Ford House Care Home Limited

Ford House

Inspection report

140 St Neots Road
Eaton Ford
St Neots
Cambridgeshire
PE19 7AL

Tel: 01480472017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Ford House is located on the main road in Eaton Ford, within walking distance of the town centre of St Neots. The original building is over 500 years old and has had a number of extensions since its conversion to a care home. The home provides accommodation for up to 46 people who require nursing and personal care. There are communal dining and lounge areas as well as bedrooms on the ground floor. There are bedrooms on the first floor, accessed by a lift or stirs. There are four double bedrooms and the rest are single, some of which have an ensuite toilet and washbasin.

This comprehensive inspection took place on 19 and 26 July 2016 and was unannounced. There were 41 people living at the home when we visited.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the home is run. The registered manager had been in post for four years.

People received their prescribed medicines, which were managed safely. There were recruitment procedures in place to ensure as far as possible that only staff suitable to work in this environment were employed.

Staff had undergone training and were competent to recognise and report any incidents of harm. Potential risks to people and to their health were assessed, recorded and managed so that people were kept as safe as possible.

There was not a sufficient number of staff effectively deployed to ensure that people were safe and their assessed needs were met in a timely manner. Staff had undertaken a range of training courses so that they were equipped to do their job.

The CQC monitors the operation of the Mental Capacity Act (MCA) 2005 and the Deprivation of Liberty Safeguards (DoLS), which apply to care services. People's capacity to make decisions for themselves had not been satisfactorily assessed. Staff did not demonstrate sufficient knowledge and understanding of the principles of the MCA and DoLS to ensure that the rights people who did not have capacity to make decisions for themselves would be protected.

People were supported to maintain good health and their healthcare needs were met by the involvement of a range of healthcare professionals. People were given sufficient amounts of food and drink and the nutritional needs of people who required special diets were met.

There were some warm and caring interactions between the staff and the people they were supporting.

People and their relatives had mixed views about the quality of the care that people were given. Staff respected people's privacy and dignity. People were given opportunities to make choices in some aspects of their lives and visitors were welcomed to the home at any time. People's personal information was not always kept securely, which meant that confidentiality was not always maintained.

Care records included care plans which gave staff guidance on how to meet people's assessed needs. Staff were not always aware of the information in the care plans and did not always follow the guidance. People and their relatives knew how to complain and complaints were responded to in a timely manner. Some activities and entertainments were provided. Some people, especially those who remained in their rooms, were not always getting the stimulation and relief from isolation that they needed.

People and their relatives were encouraged to share their views about the service being provided to them in a number of ways. Staff were also given opportunities to share their views about ways in which the service could continue to improve. The quality of the service being provided was checked by a range of audits that were carried out. These audits had not identified or addressed the issues we found.

The provider had not notified CQC about the outcome of an application to deprive a person of their liberty, which is required by law.

We found two 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 the 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 always safe.

There was not always a sufficient number of staff effectively deployed to ensure that people's needs were met and that people were kept safe. Staff recruitment had been done in a way that made sure that only staff suitable to work in a care home were employed.

Potential risks to people were identified, assessed and managed so that risks to people's safety were reduced. Staff had undertaken training in safeguarding and knew how to keep people safe from harm.

People received their medicines safely and as they had been prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

Assessments of people's mental capacity to make certain decisions had not been satisfactorily assessed and not all staff were aware of the principles and application of the MCA and DoLS. There was a risk that the rights of people who lacked capacity to make their own decisions were not protected.

Staff had received training and support to enable them to carry out their role.

People's healthcare needs were monitored and met. People received suitable food and drink in adequate amounts so that their nutritional needs were met.

Is the service caring?

Requires Improvement

The service was not always caring.

Staff were kind and caring but the quality of care was not always maintained.

People were treated with respect and were supported to

maintain their dignity. People were not given enough opportunities to make choices about their daily lives.

People's confidentiality was not always preserved as their personal information was not always kept securely.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were in place and gave staff guidelines on the care needed by each person. Staff did not always read or follow the guidance in the care plans.

Some activities and entertainments were arranged but for some people there was not enough for them to do to keep them stimulated and reduce their isolation.

People's relatives knew how to complain and their complaints were responded to in a timely manner.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a registered manager in post. People, their relatives and the staff had opportunities to give their views about the service provided.

Quality assurance checks on various aspects of the home had been carried out but these had not always identified shortfalls.

Notifications had not always been sent to CQC as required by the regulations.

Ford House

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 home, and to provide a rating for the service under the Care Act 2014.

This inspection included two visits to the home and was carried out by one inspector. An expert by experience assisted with the inspection at the first visit. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service.

Prior to the visits we looked at information we held about the home and used this information as part of our inspection planning. The information included notifications. Notifications are information on important events that happen in the home that the provider is required by law to notify us about.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our visits to the home we observed how the staff interacted with people who lived at Ford House. We spoke with 14 people who lived there, 12 members of staff (two nurses, the activities coordinator, the administrator and eight care workers) and the registered manager. We also spoke with seven people's relatives and the provider's representative. We looked at two people's care records as well as some other records relating to the management of the home.

Requires Improvement

Is the service safe?

Our findings

During our visits to Ford House we checked whether there were enough staff on duty to ensure that people were kept safe and their needs were met in a timely manner. People we spoke with, staff and three out of four relatives told us that there were not enough staff to meet people's needs. One relative told us, "Staff are hard-pressed so don't always have time to care." One member of staff said that more staff were needed "now we're filling up." The registered manager told us, "We need more staff, hence the recruitment."

In the written survey that the provider had sent to people and their relatives in May 2016, when asked if there were any other areas for improvement, two respondents had raised the issue of staffing 'especially at weekends.' In their response the provider stated, 'The home is aware of this and is recruiting in order to reduce the amount of agency staff in use.'

People and relatives reported that the time taken by staff to answer the call bell was not acceptable. One person told us, "When I need anything I ring the bell. It can take up to an hour for the staff to come." This person's relative confirmed this, adding, "It is due to the shortage of staff. It's been like that for a long time." Another person said, "I don't use mine [call bell] very much but staff are late for other residents." A third person's relative told us that for about the first three months that their family member lived at the home, the time it took staff to respond to the call bell "was bad".

Staff would not have been aware of the reasons people were calling for help. For example, several people who lived at Ford House had been assessed as being at risk of falling; several people were alone in their bedrooms for long periods of time; and we noted that staff were not always present in communal areas. This meant that people's safety was at risk and it was important that people were responded to quickly.

Staff told us that the home was often short-staffed, especially at weekends. They told us about two recent weekends when several staff had rung in sick. The registered manager confirmed that there had been a lot of last-minute sickness on these weekends and that they had been unable to cover the shifts. Several staff told us about the high number of people who needed assistance with their meals. They also told us how difficult it was during the afternoon to give people the food supplements they had been prescribed. They said that some people had these so late that they did not want their evening meal.

In the PIR the provider told us that, on admission, each person 'has a dependency assessment to identify level of need. The appropriate staffing is maintained based on the dependency of residents.' Care records showed that these had been updated monthly. Nevertheless, there were not enough staff effectively deployed to make sure people were safe and that their needs were met in a timely manner.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who lived at Ford House told us they felt safe living there. One person said, "The staff are nice….. I do feel safe." Another person told us, "I do feel safe here. The staff don't hurt me and they never call me names."

People's relatives said they felt their family members were safe at the home. One person's relative told us, "[Name] is safe here. The staff are respectable and very accommodating." A second person's relative stated, "It's a lot better than I thought and I feel [name] is safe here." The relative of someone who had fairly recently been admitted said, "I know [name's] safe. [Name's] got people [staff] around to check [name] every hour in the night." A healthcare professional told us, "I wouldn't send people here if I didn't think they were safe."

The provider had systems in place to keep people safe from avoidable harm. Staff told us they had received training in keeping people safe from abuse and harm. They demonstrated a good understanding of the meaning of safeguarding and showed that they would recognise if a person was suffering harm. Staff knew how to report any concerns, to their managers and to external authorities but said they had never needed to. There were posters on various noticeboards advising people, visitors and staff of what to look out for and giving telephone numbers of who to call if they had any concerns.

Care records showed that any potential risks to people had been assessed and guidance for staff had been put in place to minimise the risks. Assessments included the use of bed rails; nutrition and hydration; mobility; and the risk of the person developing pressure ulcers. Each risk assessment was linked to the relevant care plan.

The provider had a recruitment process in place to ensure that only staff suitable to work in a care environment were employed. Staff told us that all pre-employment checks, such as references, proof of identity and a criminal record check had been undertaken before they started work. One member of staff said, "I had to wait [for the checks to come back] before I could start work." The registered manager confirmed this. They stated that they were waiting for all the checks to be completed for new staff who had recently been offered work, before the staff would be able to start. The registered manager also explained that staff "who don't do the job properly, don't stay." They told us about staff who had been dismissed recently, one for excessive absence and one who "didn't want to listen or learn". This demonstrated that the provider took appropriate action to ensure that only staff who were suitable and willing to do their job well were employed.

We looked at the way medicines were managed and found that people were being given their medicines safely and as they had been prescribed. Two people's relatives told us they were satisfied with the way their family members' medicines were handled. They said medicines were always given at the right time. We looked at medicine administration record (MAR) charts and found they had been signed as required to show that medicines had been given. Information had been hand-written on the MAR charts and signed by two nurses when the GP had changed a prescription, which was good practice. We checked the amounts of some medicines remaining in their original packets and found that in five out of six checks the amounts tallied with the records.

We checked one nurse's knowledge about how they gave some medicines, such as Levothyroxine and Alendronic acid, which had special administration instructions. The nurse was very knowledgeable and confirmed that these medicines were given correctly. The registered manager told us that several of the nurses, including herself, were undertaking an advanced distance-learning course to ensure that they were fully up to date with the law and good practice regarding administration of medicines.

Most medicines must be stored below 30 degrees centigrade. We noted that the temperature of the medication room had been recorded daily and some of the temperatures had been quite high; up to 27/28 degrees centigrade. The registered manager said that an air-conditioning unit was "on order". However, during the day the medicine trolleys were stored in the corridors, not in the medication room. No temperatures of these areas had been taken. On our first visit, the registered manager told us the outside

temperature was in excess of 30 degrees centigrade. At our second visit the registered manager told us that the nurses had been instructed to store the trolleys in the medication room at all times when they were not in use. They also told us that the air-conditioning unit had been installed in this room. We saw that the trolleys were no longer stored in the corridor.

Requires Improvement

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

Care records included an assessment of the person's mental capacity. However, these had not been fully completed. For example, although the registered manager told us that assessments were "decision-specific", there was no record of the specific decisions that the assessment related to. In one example, the final decision as to whether or not the person had mental capacity had not been recorded.

The registered manager told us that training relating to the MCA and DoLS was delivered in-house as well as via a computer programme. They said all staff had undertaken this training and it was followed up by in-house discussions. However, staff told us they could not recall undergoing this training and we found that they had very limited understanding of mental capacity and consent. They could not tell us anything about the principles of the MCA. One senior member of staff was not aware that some people who lived at Ford House were the subject of a DoLS authorisation. Another member of staff thought it only related to giving medicines covertly (that is, without the person's knowledge).

This meant that the provider did not have sufficiently robust procedures in place to ensure that staffs' knowledge and application of the MCA and DoLS enabled people to be cared for in a lawful way. There was a risk that people who were not able to make decisions for themselves would not have their rights protected.

This was a breach of Regulation 11of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at whether staff had the knowledge and skills to do their job properly. People and their relatives told us they felt the staff knew what they were doing. One relative said, "Staff have care training. There are staff with dementia training and some are nurses." Another relative told us, "There are many [trained] nurses here and the carers have to go to school every now and again." One person said, "I think the staff learn as they go along." A healthcare professional said, "Nurses' knowledge is sufficient."

In the PIR the provider wrote 'Staff receive a full induction once they start, also training is regularly reviewed

to identify any gaps.' Staff confirmed that they had received an induction when they were first employed. One new member of staff told us they had spent a week on their induction and then a week "shadowing" [working with] more experienced staff.

Staff told us they had undertaken a range of training relevant to their work. They said that topics included moving and handling; health and safety; fire safety; food hygiene; and safeguarding. The registered manager told us that training sessions relating specifically to the health needs of people who were admitted to Ford House were arranged for the nurses when required. For example, some staff had undertaken training in male catheterisation and in the delivery of palliative care.

Staff said they felt supported by the management team. They said they received regular supervision sessions with the registered manager, which gave them the opportunity to talk about what was going well and what they needed to do better. The registered manager told us they gave staff additional support and training if the individual staff member needed it. Staff also told us they felt supported by each other. One member of care staff said, "I think it's a really good team of staff that we've got, really brilliant at explaining things, really supportive."

The provider used a recognised method to assess people's nutrition and hydration needs and we saw that the assessments had been updated. People were weighed each month, or more often if they were at risk of losing weight, and staff requested advice from the community dietician service when necessary. People who needed them had been prescribed dietary supplements by their GP. A healthcare professional told us that one person's diet had improved, which had resulted in an improvement in their medical condition. A member of staff told us, "Lots of people come in not eating and now they're eating." The weather was unusually warm on the first day we visited the home. The registered manager told us that staff were offering people cold drinks, ice lollies and ice creams to help keep them hydrated and cool. This meant that people's nutrition and hydration needs were met.

Care records showed that people were supported to access external healthcare professionals to help them to maintain their health. These included an optician and a chiropodist who visited the home regularly. The registered manager told us that the local GP visited the home when people needed to see a doctor. The GP also did a "housekeeping round" once a fortnight to make sure that their patients were receiving the healthcare they required. People accessed dental care at their local dentist's surgery when they needed to and staff supported people to attend hospital if their relatives were not able to do so.

Requires Improvement

Is the service caring?

Our findings

People and their relatives were mostly complimentary about the staff. One person said, "The staff are nice." Two relatives described the staff as "nice". One said, "You can't get better. [I give them] 10 out of 10." Another relative said, "The staff are very caring and considerate" and a third relative told us, "Staff are so friendly, very good, you feel it's almost part of your family." In the PIR, when we asked the provider to outline themes from any compliments the home had received, they wrote, 'How caring the staff are and how welcoming the home is.' One person said that a couple of the staff "get [irritated] with me" and a relative told us there were "one or two carers that [annoy me]."

There were some mixed views about the care that was delivered by the staff. One person stated, "The care is OK." One relative said, "The care here is what [family member] needs. I can't fault it." Another relative described the personal care given to their family member at Ford House as "much better" than in their family member's previous care service. A healthcare professional told us, "The care is good." However, one relative said the care had deteriorated recently and gave us an example of this. Staff told us there had been occasions recently when they had not had time to care for people in the way they wanted to or in the way people needed.

During our visits we saw that people were comfortable with the staff and there were some warm and caring interactions between staff and the people who lived at the home. Some of the staff showed they genuinely cared about the person they were looking after. For example, one person started to get upset. The member of staff acknowledged the person's feelings but gently turned the conversation to another topic which was less upsetting. The person visibly settled and became calmer. One relative told us, "The staff speak nicely to [name]" and another relative said, "Staff call [my family member] by their name."

Staff respected people's privacy and dignity and we saw that personal care was offered discreetly. A member of staff described ways in which they maintained privacy and dignity, including making sure that curtains were closed and doors shut when providing personal care. They also said that it was important not to talk "over people." They explained that, "Just because someone doesn't talk, they do understand." At lunchtime we noted that staff assisted people who needed assistance with their meal in an unhurried way, sitting with each person until the person had finished. Staff took the time to encourage people to do as much as they could for themselves so that people would maintain their independence. We saw that in the recent survey sent out by the provider to people and their relatives, all those who responded had said 'yes' when asked if they and their loved ones were treated with dignity and respect on a daily basis.

Staff demonstrated that they knew people's likes and dislikes. For example, one member of staff told us that one person's favourite meal was spaghetti hoops on toast and another person really loved chocolate. One person, whose religious beliefs meant they did not celebrate Christmas or birthdays, was grateful that staff "understand my religion". They said, "I tell staff to ignore me at these times and they do."

Staff told us that people were given choices in their daily lives. For example, people could choose where they wanted to eat their meal, either in the dining room, in one of the sitting areas or in their bedroom. We saw

that each person was asked where they would like to sit when they were assisted to the dining room. People told us they were given a choice of food and drinks. One person explained there were two choices for lunch but if they did not like either of them the chef would make them an alternative meal. A relative confirmed that their family member was offered choices that were in line with their food preferences. People who needed a modified diet, such as pureed food, received it. However, staff told us there was no choice of pureed food.

There were other areas of care in which people did not have a choice. A relative told us that their family member was not given a choice about whether female or male staff attended to their personal care needs. Staff confirmed that this was the case. Three people told us that although they were satisfied with the times they were assisted to get up or to go to bed, they were not given a choice. One person said, "I get put to bed early and that suits me." A member of staff explained that one result of there being insufficient staff on duty meant that people were not assisted when they wanted to be. For example, people did not always get their morning wash before lunchtime and one evening a lot of people had had to wait a lot longer to be assisted to bed than they had liked.

Visitors were always welcomed at Ford House and there were no restrictions on visiting. The only exception was at meal times, which the registered manager described as "protected". They said that if visitors did come during lunch there was an expectation that they would join in and have a meal. We saw lots of visitors coming and going throughout the day. One relative told us they were grateful they were able to visit their family member early in the morning before they went to work. Another relative said, "You're welcome day or night. You can even bring in well-behaved dogs and noisy grandchildren." A third relative told us that they were at the home with their family member all day, every day. They were made to feel welcome and were given drinks and meals. In one person's room we saw that there was a camp bed. This person's relative told us that they had been provided with a camp bed in their family member's room so that they could stay overnight when their family member had been very unwell.

We asked the registered manager if there were any advocacy services available to people if they wanted an independent person to act on their behalf. The registered manager told us that an Independent Mental Capacity Advocate (IMCA) had been involved for one person who needed their support. An IMCA is a legal safeguard for people who lack the capacity to make specific important decisions, including making decisions about where they live and about serious medical treatment options. An IMCA had been appointed for one person who did not have a relative or friend to act on their behalf. The registered manager also told us that information was available about advocacy services that people who had capacity to make their own decisions could contact if they wanted to.

People's confidentiality was not always respected and maintained. Although most care records were kept in the nurses' office, folders containing records of personal information, such as bowel movements and food/fluid intake, were found in the dining room. This put people's personal information at risk of being disclosed to other people and visitors who had no right to see it. On the second day we saw that these folders had been moved.

Requires Improvement

Is the service responsive?

Our findings

In the PIR the provider wrote, 'An initial assessment is completed prior to resident's admission to the home.' The registered manager confirmed that they carried out full assessments of each person's needs before they agreed to admit the person and we saw these in people's care records. They told us that only very rarely had someone been admitted as an emergency without an initial assessment having taken place. In those instances, the home relied on assessments carried out by other healthcare professionals.

Each person had a care plan in place, developed from the initial assessments and reviewed as staff got to know each person. The care plans were personalised and gave staff guidance on the care the person needed and the way the person preferred to be supported. Care plans included goals that the person wanted to achieve and details of 'how staff can support me.' Care plans were linked to each risk assessment that had been carried out and the person's needs were reviewed monthly using a 'dependency level' chart.

We saw that the care plans had been reviewed and evaluated and either the person or their relative had signed to confirm that they had reviewed and agreed with the care plans. One person's relative said, "We spoke about the care he needs; he definitely gets what he needs…. They even asked if there's any special foods he likes." One person knew about their care plan and the guidelines it gave to staff for their care. They told us, "Yes, there is a care plan. It says I need assistance when walking…and support when getting up."

One senior member of staff made it clear that staff did not often look at the care plans. This member of staff was unaware of some important information that was in one person's care plan. Other staff told us they found little time to look at the care plans. One said they received information about people from the nurses at handovers and from people themselves. One person, who was clear about what was in their care plan, told us that not all staff followed the guidance. They said that although their care plan stated they needed assistance to get out of bed, some staff expected them to do this without help. This meant that although people and their relatives had been involved in planning the person's care, the care plans were not being used as working documents. There was a risk that not all staff would know about changes to a person's care, especially if they had not been at work when the changes were discussed at handover.

'Daily progress notes' had been completed by the nurses and gave details of the care each person had received during the day. Care staff completed various charts that were required for individuals, such as food and fluid intake and repositioning charts.

A relative told us that staff responded to all their family member's needs. They told us, "[Name's] settled in well. Anything you need or want they get it for you." They were particularly pleased that staff had been willing to assist their family member, with the use of the hoist and a wheelchair, into the garden. This person had recently spent six weeks in bed in hospital. This relative was also impressed that staff had brought another person into the garden and had sat with them while they enjoyed a cigarette. They said they felt this was "over and above" what staff should be expected to do.

However, we found that staff did not always have time to respond to everyone's needs. For example, during

our first visit we noted that although staff started serving lunch at 12:40pm, the last person was not given their lunch until 2:15pm. Some staff had not been able to assist with lunch service because at 1pm they had not finished giving everyone their morning personal care. The registered manager told us this was due to the exceptionally warm weather on that day. They said that on a "normal day" people were usually up by 11:30am to 12pm and that lunch was usually served by 1:30pm. However, on our second visit to the home a week later we again saw the last lunch being taken to someone at 2:15pm. People did not always have assistance to get up or go to bed at the time they would have preferred.

A member of the care staff had recently been appointed to the role of activities coordinator. The registered manager told us that the activities coordinator worked on four days a week. On the first day we visited, a singer came in during the afternoon to entertain people. Quite a large crowd gathered in the dining room and we could hear that people were enjoying listening to and joining in with the singing.

One person told us, "We do have activities here. I like to knit and one of the cleaners can sew so between us we make blankets." This person also said, "There is entertainment: Elvis is good, it's a good look-alike. There's bingo and cake-making. A hairdresser comes here on a Wednesday." Another person said, "I might join in the bingo." One relative told us, "There are no religious services here." Their family member agreed and added, "If people want to go to church it is off site."

We noted that there were a lot of people who stayed in their rooms all the time. We saw the activities coordinator playing a board game with one person who was clearly enjoying the interaction. Other than this, we did not see any staff spending time with people in their rooms, except when they were carrying out tasks such as personal care and assisting with meals. Staff told us, and we saw, that they were very busy and did not have time to chat to people or do any activities with them. One member of staff said, "There is not time to spend with people." Another member of staff, talking about spending time with people, said, "Not as much as we'd like to. It's a shame, some of the conversations are fantastic but we only get a few minutes while doing personal care." They added, "[Name of activities coordinator] can only do one [person] at a time." One person said, "There are so many [people] to look after staff haven't time for me. No-one has time to sit and talk." This demonstrated that people were not always getting the stimulation and relief from isolation that they needed.

The provider had an effective complaints policy and procedure in place. This was displayed around the home and we saw a copy in the welcome pack given to each person when they moved into Ford House. The provider stated, in the PIR, 'All complaints are recorded and investigated in line with company policy and all concerned are kept informed of outcomes and responses to reduce risk of recurrence.' During the course of this inspection we saw that a relative had made a complaint to the registered manager about some aspects of the care their family member had received. The complaint was investigated and the registered manager responded to the relative within the timescales of the complaints policy.

People and their relatives told us they knew who to talk to if they wanted to complain about anything. One person said, "I tell them [staff] what I think." One relative said, "I liked it [the home] from day one. I honestly can't fault this place …or any of them [staff]." They added, "Definitely I'd be happy to talk to [name of registered manager] if anything was wrong." Another relative told us they were "more than happy to speak up." They said, "If I don't like something I say so."

Requires Improvement

Is the service well-led?

Our findings

People and their relatives were given opportunities to comment on the quality of the service being provided at the home and to make suggestions for improvement. Relatives told us that meetings with the registered manager were arranged regularly and they were invited to attend. One relative told us, "There are family meetings. We have a meeting to debate if we want changes, and also if we want to raise an issue. There are minutes. The [registered] manager always attends. It gives a chance to express oneself."

The registered manager showed us that a written survey had been sent to people and their relatives in May 2016, asking them to tell the provider their views on the service. About 40% of the surveys were completed and returned and the responses had been collated into a report. This had been made available for everyone to read. The report showed that the provider had listened to what they were being told and had made some changes. For example, they introduced a new laundry system to try and ensure that each person had their own clothes returned to them. Staff also told us they were given opportunities to put forward their ideas. One member of staff said, "[We] get listened to." Another said, "You feel like your voice is being heard." In the PIR, the provider wrote, 'There is an open-door culture at the home and all comments are taken on board and utilised in the effective running of the home.'

There was a registered manager in post. They had been in post for four years. The registered manager was a registered mental nurse. Most of the relatives and some people we spoke with knew who the registered manager was. One person told us, "If anything upsets me I can speak to the [registered] manager who is understanding and respectful of my wishes." Another person said, "The [registered] manager is OK." A relative told us, "The [registered] manager here is ten out of ten [high praise]." Another relative said, "[Name of registered manager] is a good manager." A member of staff said, "It's [management is] better, more organised."

On the day of our visit we saw the registered manager around the home, assisting people and supporting the staff. They were ensuring that staff were giving people drinks and ice creams if they wanted them as the day was so warm. One person told us, "The [registered] manager comes round every now and then. I usually see the [registered] manager in the mornings." However, another person said, "The [registered] manager should have more to do with the service users. The [registered] manager is not very visible." In the provider's report of the recent survey, they stated that one respondent had said that there 'was sometimes a problem at weekends' with approaching the staff with any issues. In response, the provider said the registered manager would now be working 'part of a weekend at least once a month.' The provider also reported that 'manager surgeries' had been set up during the evening for relatives not able to visit during the day. They wrote, 'The response to this was zero therefore it was stopped.' The registered manager confirmed that they had worked parts of some weekends.

Generally we found that people and their relatives were content to be at Ford House. One person said, "There is nothing I would change. The staff all do a good job. My [relative] would say the same." A relative told us, "I haven't come up with anything I would change so far." Another relative said, "I chose Ford House because it's local and they do palliative care. It's lovely, very easy-going…. Straightaway I just got that feel

that it was nice."

Staff told us they were happy working at Ford House. One member of staff said, "I love it here." Another member of staff said, "I like working here. [I like] the residents and the staff." And another stated, "It's totally different now, much improved. I enjoy coming to work here , it seems to run smoothly." A healthcare professional commented, "Everyone is very friendly. The patients [people who lived at the home] all seem happy, chatty and jovial. I've no concerns." The registered manager talked about the staff. She said, "I'm proud of my care team, they're a good bunch…. The nurses are getting there." Staff told us the management team were "really supportive" as they were trying to "get more staff in."

The provider had a system in place to make sure that a good service was delivered to people by the staff team. The registered manager told us that they carried out monthly audits of a range of aspects of the service. The provider's representative audited the audits and completed a 'Compliance Audit Tool' every six months. Actions plans were drawn up, with a timescale for each action to be completed. A check that the actions had been completed within the timescales was part of the next audit. However, we noted that these audits had not identified or effectively addressed the issues we found during the inspection.

All care providers must notify us about certain changes, events and incidents affecting their service or the people who use it. Our records showed that we had received notifications about deaths of people who lived at the home, but we had not received any other notifications. In discussion with the registered manager and the provider's representative, they stated that there had not been any notifiable incidents or events, other than the authorisation of an application to deprive a person of their liberty. The provider had not sent us the required notification relating to this.

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 11 HSCA RA Regulations 2014 Need for consent People who used the service were not protected against the risk of their care being delivered without valid and lawful consent. Regulation 11(1), (2) and (3)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There was not a sufficient number of staff effectively deployed to fully meet the needs of each person who lived at the home. Regulation 18(1)