Fynvola Foundation

Lady Dane Farmhouse

Inspection report

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Date of inspection visit:
03 January 2017
05 January 2017

Date of publication:
03 March 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out on 03 and 05 January 2017. The first day of the inspection was unannounced.

Lady Dane Farmhouse is a purpose built nursing home providing accommodation and nursing care for up to fifteen people with a learning disability. The service is provided by the Fynvola Foundation, which is a registered charity. The home is a two storey building with a passenger lift to rooms on the first floor. One person occupied a room on this floor during the inspection. On the second day of our inspection the lift had broken down. There is a separate building in the grounds used as an activities centre by the people who live in the home. There were 11 people living at the home when we inspected.

The service did not have a registered manager. 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. The previous registered manager had left the organisation in October 2015. There had been a lengthy delay in submitting an application to register a new manager. The service had a home manager in place who submitted an application to register in December 2016.

At our previous inspection on 03 and 05 November 2015, we found breaches of Regulation 12, Regulation 17 and Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Medicines had not been properly managed. Systems to monitor quality and safety were not always operated effectively and records were not always accurate and complete. The provider had not established and operated effective recruitment procedures. We asked the provider to take action to meet the regulations. We did not receive an action plan from the provider. At this inspection we found that the necessary improvements had not been made.

Relatives told us their family members received safe, effective, caring and responsive care and the service was well led.

Effective recruitment procedures were not in place to ensure that potential staff employed were of good character and had the skills and experience needed to carry out their roles.

Medicines were not always well managed. Medicines had not been stored and administered appropriately.

Risks to people's safety and wellbeing were not always managed effectively to make sure they were protected from harm. Risk assessments did not always detail how to minimise the risk of harm.

People's care plans did not always contain information for staff about how to meet a person's assessed needs.

Effective systems were not in place to enable the provider to assess, monitor and improve the quality and safety of the service.

Information about people was not always treated confidentially. People's daily observation charts which included observations, repositioning were found outside of people's bedrooms in communal areas which meant they were accessible to everyone.

The provider had failed to notify CQC of incidents and events such as deaths, serious injuries. The provider had failed to display their rating in the home.

People had not always received medical assistance from healthcare professionals when they needed it.

People had choices of food at each meal time. People that did not want to eat what had been cooked were offered alternatives. People with specialist diets had been catered for.

There were suitable numbers of staff on shift to meet people's needs. A nurse was allocated on each shift. Dependency levels were assessed to check the level of support each person needed. However, this did not then inform an assessment of whether there were enough staff to provide that level of care.

Staff knew and understood how to protect people from abuse and harm and keep them safe.

Most nurses and care staff had received appropriate training to carry out their roles. The service had not followed good practice guidance to ensure that new staff received a comprehensive induction. We made a recommendation about this.

Staff had received training in relation to the Mental Capacity Act (MCA) 2005. Mental capacity assessments did not always follow the principles of the MCA. We made a recommendation about this.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. Deprivation of Liberty Safeguards (DoLS) applications had been made to the local authority and had been approved. The provider had a system in place to monitor and track these but this was not robust. We made a recommendation about this.

The service had been well maintained, clean and tidy. Some areas of the home, such as people's bedrooms felt cold.

The complaints procedures were detailed to ensure people and their relatives knew who to contact if they had a complaint.

Staff knew how to ensure that people were respected and treated with dignity. Staff told us they ensured people had choices and were involved in their care.

We observed friendly and compassionate care in the service. The staff were happy and up-beat, they enjoyed their work and this was reflected in the care we observed them providing.

Relatives told us that they were able to visit their family members at any reasonable time, they were always made to feel welcome and there was always a nice atmosphere.

Relatives confirmed that they received regular surveys and were asked to feedback about the service their

family members received.

Relatives and staff told us that the home was well run. Staff were positive about the support they received from the manager. They felt they could raise concerns and they would be listened to.

Communication between staff within the home was good. They were made aware of significant events and any changes in people's behaviour. Handovers between staff going off shift and those coming on shift took place to make sure all staff were kept up to date.

Staff showed us that they understood the vision and values of the organisation; we observed practice to show that staff had embedded this into their work.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Effective recruitment procedures were not in place. Records relating to employment were not complete. There were enough staff deployed in the home to meet people's needs.

Risks to people's safety and welfare were not always well managed to make sure they were protected from harm.

Medicines were not always administered following the prescribers instructions.

Checks and maintenance on the building been completed, repairs were completed in a timely manner.

Staff had a good knowledge and understanding on how to keep people safe from abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People had choices of food and where they wished to eat their meals. The menus were written and were not in an easy to read format to help people understand.

Most nurses and care staff had received appropriate training to carry out their roles. The service had not followed good practice guidance to ensure that new staff received a comprehensive induction.

Mental capacity assessments were undertaken however, they did not follow the principles of the Mental Capacity Act (2005). The provider had a system in place to monitor Deprivation of Liberty Safeguards. The system was not robust.

Most people had received medical assistance from healthcare professionals when they needed it.

Is the service caring?

Good

The service was caring.

Staff knew people well and there were positive interaction between people and staff.

Staff treated people with kindness and understanding. Staff made time to talk with people whilst going about their day to day work.

Staff were careful to protect people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care plans did not always give clear details about how staff should meet their needs.

A variety of activities were on offer for people within the home. People were encouraged to take part in their local community.

People and their relatives knew who to contact if they had a complaint. Complaints procedures were in place.

Is the service well-led?

Inadequate

The service was not well led.

Systems to monitor the quality of the service were not effective. Systems to support the management of the home were not robust. People's information was not always treated confidentially.

The provider had not reported incidents to CQC. The provider had not displayed the rating from the last inspection in the home.

Staff were aware of the whistleblowing procedures and were confident that poor practice would be reported appropriately.

Staff were positive about the support they received from the management team.

Lady Dane Farmhouse

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 03 and 05 January 2017 and was unannounced.

The inspection team consisted of one inspector, a specialist advisor who was a trained nurse with a background of working with people with learning disabilities and an expert by experience. An expert by experience is a person who has personal experience of using similar services or caring for learning disabled family members.

Before the inspection we reviewed previous inspection reports, information from whistle blowers and two notifications. A notification is information about important events which the service is required to send us by law.

We spoke with 11 staff including support workers, nurses, maintenance staff, the cook, the head of care, the manager and one of the trustees of the charity. We also spoke to another member of staff outside of the inspection visit.

Most people were not able to verbally express their experiences of living in the home. We observed staff interactions with people and observed care and support in communal areas. We spoke with two relatives by telephone after we inspected.

We contacted health and social care professionals including the local authorities' quality assurance team and care managers to obtain feedback about their experience of the service.

We looked at records held by the provider and care records held in the home. These included five people's care records, 11 medicines records, risk assessments, staff rotas, five staff recruitment records, meeting minutes, quality audits, policies and procedures.

We asked the manager to send additional information after the inspection visit, including training records, policies and some contact telephone numbers. The information we requested was sent to us in a timely manner.

Requires Improvement

Is the service safe?

Our findings

At our last inspection on 03 and 05 November July 2015, we identified breaches of Regulation 12 and Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had not properly managed people's medicines. Safe recruitment procedures were not in place to make sure staff were suitable to work with people. We asked the provider to take action to meet the regulations.

At this inspection, we found that recruitment procedures and medicines practice had not improved.

Some people were unable to verbally tell us about their experiences. We observed that staff supported people to maintain their safety within the service.

Relatives told us their family members received safe care. Comments included, "They look after [person] very well, I can't praise them enough"; "There are always nurses on shift" and "He's a lot safer there than in hospital".

At this inspection we found that all of the staff recruitment records contained photographs of staff. References had been received by the provider for all new employees. The provider had employed new staff since the last inspection and had not checked reasons for gaps in employment for four staff. One new staff member had a gap of 12 years in their employment history. Another had a gap of 18 years in their employment history which had not been explored. Therefore, the provider had not carried out sufficient checks to ensure the staff members were suitable to work around people who needed safeguarding from harm.

This failure to carry out adequate employment checks was a breach of Regulation 19 (2)(a)(3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff had started work after relevant checks had been made through the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services. Nurses were registered with the Nursing and Midwifery Council and the manager had made checks on their PIN numbers to confirm their registration status.

At this inspection, we found that medicines practice required further improvement. Prescribed fluid thickeners, which are used to thicken drinks to help people who had difficulty swallowing, were left accessible and unattended in the dining area of the home. Published guidance recommends that prescribed thickeners should be kept locked away to prevent accidental ingestion of the powder. A patient safety alert had been cascaded by NHS England in February 2015 which warned care providers to the dangers of ingesting thickener. The manager did not know about this safety alert; however they told us that the thickeners should be kept in a locked cupboard in the dining room.

The medicines round was carried out by a nurse who had undergone relevant training. Medicines records

were clear and accurate. We checked the medicines records for the month and found that people had received the medicines they had been prescribed. Each person's MAR included a photograph. Staff only signed the MAR once the medicine had been administered. The nurse measure out a person's liquid Paracetamol, which was as the GP had prescribed; they then added another person's prescribed thickener to the Paracetamol to thicken the fluid to the desired thickness to help the person swallow. We spoke with the nurse and asked why they had used another person's thickener. The nurse said that all the people living at the home were prescribed the same thickener. We reported this to the manager to highlight the legal requirements around using other people's prescribed medicines for another person.

There were no protocols in place to detail information and guidance for staff in relation to 'as and when required' (PRN) medicines. This guidance should be in place to detail how a person communicated pain, why PRN medicines were needed, reason for administration, the frequency, and the maximum dose that could be given over a set period of time. The nurse was unable to detail how people communicated whether they were in pain. This put people at risk particularly when staff who were new or were supplied by an agency were on shift as they would not necessarily know if people were in pain or not.

There were oxygen cylinders stored in the clinical room with clear signage on the door. There were eight small oxygen cylinders in the clinical room leaning up against a wall which were not secured. The correct way to store oxygen had not been followed. Small oxygen cylinders should be stored horizontally on shelves. A small number of cylinders only should be stored in the clinical room. Any excess bottles should be stored outside of the home in a suitable locked store to reduce the risk of rupture and minimise fire risks.

This failure to ensure that medicines were suitably administered and stored was a breach of Regulation 12(1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risk assessments had been undertaken to ensure that people received safe and appropriate care. Risk assessments included a list of assessed risks and care needs, they detailed each person's abilities and current care needs. Risk assessments corresponded with each section of the care plan. For example, risk assessments were in place for moving and handling people. Moving and handling risk assessments did not always detail what size sling a person needed. Risk assessments showed that nursing staff had assessed people's skin integrity. However, some risk assessments did not always detail what action staff should take to reduce the risk to people. One person had a falls risk assessment in place which showed they had fallen, however it did not show what action had been taken to address the issue in line with the guidance on the form.

Accident and incidents had been recorded. However, it was not always clear what action had been taken as a result of the incident/accident. Some records showed that the local authority care manager had been informed and some had not. Some had been filed away without management action. We read about one incident where a person had been mistakenly left in the activities centre and locked in. whilst the manager was able to verbally tell us what action was taken and how it was addressed with staff, a risk assessment had not been put in place to detail what staff should do to mitigate the risks of it happening again.

This failure to ensure that risks were managed to ensure people were safe from harm was a breach of Regulation 12(1)(2)(a)(b)(d) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had been well maintained, clean and tidy. Some areas of the home, such as people's bedrooms felt cold. Staff had reported these issues to the maintenance team. The maintenance book evidenced that this was a regular issue. The manager told us that heating engineers had visited the service to make repairs. Some portable electric heaters were available to use, however these were not always in use when the rooms

felt cold. People were offered extra blankets to keep them warm. There had been intermittent issues with the lift for a number of months. On our second day of inspection the lift had broken down again and was not in use. This meant that one person had to use the stairs to get to their bedroom. Systems were in place to protect people from the risks of fire, each person had a personal emergency evacuation plan (PEEP) in place which was individual to their needs. Fire tests had been carried out frequently.

There were suitable numbers of staff on shift to meet people's needs. A nurse was allocated on each shift. One relatives told us, "There is usually enough staff around". The staffing rotas showed that there were plenty of staff, on occasions this was reduced due to staff sickness, however staff were offered overtime to fill these hours. Agency nursing staff were deployed to fill nursing shifts when needed. There was no system in place to calculate and review staffing levels to evidence that staffing levels changed when people's needs increased. We found that people's dependency was assessed as to what level of care and nursing care they required however this did not then inform an assessment of whether there were enough staff to provide that level of care. We spoke with the manager and head of care about this and they told us that the staffing levels had been the same for a long period of time. The staffing levels had recently been reduced because the number of people living in the home had reduced. The head of care had recognised that they did not have a system in place and had already explored different tools available to find one that was suitable.

People were protected from abuse and mistreatment. Staff had completed safeguarding adults training. The staff training records showed that 36 out of 38 staff had completed training. Staff understood the various types of abuse to look out for to make sure people were protected from harm. They knew who to report any concerns to and had access to the whistleblowing policy. Staff all told us they were confident that any concerns would be dealt with appropriately. Staff had access to the providers safeguarding policy as well as the local authority safeguarding policy, protocol and procedure. This policy is in place for all care providers within the Kent and Medway area, it provides guidance to staff and to managers about their responsibilities for reporting abuse. The manager knew how to report any safeguarding concerns.

Requires Improvement

Is the service effective?

Our findings

Some people were unable to verbally tell us about their experiences. We observed that staff confidently interacted with people showing empathy and understanding of needs such as anxiety.

Relatives told us their family members received effective care which met their health needs. Relatives told us that the service was good at communicating changes or concerns with them in a timely manner. Comments included, "A couple of times Fynvola have communicated that [person] had chest infections"; "They notify me straight away when he's not well"; They make a note of all the drinks he has"; "They are good at communicating" and "I have never come across anyone [staff] that is not understanding and empathetic".

People had not always received medical assistance from healthcare professionals when they needed it. One person's care records showed that they were prone to urine infections and regularly took medicines to manage this. Nursing staff regularly checked the person's urine when the person displayed signs that they may have an infection. However, action had not always been taken on 01 January 2017 when the test results showed that the person may have an infection. We spoke with a member of nursing staff who confirmed that the test results should have been reported to the GP. The GP was contacted about another person who had been experiencing increased seizure activity whilst we inspected. The nurse reported that the person had been experiencing increased seizures but had not detailed how many which may have escalated the concern to the GP. Records showed that the person had experienced 26 seizures in three days. The person did not have a formal diagnosis of epilepsy and nursing staff had explained they had reported the seizures to the GP with the hope that the GP would refer the person on to the epilepsy nursing service so they could get further support to help manage the person's health.

The provider had failed to effectively meet people's healthcare needs. This was a breach of Regulation 9 (1)(a)(b)(c)(2)(3)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Everyone was registered with a local GP. During the inspection we observed a nurse contact a GP to request a visit for a person who was unwell. The GP arrived the same day and prescribed the person antibiotics. Another person was supported to attend a hospital appointment. Relatives told us that staff were quick to notice changes in their family members and took action quickly.

People had access to speech and language therapist (SaLT), occupational therapists and other specialist services. Referrals had been made to SaLT and the dietician when people needed it. Records demonstrated that staff had contacted the GP, diabetic nurses, respiratory nurses, physiotherapists, the ambulance service, hospital, local authority care managers and relatives when necessary. Care plans covered risk in relation to people and the condition of their skin. The care plans could be cross referenced with risk assessments on file that covered the same area.

People were provided with food and drink that enabled them to maintain a healthy diet and stay hydrated. People were weighed regularly. Records were made of all food eaten and fluid drunk so that people's nutritional and hydration needs could be monitored by staff. Care plans detailed people's food preferences.

People had their nutritional needs assessed and were provided with a diet which met their needs and preferences. People's dietary requirements were understood by the staff preparing, cooking and serving the food and the staff assisting people. People's preferences were met by staff who gave individual attention to people who needed it.

We observed staff chatting to people whilst assisting them to eat; they were kind and considerate throughout. The dining room was a friendly and relaxed atmosphere. We observed staff prompting and encouraging people to eat, this was done in a non-hurried manner. Relatives told us, "It [food] is mashed. Food always smells good, He always has a good appetite" and "[Person] has mashed food, she had soup last week and really enjoyed it". One person told us the food was, "Nice".

People had choices of food at each meal time and chose to have their meal in the dining room or their bedroom. People were offered more food if they wanted it. Hot and cold drinks were offered to people throughout the day to ensure they drank well to maintain their hydration. Staff sat with people to assist them at meal times to encourage people to eat well. The food looked good. It was colourful and presented well. Menus were displayed for people to read. However, this was written on to a chalk board. There was a pictorial menu in place which was designed to support people to see what was on offer, but this did not relate to the written menu on the board. This meant that people may not know and understand what choices were available to them.

Staff supervision and annual appraisals had been recorded in their files. Staff told us they received regular supervision. One staff member said, "We have supervisions once a month. They can be individual meetings or group meetings, we can choose". Nurses received clinical supervision from the manager who was a trained nurse. Staff were due to have their annual appraisal within the month of January 2017.

People were supported by staff who were qualified and trained to meet these needs. Systems and procedures were in place to provide support to nursing staff in order to maintain their skills and Nursing and Midwifery Council (NMC) registration as part of the revalidation process. Systems were in place to support the nursing staff achieve revalidation. Specialised training courses were available to nursing staff to enable them to learn or refresh nursing tasks such as venepuncture (which is the process of obtaining blood for sampling) and enteral feeding.

The nursing team were made up nurses who had general nursing background and learning disability nursing backgrounds. Most nurses and care staff had received appropriate training to carry out their roles. This included statutory mandatory training, infection prevention and control, first aid and moving and handling people. One staff member said, "We definitely have enough training, it helps to refresh the mind. I can ask for training". Our discussions with staff confirmed they understood people's care needs. For example, staff could describe who needed additional staff to assist when they were moved using equipment like hoist, which people were on specialised diets and which people needed staff support at meals times to help them maintain their health and wellbeing through eating and drinking enough.

Training records showed that four nurses, three of whom had commenced employment in 2016 had a number of gaps in their mandatory training, such as food hygiene, Control of substances hazardous to health (COSHH) and fire training. Nursing staff are expected to lead the shift and provide direction to care staff in the event of fire. Six other staff had not completed fire training. This meant that staff may not have the knowledge and understanding of the fire procedures which meant people may be at risk in the event of a fire. Fifteen staff had attended learning disability awareness training. There were a number of gaps in training for staff in relation to other mandatory courses. This meant that some staff had not received training to enable them to carry out their roles to enable them to keep people safe.

The service had not followed good practice guidance to ensure that new staff received a comprehensive induction. 'The Care Certificate' was in place to support staff induction. However, this had not been fully embedded into practice. Observations and checks by the management team were not carried out to check staff competency. We spoke with the head of care about this. They told us that they were looking to commence observations of staff to support the induction process.

We recommend that the provider reviews their training for all staff working in the home.

Policy and procedures were in place in relation to the Mental Capacity Act 2005 (MCA). Staff were knowledgeable concerning the need to seek consent when providing care for people. One staff member said, "Give people choices of what to wear and whether they want their breakfast in their room on the dining room". Another staff member explained how one person could become distracted in noisy and busy environments and recognised that if the person needed to make choices, staff would need to take them somewhere quiet to offer choices. They did this by showing choices. The staff member said, "Today she chose her top". We observed staff gaining people's consent before undertaking tasks. People were involved in decision making where ever possible. Mental Capacity assessments undertaken to determine people capacity to make decisions did not follow the principles of the MCA. The assessments were not time specific or decision specific. One person had been assessed as having the capacity to make decisions, however their relatives had signed consent forms for blood tests.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The manager understood when an application should be made and how to submit one. DoLS applications had been made to the local authority. The provider had a system in place to track when DoLS authorisations were due to expire. However the tracking system did not capture whether DoLS authorisations had conditions within them and whether these conditions had been met. The manager did not know if authorised DoLS had conditions that must be met. Where decisions had been made in relation to 'Do not attempt resuscitation' (DNAR) for people by GPs or consultants, there was no evidence to show that people, their families and others had been involved in the decision making process. We spoke with the manager about this and they told us that meetings had been held with relevant people. However, the best interest meeting records and decisions associated with this were not found in any of the care records. Relatives we spoke with confirmed that they had been involved with making decisions of this nature. They described the process and how healthcare professionals had been involved in this.

We recommend that the provider reviews systems and processes in relation to mental capacity assessments and DoLS.

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Good

Is the service caring?

Our findings

Some people were unable to verbally tell us about their experiences. We observed that staff interacted with people in a respectful and polite. Staff engaged with people in a person centred manner. We observed staff providing reassurance and one to one time to a person who had become visibly upset. Staff members spent time with the person reading to the person which clearly distracted the person and helped them calm.

Relatives told us the staff were kind, caring and friendly toward their family members. Comments included, "I can't criticise them in any way, they have been brilliant. They look after [person] very well. I can't praise them enough" and "Staff genuinely care and are dedicated to working with people at the end of their life".

Staff knew how to ensure that people were respected and treated with dignity. Staff told us they ensured people had choices and were involved in their care. Staff were clear that when they provided care to people they did so in a manner to respect the person such as closing doors and curtains, ensuring they had all the right equipment before they start, keeping the person warm and respecting decisions. One staff member said, "Be professional and caring, do things that I would want if I was receiving care". Another staff member told us, "When providing personal care undress them [people] and cover them up, put towels over people to make sure they are not exposed". We observed that all staff knocked on people's doors before entering their rooms.

We observed friendly and compassionate care in the service. The staff were happy and up-beat, they enjoyed their work and this was reflected in the care we observed them providing. The staff were respectful and caring towards people.

People were involved in their care and made choices about what they wanted, such as where they wanted to sit, clothes they wanted to wear, food and drinks and whether they wanted their personal care needs met. Staff explained to people what was happening and gave people time to process information.

Staff built good relationships with the people they cared for. This resulted in people feeling comfortable and relaxed. People responded well to the quality of their engagement with staff. We observed staff used touch during interaction through hand massage. People enjoyed the session, they were smiling. The atmosphere was calm and relaxing. The session could have been improved by staff removing the gloves they wore. The gloves created a barrier between them and the person.

Throughout the inspection we observed staff treated people with kindness and understanding. Interactions and conversations between staff and people were positive and constant. Staff made time to talk with people whilst going about their day to day work. It was clear staff knew people well. We observed staff reassure people if they were anxious, upset or distressed. A staff member spent time reading story books to them in the hallway. This helped the person become calm and relaxed. The person became distressed at another time and asked to go to their bedroom; staff responded and assisted the person to go to their room to lie down. This meant that staff responded to people's needs and enabled people to make choices about their day to day lives.

People's bedrooms were personalised and individual to each person. With items of personal interest. People's bedrooms were spacious which meant they had plenty of space to move around and plenty of room for equipment which helped with their care.

Relatives told us that they were able to visit their family members at any reasonable time, they were always made to feel welcome and there was always a nice atmosphere. A staff member told us that relatives were able to visit their family members late at night. They gave an example of one person's relative who lived far away, who had stayed in a spare room at the service to enable them to spend quality time with their family member.

Requires Improvement

Is the service responsive?

Our findings

Some people were unable to verbally tell us about their experiences. People were encouraged to participate in activities to keep them active and stimulated, although an activity centre was available on site, staff did not use this on the first day of the inspection. Staff told us that because people had been poorly with chest infections and colds they were staying in the warm rather than going out in the cold. This showed that staff had responded to people's health needs by providing activities in a different way.

Relatives told us that the service was responsive to their family member's needs. Comments included, "They try to engage her in activities. She went to a show which she really enjoyed" and "They always have celebrations [for people's birthdays]" and "They've had him up doing activities in the activities room today".

Each person had a detailed activity plan, although these had been personalised to each person, the activities for each person was the same. For example, Monday mornings were painting and afternoons were crafts. Activities that took place during the inspection included listening to a staff member play the piano, singing, reading, hand massage. We spoke with the activities staff who explained the plan was used as a good guide. They explained that during the summer months people are encouraged and supported to get out in to the community on a daily basis, it was not as easy in the winter due to people's health and poor weather. The activities staff planned entertainment such as visits from mobile zoos, music for health, therapeutic sessions with pets as therapy (PAT) dogs and other music events. They explained that they had a visiting pantomimes and a choir at Christmas. The activities centre had a sensory room which had been decorated and fitted to meet people's sensory needs.

Care plans had changed since our last inspection. Improvements had been made to make the care plans more person centred, some care files had an all about me section which gave good information about the person, their family and how the person communicated. Further work was required to make the care plans clearer for staff. Some care plans lacked key information. For example, several care plans detailed that people had seizures. The care plan did not describe what a typical seizure looked like for each person which meant staff did not have clear information about how to support the person and when to seek further help from the emergency services. Activities care plans had not detailed what specific sensory equipment people enjoyed. We spoke with activities staff about this who agreed this care plan needed to be put in place as there was a risk that all of the sensory equipment could be switched on at the same time which could cause a person to have a sensory overload. Medicines care plans for some people lacked information about what medicines they were taking. One person's stated, '[Person] requires support to take her medication' but did not list what medicines and whether they were able to swallow tablets or liquid medicines only.

Care plans had sections for end of life care. These were not filled out for some and others had little information about people's likes, preferences and wishes. One person's end of life care plan simply stated '[Person] would like to remain at Lady Dane Farmhouse for the rest of her life. Unaware of funeral wishes'. Time had not been taken to meet with the person and their relatives to explore this further. For example, there was no record of the music the person liked or people they were close to which could have been recorded for future reference, to help and support relatives when arranging a funeral.

It was not clear from the care records that people and their relatives had been involved in reviewing the care. One person told us they had not been involved in meetings to review their care. Nursing staff reviewed the records on a monthly basis to ensure that the care plan matched the person's current needs.

This failure to ensure that care plans were in place for all aspects of people's assessed needs was a breach of Regulation 9 (1)(a)(b)(c)(2)(3)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

A daily records check was completed each day by the management team; this checked that each person's daily records had been appropriately filled out, such as food and fluid charts and handover records. This meant that adequate systems were in place to monitor people's health and wellbeing.

Relatives knew who to complain to if they were unhappy about the service they received. One relative told us, "I have raised concerns in the past, these were dealt with appropriately". There had not been any complaints since we last inspected the service. The complaints procedure gave information about who to if a person was not happy with the complaint from the provider, which included the local authority and Local Government Ombudsman (LGO) and detailed the timescales for acknowledgement and investigation. However it did not provide contact details for the local authority and the LGO.

Records showed that the service had received a number of compliments about the care provided. These included, 'A big thank you to you all for the devotion, kindness, support and gentle care you have given'; 'Thank you all for making [person] so welcome at Lady Dane. He has loved living with you. It's with a heavy heart he moves on' and 'We all want to thank you and the staff so much for all you have done for her. She is a different person, and we do hope she will be happy in her new home'.

The provider's communication policy detailed that 'Regular meetings of 'residents' and their families will be organised and the outcomes recorded'. There were no 'residents' meetings held at the service. There was no formal mechanism in place to gain feedback about people's experience of living in the home. The manager explained that because most people did not verbally communicate it was difficult to gain feedback. The provider had not explored other ways of gaining feedback from people.

Relatives confirmed that they received regular surveys and were asked to feedback. One relative said, "They send questionnaires a few times a year, we can give feedback". Relative's satisfaction surveys were last sent out in September 2016. We looked at 13 completed surveys. The responses showed mostly positive information. Comments included, 'Very happy with every aspect of [person's] care'; 'I have only praise for the service provided and thank staff for all their support given to my sister' and 'As parents we are so grateful for the care given to our daughter'. One family member raised a concern about communication which meant things did not get actioned quickly. Another relative raised that sometimes chairs and wheelchairs looked dirty and in need of a clean. The surveys had been collated and a short summary had been provided to detail what action had been taken to address the concerns; such as implementing a new cleaning schedule for night staff to include chairs and wheelchairs. The provider sent newsletters regularly to relatives to share news and updates about the service, such as fund raising activity, extension, staffing news and future plans.

Inadequate

Is the service well-led?

Our findings

At our last inspection on 03 and 05 November July 2015, we identified a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had failed to ensure effective systems and processes were in place to monitor quality and safety. The provider had failed to ensure that records were accurate and complete. We asked the provider to take action to meet the regulations.

At this inspection we found that the quality assurance systems had not improved.

Some people were unable to verbally tell us about their experiences. We observed that people knew staff including the head of care and the manager.

Relatives told us the service was well led. One relative said, "I do feel the service is very well run"; and "The trustees are very understanding, I see them frequently. They are in tune with us as relatives".

At this inspection we found that provider had audit systems in place within the home. The audits had failed to identify and action the areas of concern found during the inspection. For example, they had failed to capture that the recruitment records did not fully detail each employee's full employment history and reasons for gaps. The audits had not evidenced the concerns relating to risk management, medicines administration and storage, confidentiality of records, staff training, induction, people's meal choices, healthcare, mental capacity assessments and deprivation of Liberty Safeguards (DoLS) and care plans. The provider did not have a copy of the up to date regulations or provider guidance to meeting these.

Audits had been undertaken in an inconsistent manner. We spoke with the manager about this and they had identified they needed to be doing these. We found that there had been one health and safety audit carried out on 12 October 2016, which had checked areas of the home, fire safety, calls bells, boilers, electrics and vehicles owned by the service. Another health and safety audit had been carried out by the trustees on 30 November 2016. This identified work required which had not yet been actioned. The audits were not being done regularly enough to keep identify what improvements were needed. No audits had taken place of staffing records and care files. There was no formal system of regular audit checks of medication administration records and regular checks of stock which would indicate the provider had an effective governance system in place to ensure medicines were managed and handled safely.

Adequate systems were not in place to monitor all accidents and incidents. It was not always evident that the provider and manager had reviewed accidents and incidents to ensure action was taken.

The management arrangements were not robust as the provider and manager did not appear to work together in a coordinated way to ensure that management tasks and actions from the previous inspection were completed.

The management team and provider did not meet up with other registered managers and providers which

meant they worked in an isolated manner. Developing links with other organisations through forums and other networks enables providers and registered managers to share information and good practice, provide each other support and tackle key issues. The manager agreed this was an area for them to develop in the future to make improvements and share good practice.

There were a range of policies and procedures governing how the service needed to be run. They were not kept up to date with new developments in social care, which meant that staff did not have all the necessary information to support them in their roles. Some of the policies had not been updated since 2012. One policy relating to how to manage in emergencies such as when there is a power failure referred to the service having an emergency generator. We checked that this was in place. The service did not have one. The trustees had recognised the policies were outdated and had started the process of reviewing and updating these. However, the updated policies and procedures did not refer to up to date good practice guidance and regulations. We met with the trustees to share our concerns about this.

Appropriate action had not always been taken to refer staff to the Disclosure and Barring Service. We spoke with the manager about one situation which meant a staff member who was no longer employed should have been referred to alert the service and potential future employers of a concern. The manager confirmed the staff member had not been referred but agreed to do this as a priority.

People's information was not always treated confidentially. Whilst personal records such as care plans and health information was stored in an office, this office was not locked to keep information secure. People's daily observation charts which included observations, repositioning were found outside of people's bedrooms in communal areas which meant they were accessible to everyone. People's food and fluid records were also kept in a communal area. Staff were aware of the need for confidentiality. We observed they were careful when discussing personal information. They evidenced that they followed the confidentiality policy. Nursing staff ensured that the office door was closed prior to making or answering phone calls.

The failure to establish and operate effective systems and processes to monitor the quality of the service and failure to secure confidential records was a breach of Regulation 17 (1)(2)(a)(b)(c)(f) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries, Deprivation of Liberty Safeguards (DoLS) authorisations and deaths. The provider had not notified CQC about important events such as, Deprivation of Liberty Safeguards (DoLS) authorisations, deaths, serious injuries, events that affect the running of the service and safeguarding events that had occurred.

Failure to notify CQC of these events is a breach of Regulation 18 of The Care Quality Commission (Registration) Regulations 2009.

The provider had not displayed the rating of the last inspection in a prominent area so that people, visitors and relatives could view the rating given by CQC following the previous inspection. They had however displayed this on their website.

Failure to display the rating is a breach of Regulation 20(A)(1)(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff were aware of the whistleblowing procedures and voiced confidence that poor practice would be reported. Staff told us that they would escalate concerns to CQC as well as the local authority. Effective

procedures were in place to keep people safe from abuse and mistreatment.

Staff told us that communication between staff within the home was good and they were made aware of significant events. There were various meetings arranged for staff. These included daily shift hand over meetings. The staff meetings were recorded and shared. Staff also confirmed that they attended team meetings and handover meetings. Staff felt that they could speak up at meetings and that the manager listened to them. Staff told us that all the staff worked well together as a team, we saw that when there was sickness or staff members were running late for work other staff stayed on to help out to ensure that there was adequate cover.

Staff were complimentary about the support they received from the manager and head of care. They all told us that the management team were approachable and friendly and they felt comfortable talking to them about work and personal matters. Staff told us that the trustees visited the home regularly and were also friendly and approachable. The manager received clinical supervision from a trustee and an ex trustee which they found helpful.

The manager told us the trustees were more involved with the service and regularly popped in and out as well as being present one day per week. One trustee had visited the service on Christmas Day and Boxing Day.

The provider had sent an employee survey to all staff. In total 13 staff had responded to the survey. This meant staff had an opportunity to provide anonymous feedback to the management team and provider if they wished. The provider was in the process of collating and responding to feedback.

Staff were all passionate and committed to their roles. Staff told us how happy they were and they enjoyed their jobs. Comments included, "I like the thought of making a difference [to people's lives]"; "I am passionate about care" and "I get a lot of job satisfaction. It is nice to make people happy".

The provider's website stated the aim 'The Fynvola Foundation is dedicated to providing the highest quality of nursing and palliative care for people with Learning Disabilities. Our units offer a unique and much needed service to those who have nursing care needs and end of life care in a modern bespoke house that provides a safe, comfortable environment. All our residents are valued as individuals and are assisted to participate in planning their own care needs and activities. We welcome families and carers to remain part of the care and to continue to support the Fynvola Foundation'. We observed good practice from the staff providing care and support and saw that the values were deeply embedded into their work.

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 18 Registration Regulations 2009 Notifications of other incidents Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries, Deprivation of Liberty Safeguards (DoLS) authorisations and deaths. The provider had not notified CQC about important events such as, Deprivation of Liberty Safeguards (DoLS) authorisations, deaths, serious injuries, events that affect the running of the service and safeguarding events that had occurred. Regulation 18 (1)(2)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had failed to ensure that care plans were in place for all aspects of people's assessed needs. The provider had failed to ensure that people's health needs were adequately met. Regulation 9 (1)(a)(b)(c)(2)(3)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider had failed to ensure that medicines were suitably administered and stored. The provider had failed to ensure that risks were managed to ensure people were safe from harm.

Regulation 12(1)(2)(a)(b)(d)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had failed to carry out adequate employment checks. Regulation 19 (2)(a)(3)(a)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments The provider had not displayed the rating of the last inspection in a prominent area so that people, visitors and relatives could view the rating given by CQC following the previous inspection. Regulation 20(A)(1)(3)

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had failed to establish and operate effective systems and processes to monitor the quality of the service and failed to secure confidential records. Regulation 17 (1)(2)(a)(b)(c)(f)

The enforcement action we took:

We served the provider a warning notice and told the provider to meet the regulation by 14 March 2017.