not flagged up on the daily handover report. This meant people at risk of weight loss and malnutrition were placed at higher risk because critical information was not passed on. The nurse told us an urgent referral would be made to the nursing home team to ensure this person was reassessed. We found there to be breaches of Regulation 14 (1, a,b 4,d). of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 because people were not protected from the risk of malnourishment and dehydration.

At the last inspection we found there was a breach of regulation relating to the skills and knowledge of some of the staff. We checked to see if improvements had been made.

We found that some improvements had been made with a number of staff telling us they had recently attended safeguarding training. However one of the bank nurses employed by the home told us they had not received any training at Fresh Fields.

We asked night staff about their understanding of safeguarding and although they had awareness of what safeguarding meant they were unable to locate the safeguarding policy as it was not in the policy filing cabinet. We asked the staff if there was a safeguarding incident who they would report it to. They told us there was a telephone number they would ring and that it was on the notice board in the kitchen. On looking this could not be found. This meant that the night staff would not be able to make a safeguarding referral because the nurse in charge was neither aware of the referral process or the telephone numbers to ring.

Another member of staff told us that they had not seen or read care plans/risk assessments and would not know how to access them. They told us they had not been shown how to use the care doc system and so could not update any care plans. They told us they had not received an induction but other staff showed them what to do.

We asked the staff if they had received supervisions. All staff said they had had one in July with the clinical lead who had now left. Some staff also said they received supervision with a nurse who had also left. Staff were asked how they were able to raise any issues they had. One said, "Managers just go; we don't know why, we are kept in the dark, I may go to [head of quality and compliance but not to [provider]. Happy to talk with [manager]."

We wanted to check how well the staff knew the care needs of the people they were supporting. We found the majority of the care staff knew people well, but the nurses, because they were new to the home and not permanent did not. We found this impacted on the quality of care provided and put people at risk.

We asked to see the training matrix and were told it would be sent on after the inspection. We did not receive this.

We found the ongoing lack of support for staff and the lack of staff insight of the impact their lack of knowledge may have on the individuals they supported was a continued breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to

take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

At the last inspection we found that staff working at the home, including nurses, had no understanding of the Mental Capacity Act 2005 or the process which should be followed if someone needed to be deprived of their liberty.

We saw the manager had begun the process of assessing the capacity of people who we were told by the provider were at the highest risk. We were then shown applications which had been made to the authorising body in line with the MCA. We asked to see the capacity assessments for two people because we believed, through conversations and observations, that they did have capacity when they had been assessed as having no capacity. The provider told us the nursing home team had done the assessments for one of these people and they were in the process of challenging the outcome as they also believed the person had capacity. We asked the provider to send us a copy of this assessment but they did not. We saw improvements had been made in relation to the application of the principles of the act but this process had not been completed for all people and it was a concern to us because the acting manager had left.

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Requires Improvement

Is the service caring?

Our findings

At the last inspection people told us, "We all get on well, most staff are kind when they have the time they talk to me", and, "I've been quiet happy with the care but the atmosphere at the home is a bit down, there is no continuity of staff. There is poor communication between staff and management." We found people's views had not changed at the inspection in August but some people did comment that the presence of the manager was positive. They told us, "the manager is lovely, our only hope is that she stays." A visiting relative told us , "The care is very good with the new staff, [manager] she has held a few meetings with us, I'm going to get [name] assessed at last, something I've been trying to do for ages. They are still short of staff at times"

We carried out observations in the home over both floors and spoke to people about their care and treatment. We found some staff interacted well, but others did not. We also found people were not involved in aspects of their care and some were not treated with dignity.

For example, during our observations, we saw one person was sat in the dining area of the communal room alone and away from other people. We asked the person why they were sat alone. They replied, "They just plonked me down here, I don't know why, I usually sit in one of the chairs with the others." Through checking their care plan we noted that this person had a bacterial infection, which required them to be barrier nursed during the infectious period. However when we spoke with staff they were unsure whether this person was infectious or not. A sign in their room indicated they were being barrier nursed, this read, "All staff: wipes, gloves, aprons for use in this room only". We then saw the person being wheeled out of the room to the hairdressers and to the lounge area. Not knowing whether this person was infectious or not meant other residents were put at risk by non-implementation of correct infection control practices. It also meant that this person was being isolated inappropriately.

Another person who was sitting in the lounge area upstairs told us they would rather be in their room. They said, "I have to sit here listening to the radio, I hate it but they won't let me stay in my room, they said I might choke." When we checked the care plan for this person we could not see any information pertaining to the risk of choking.

When we arrived on the first day of inspection we arrived early in the morning so we could ensure there were the correct numbers of staff on duty to support the needs of the people living at the home. We observed there were three care staff and one nurse. We also observed one person still dressed and in bed. The night nurse was unable to tell us why so asked the care staff. They said that it was usual practice because the day staff expected them to get a number of people up before they arrived on shift and that there was a like for like agreement that day staff put people to bed before the night shift began. We found six people had been woken, washed, dressed and put back to bed. When we asked staff whether the person we had seen minded being woken up we were told that the person was unable to communicate so wasn't asked.

At the last inspection we found improvements were needed at mealtimes to ensure people enjoyed their mealtime experience and were offered an opportunity to sit together and dine. We discussed with the provider the importance of ensuring the mealtime experience was a positive one for everybody. At this

inspection we found there was no improvement. Some staff interacted well with the person they were supporting whilst others did not. People were not given the opportunity to sit together and would not have been able to because there were not enough tables and chairs to accommodate more than seven people. Some staff were supporting two people to eat at the same time and made no effort to communicate with either.

We found the continued lack of consideration for the dignity of and lack of respect for people's wellbeing was a breach of Regulation 10 (1, b) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Inadequate

Is the service responsive?

Our findings

At the last inspection in April 2016 we found breaches in relation to the provision of person-centred care, so we looked to see if improvements had been made. Person-centred care planning is particularly important when supporting people who are living with dementia or do not communicate verbally or in conventional ways.

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. The provider told us they had asked families to complete a booklet which would help staff know more about people. One family member told us,
"My wife usually deals with everything for her [relative]. I know she has been asked to fill in a booklet about her life; It's quite extensive with lots of information asked. "

We looked at the care docs system to see what improvements had been made in relation to understanding people's individual preferences, things which were important to them and things which may affect the way they receive support. We looked to see if people were being cared for in a person centred way.

At the last inspection we found for one person, who was unable to communicate in a conventional way, their communication aids were not being used and staff were relying on the activities co-ordinator to interpret what this person wanted. It was therefore not clear to us how this person would indicate to agency staff or staff who did not know them well what they wanted or needed or if they were in pain.

We saw work had been done with staff to help them understand this person better and we were told by them that the person did not want to use communication aids as they felt embarrassed doing so. We spoke to the person concerned who showed us a new communication passport staff had made but they also indicated to us that they didn't want to use it. We then checked the care plan for this person which also indicated that they had communication aids if needed but that they didn't like using them. This meant staff had ensured that this person's choice was respected and that their decisions had been clearly recorded in their care plan.

However we found person centred care was not offered to all people at the home particularly in relation to their mental health and wellbeing. For example we noted one person did not have their prescribed medicine, Trazodone, to reduce any behavioural and psychological symptoms. Their care plan did not outline this medication was to be given. This meant this person was at risk of inappropriate care and treatment as support was not offered in line with their assessed needs.

We found another person was at risk of inappropriate care because their needs had not been accurately assessed and appropriate plans had not been put in place to manage the risk. For example, the care plan we looked at stated that 'frustration' was the main cause of behaviour which may be perceived as challenging. A member of staff informed us that this person had behaviour that can be perceived as challenging when she is in pain; however her care plan did not reflect this. We saw the person was prescribed a controlled drug

(CD) (butran patch) which should have been replaced every seven days. We noted that a patch had been applied on 2 August and on the 9 August the Medicine Administration Record was signed to say the patch was out of stock. We saw a supply of patches had arrived at the home on 11 August and had been recorded in the CD register but was not given to the person who needed it until 16 August 2016 leaving a period of seven days without pain relief. During this time daily records we looked at stated that this person had, "been in an irritated mood today and flung her beaker of tea across the room." This was recorded on the 15th August with a further entry of this person being "unsettled in the night." The provider had updated the care plan but had not considered why this person may have been unsettled or looked at any trends which may have indicated reasons this person had behaved in this way.

At the last inspection we had found a breach in relation to person centred care because people who were living with dementia did not have care plans to enable staff to know about or support people to manage their condition. After the inspection we were sent two dementia care plans which had been completed by the provider in July 2016. We were also shown a list of people who were living with dementia in relation to their capacity and ability to make decisions and to identify the "primary short term outcome relating to the resident and his/her dementia". We noted that out of 23 people on the list 12 had the outcome " to promote safety in day to day life to reduce the likelihood of harm" whilst the other 11 had the outcome, " to maintain current level of independence ability and confidence". This meant that for each person the answer had been a cut and paste exercise rather than assessment which was person centred to meet their individual care needs

We spoke to the provider about this they said that they had been in communication with a company to deliver some training and resources on person centred care and that this was to be commissioned in the near future and had not yet been implemented.

We therefore found there was a continued breach of Regulation 9 (1 a, b, and c) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection in April 2016 we,' looked at whether assessments for people living at the home were regularly reviewed and updated. We saw they were but found gaps in the recording on the Care Docs system. We spoke with the nursing home team who were visiting and asked their views on how the home assessed and monitored people's care needs. They told us, "It's been impossible as they [the nurses] have not had management supervision or clinical supervision. If they were given time and training and support they could do it. The nurses feel panic-stricken if they have a day off." We checked to see what improvements had been made to make the care plans more accessible.

We found access to the Care Docs system was still an issue. There were only two terminals available for people to work on and these were located in the nurse's room's upstairs and downstairs away from the communal areas of the home where most people were located throughout the day. Therefore we found an issue for staff wanting to write daily notes because they were away from the floor and there was lack of time to read care plans. They told us this could leave only one staff member on the floor of the home when the other was trying to update Care Docs. They told us this meant care and support was delayed at times and people did not receive care in a timely manner in line with their assessed needs. Staff also told us the two terminals were being used for the e-learning courses and GPs and nurses also need to use the terminals to write their notes so staff had to wait.

One staff said, "The only issue is the Care Docs system. It's not possible to keep it up to date as there isn't enough time to do it. You can't re-read what you have put in – it is difficult to see what staff put in the day before." Another said, "It's a long winded system to put all the information into so takes a lot of time."

The registered nurse we spoke with said, "Care Docs is not fit for purpose. Staff have no access to read the care plans and so all the information is in their heads to pass on to other staff."

The provider had told us they had provided tablet computers to staff so they could update care plans and access information when they needed it. However the tablets did not work when we asked staff to show us and they did not know their passwords.

We saw the provider and the head of quality and compliance had updated care plans throughout the month of July. One member of staff told us they thought it had been done as a "tick box" exercise. We also found evidence that records and updates were not an accurate reflection of what people needed.

We therefore found the continued failure to ensure records were up to date and accurate was as a result of the lack of leadership and management within the home. This was a breach of Regulation 17 (c) of the Health and Social care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we found there was a breach in relation to how the provider managed complaints. At this inspection we spoke with some of the people who had previously complained. They told us, "She [the manager] dealt with it immediately; she called a team meeting of staff straight away and told the staff that such behaviour was unacceptable." And, "she [the manager] is slowly getting on top of everything. She is working really hard, communications are so much better now. It's work in progress but I'm more confident now in the home and the care mum receives."

We found that the manager had introduced systems to effectively manage complaints and people were happy with the progress which had been made in relation to this. We therefore found the provider was no longer in breach of this regulation. However as the acting manager and head of quality and compliance had left we will continue to monitor this closely.

Inadequate

Is the service well-led?

Our findings

At the last inspection we found the provider had started to address some of the issues which staff were unhappy about. We noted that, "This included unpaid wages and invoices and new equipment which was needed. The provider had recruited a finance manager who confirmed they were in negotiation with contractors for the provision of services within the home such as clinical waste removal and food supplies."

However at this inspection we were made aware that the manager had received phone calls from people wanting payment for things and services such as agency nurses they had provided to the home and had not yet been paid for. This had been an ongoing concern from the previous year when we were made aware that bailiffs had attended the home to seize goods due to non -payment of bills.

At this inspection the provider again said they were willing to make a financial commitment to the home. We did not see any evidence that the provider had made any investment following on from the last inspection.

During the inspection members of the management team told us, [name of provider] does not seem to understand the seriousness of the situation they are in. They need to do what they say they are going to do and stop making promises about things they can't deliver. It sickens me to think that bills are not paid and staff worry they won't be paid and we don't even have two chairs that match for people to sit on."

At the last inspection we found the provider had not ensured that effective systems for monitoring the safety and quality of service provision were implemented which was a continued breach of Regulation 17 (1) with reference to (2)(e, f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They had previously been in breach of this regulation in the inspections of July 2015 and January 2015.

We noted, "This was because they had not ensured appropriate checks were done to monitor and improve the quality of the service. We checked the audits which had been carried out. We found despite some good systems for recording and monitoring the quality of the service these had not been used consistently or at all. This meant the provider had no oversight of the issues within the home and had not taken responsibility for ensuring this was managed. This had resulted in a breakdown of trust between the staff, families of people who use services and the provider."

In the response to our last inspection the provider sent us an action plan dated 24 June 2016 outlining that the, "Assurance and auditing systems or processes have been improved. Staff have received and will continue to receive further training on writing up care notes, documenting key health information and a clear audit trail of information."

We found that auditing tools had been established but were not being used to drive improvement and they had not been effective in finding the things we had found during the inspection. Staff had not received training in writing up care notes and there was not a clear audit trail of information.

We had received several emails from the provider over June, July and August 2016 outlining improvements

they were planning or had already made. At the inspection in April 2016 we noted that a consultant had been commissioned by the provider to look at quality across the service. We were then told that a head of quality and compliance had been employed and that they had worked at the service previously. After we carried out the safety and welfare check on 30 August we were made aware that the head of quality and compliance had decided to leave the service and the provider advised that they had commissioned another consultant to look at quality control and auditing and to crisis manage the service. This meant that since the inspection in April 2016 the provider had commissioned three different individuals or agencies to provide support to the home. We did not see any evidence of robust quality audits which had been created as a result of the consultants hired.

We considered that the provider had not ensured that effective systems for monitoring the safety and service provision were operated which had resulted in a risk of harm to some of the people who used the service. This was a continued breach of Regulation 17(1) with reference to (2)(e, f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We considered this to be an extreme risk because of the provider's continued non- compliance with this regulation and lack of understanding of the impact this had on service all aspects of service provision and people's health and wellbeing.

At the last inspection we found that the home had not informed us of incidents which had occurred in line with their statutory duty. Improvements had been made since the appointment of the manager and we had been kept informed of the things we needed to know about. However it was a concern to us that the manager had left and so we asked the provider to send us information about how the home was to be managed. They told us that they would be managing the home until another interim manager was appointed. We will continue to monitor this closely.

At the last inspection we found the provider had not displayed their ratings as outlined in Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We saw at this inspection that the ratings were displayed both in the home and on the website.
At this inspection we found the same failings which we had summarised previously in April 2016. "Overall, we found the lack of a registered manager within the home and the lack of leadership, management and governance from the nominated individual had compromised the quality of care in all aspects of service delivery. Improvement was needed in all areas to ensure people received safe, effective, responsive and well led care."

We met with the provider after the inspection in 2015 and had received assurances that improvements would be made. We met them again in April and June 2016 and received the same assurances; Our position remains the same in that, "The regulations are clear in relation to the action a provider must take to ensure people are protected in the absence of a registered manager. We found the provider did not make sufficient arrangements to ensure there was adequate staff on duty to safeguard people nor did they consider the impact this lack of leadership may have on the people who used the service

We considered this to be a breach of Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The nominated individual did not demonstrate they had the necessary skills, experience or qualifications to carry out their role which had led to people being placed at significant or actual risk of harm.