Colten Care Limited

Fernhill

Inspection report

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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

Overall summary

This inspection took place on 4, 5 and 6 November 2014 and was unannounced. Fernhill provides accommodation and nursing and personal care for up to 58 older people, specialising in care for people with dementia. There were 56 people living there when we visited. This provider is required to recruit a registered manager for this type of service. There was a registered manager in post. 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 and associated Regulations about how the service is run.

People were not safe living in the home because not all concerns about abusive practice had been reported to the local authority. The senior management team and the registered manager were not aware of the outcome of an internal investigation into these concerns.

There were not enough staff to meet people's needs. The majority of staff told us more staff were needed to meet people's needs. We observed that there were not enough staff to meet people's needs.

People received their medicines when they required them and medicines were stored safely.

Summary of findings

Recruitment checks had been completed before staff worked unsupervised at the home.

People, who did not have mental capacity to make specific decisions for themselves, had their legal rights protected. Best interest decisions involved people's representatives and health care professionals in accordance with the principles of the Mental Capacity Act 2005. The home complied with the conditions of Deprivation of Liberty Safeguards (DoLS) where they had been authorised. These safeguards aim to protect people living in care homes and hospitals from being inappropriately deprived of their liberty.

The service was not always caring. We observed some staff interactions that were not respectful and two health care professionals told us that some staff were not always respectful towards people.

People's representatives told us that staff were caring and contacted them if there were any concerns. People were supported by staff to meet their social and welfare needs. People were supported to take part in activities in the home, go out on trips and at times supported on a one to one basis with their social needs.

Staff were not always trained to meet people's needs. The majority of staff had not received training to support people whose behaviour challenged. Staff had completed training in other areas to meet people's needs and received support in meetings and in shift handovers.

The service was not well led. Audits of care provided did not always identify actions that were required to ensure people's needs were responded to. There was however an improvement plan in place to improve how audits were carried out.

People gave us mixed feedback about the registered manager. Some staff told us they were "supportive" whilst other staff told us the registered manager was not approachable or fair.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 which corresponds to regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to safeguarding people, care and welfare of people who use services, supporting people to eat and drink; and not monitoring the quality of the service effectively. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

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 safe. There were not enough staff to meet people's needs.

Some staff raised concerns that poor or abusive practice had not been responded to.

People's representatives told us that people were felt safe living in the home. One person told us that people were not always safeguarded from another resident's behaviour.

People received their medicines as prescribed.

Is the service effective?

Requires Improvement

The service was not effective. Staff support was not always effective because where poor practice had been identified actions were not followed through.

People who required assistance to eat and drink did not always receive this support.

Staff understood the requirements of the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. People's capacity to consent to their care and treatment was assessed and people's representatives were involved in 'best interest decisions'.

Is the service caring?

Requires Improvement

Staff were not always caring and respectful towards people. We observed staff talking to people in a caring and respectful manner. However two health and social care professionals told us they had observed some interactions that had not been caring or respectful. We observed that some staff interactions were not respectful.

People and their relatives were involved in making decisions about their care.

Is the service responsive?

Requires Improvement

The service was not always responsive to people's needs which resulted in their needs not being met.

People's representatives were involved in the planning of their care and felt involved. People's views and concerns were listened to and acted upon. People's representatives were encouraged to give feedback.

Is the service well-led?

Requires Improvement

There was mixed staff feedback about the management of the service. Some staff told us they did not feel the registered manager was open or approachable. The registered manager told us they were introducing changes that affected where staff worked in the home and this had caused some unrest within the staff team.

Summary of findings

The service was not always well-led. Reviews and audits of incidents and accidents were not always timely and did not always identify actions.

There was a system in place to identify improvements to how the home assessed the quality of care provided and outcomes for people. The home was working on implementing these changes.

Fernhill

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 4, 5 and 6 November 2014 and was unannounced. The inspection team included two inspectors, and a specialist advisor who was a nurse with a background in nursing. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information we held about the service, which included the provider information return and notifications.

During our inspection we spoke with a senior manager, the registered manager, head of care, seven care workers, three registered nurses, one domestic and two activity staff. The registered manager had been in post since April 2014 as the home manager and became the registered manager in July 2014. We spoke with four people who were using the service and four relatives.

We looked at the care records of eight people, four staff recruitment files, staff duty rosters, and 15 people's medicine administration records. We also looked at other records relating to the management of the service. This included servicing certificates for the fire safety equipment and testing records for legionella. We undertook general observations in communal areas and during mealtimes. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Following our visit we spoke with six health and social care professionals who provided us with information about how the service met people's needs and their experience of working with the staff in the home.

Requires Improvement

Is the service safe?

Our findings

Some people were not able to tell us about their experience of living in the home because of their dementia. Although all the relatives told us they felt their relative was safe, the service was not safe as allegations about poor or abusive practice had not always been responded to. Three members of staff told us that they were aware that concerns had been raised with senior managers about poor practice. Staff were not confident that action had been taken to address these concerns. A senior manager was not able to tell us what action had been taken in response to concerns raised by staff a few months prior to our inspection that we were made aware of during our inspection. There were no records of meetings with staff about concerns or any action taken. We were informed following our inspection that these concerns had been responded to internally and staff had been spoken to formally. A senior manager told us another member of staff had raised similar concerns the week before our inspection with them. They told us they would respond to these concerns immediately. The person left the organisation following our inspection. Another senior manager who had responsibility to oversee the home told us these concerns had not been shared with them. We raised this concern with the safeguarding authority.

The provider did not always respond to allegations of abuse appropriately. Two recent concerns about abuse had been responded to appropriately. However, the registered manager told us that a member of staff had been dismissed as they had been found asleep whilst on duty. The registered manager told us they had not shared the information with the local safeguarding authority. This did not follow the local authority protocol for responding to allegations of abuse. Consideration had not been given to referring the member of staff to the Disclosure and Barring Service (DBS). The DBS prevents unsuitable people working in care services.

Other incidents of abuse relating to a person's behaviour towards other people had not been reported to the local authority safeguarding team as required. We raised this with the registered manager and told them to raise these concerns with the local authority safeguarding team. They told us they were working with the social service team to find an alternative home for the person as they were unable to meet their needs. One person living in the home told us they felt people were not always safe because the behaviour of one person who lived there was not managed to keep others safe. They said, "They should be safeguarding people." One member of staff told us about two people they supported whose behaviour could be challenging. They said, "It is not clear in their care plan how to support them when they are challenging." We looked at the care plans and they lacked detail and guidance for staff to follow so that they could support people when they became distressed.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

There were not enough staff to provide the support people needed and to keep people safe. The majority of staff said there were not enough staff. People were left unsupported in the lounge at times. We saw from some people's care records they required support from staff to keep them safe and to meet their needs. Questions were raised in a relatives meeting in June 2014 about how the home safeguarded people from others whose behaviour challenged at times. Assurances were given that there, "should always be at least one member of staff present in all lounges". At mealtimes people did not always receive the support they required to eat. During the inspection there were times when staff were not supervising people in the lounge on the first floor. We raised our concerns about staffing with the registered manager and senior manager.

We spoke with staff and asked for their views about staffing levels and how this affected people's care. Comments included, "There are not enough staff to push fluids (support people to drink). We need more staff to help at mealtimes." and "There are not enough staff. We have agency staff sometimes. We are constantly rushed and paperwork slips. " Two other members of staff told us they felt that some people were cared for in bed as there were not enough staff. Another member of staff told us that people weren't always able to join in with activities because there were not enough staff to help people to get out of bed before activities started in the middle of the morning.

A senior manager and the registered manager had identified that staffing levels in the home needed to increase following a review of people's needs. The method

Requires Improvement

Is the service safe?

used to decide how many staff were needed was being reviewed to ensure that there were enough staff to meet the needs of people with dementia. We looked at staffing rosters for the month before the inspection and saw there had been a shortfall in the planned number of staff on 19 days out of 28. The concerns about staffing levels in the home had not been addressed.

The home was not managing some identified risks. Incidents such as falls were not reviewed promptly to check if the plan of care had been followed or needed to change to reduce the risk of re-occurrence. We saw that an unexplained significant bruising had not been checked to determine how it had happened. There were gaps in records of falls and wounds or bruising to account for these injuries. We saw that some people were protected from identified risks because staff followed guidelines to keep them safe. For example, staff followed guidelines for supporting people who were at risk of developing pressure sores. People were supported by staff repositioning them, and using pressure relieving equipment and prescribed creams. People were safe when staff were supporting them with moving and handling.

Records relating to recruitment showed that the relevant checks had been completed before permanent staff worked unsupervised at the home to ensure their suitability. These included employment references, any criminal convictions and DBS checks. We found that recruitment checks had also been completed for agency staff.

People's medicines were stored safely and there was a system for the ordering, receipt and disposal of medicines. People received their medicines safely and when they needed them. Staff recorded when medicines were given to people and medicines were always given at the correct time intervals. Skin cream charts showed staff where they should be applied and how often. There were suitable arrangements in place for people who required their medicines covertly which followed the advice from a pharmacist. Records showed that 'best interest' discussions had taken place with the person's GP and representatives regarding covert medicines. One nurse told us they had received training in the safe administration of medicines.

The building was maintained and regular health and safety checks took place. This included checks on the fire detection system and water systems to prevent legionella.

Requires Improvement

Is the service effective?

Our findings

Some people received support to eat and drink, and safe swallow guidelines were followed for people with an identified risk of choking. This included pureed meals and thickened fluids.

However this was not the case for everyone who required assistance to eat and drink. One member of staff was supporting a person with their lunch who was cared for in bed. The person was not sat in an upright position to support them safely to prevent food going into their airway. The person coughed whilst eating but the member of staff did not sit the person up. We raised our concerns to the nurse on duty who agreed the person should have been sat up in an upright position to eat.

Another person who required prompting to eat was not supported adequately which resulted in them eating their meal cold. One person required one to one support to eat but this did not happen apart from staff verbally encouraging them whilst supporting other people. This resulted in them not eating their meal.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People who were at risk of dehydration and poor nutrition were monitored and records showed that concerns were discussed with GPs. However there was no review of the effectiveness of the plan of care to support people to eat. We saw that 20 people in the home had lost more than 5% of their body weight in the last six months. One person had lost 20% of their body weight. The registered manager told us there were clinical reasons why people had lost weight, that concerns had been discussed with people's GP and referrals had been made to the dietician service. Some people had prescribed nutritional supplements and were supported to have them. Although advice had been sought, there was no evidence to support this had been reviewed in order to ensure the plans in place were effective.

There was no system of pain assessment in regular use for people with dementia care needs to ensure pain was recognised where people may have difficulties communicating with staff. We raised our concern about this on the second day of our inspection. The operations manager told us on the third day of our inspection that this had been put in place.

Staff ensured that people received medical treatment in response to developing symptoms. However one person who fell on the first day of our inspection appeared to be in pain when we met with them on the second day of our visit. The person was not monitored for any signs of pain following their fall. Their relative also identified they were in pain and they asked four staff in succession to take them back to bed. The relative indicated to the fourth member of staff they may find it painful when being moved. This member of staff replied, "I thought so this morning as they moaned (in pain) when we got them up." This meant that the person's pain had not been reported, recorded or acted upon for at least four hours.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010,which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

Staff gave us mixed feedback about how they were supported to meet people's needs. Staff attended meetings and handover's at the beginning of each shift to help ensure they understood how to meet people's needs. One member of staff told us a senior staff member provided advice and they were, "brilliant."

New staff received induction training and observed experienced staff prior to starting work unsupervised. Staff received training, including moving and handling, fire safety and infection control. Two staff told us they did not feel they had been given training to support people who could be "aggressive when distressed". There were a number of people whose behaviour challenged at times. One staff member told us, "There is no training for supporting people when they are physically challenging." However another member of staff told us they had received training on supporting people with challenging behaviour. We saw staff provide reassurance to people when they became distressed. Records showed that the majority of staff had not received training on supporting people whose behaviour challenged.

Staff were supported through supervisions (meetings with a manager) and appraisals. For two staff it had been identified and discussed in supervision that their practice

Requires Improvement

Is the service effective?

needed to change in response to concerns. However, checks had not been undertaken to ensure staff practice had changed. This meant there was a risk that staff were not supported to ensure they understood how to provide care to a high standard and to meet people's needs.

Relatives told us their family member's health needs were met because staff contacted their GP or other health professionals if needed. All of the health care professionals told us the home contacted them promptly to make referrals for health care input and followed their recommendations. One healthcare professional told us, "Referrals are made for genuine reasons. They are very good. They take advice, and constructive feedback and it is followed through."

Records showed that people were seen by health care professionals in response to changing needs and management of existing conditions. However one mental health care professional told us that the staff in the home did not always record concerns about people's behaviour or sleeping so that care could be reviewed, evaluated and changed to meet their needs. They told us this made it difficult for them to review the person's health. They had raised this with the home. Records showed that people had access to dental and foot care professionals to meet their on going health care needs.

The registered manager and staff had a clear understanding of the Mental Capacity Act 2005. People, who did not have capacity to make specific decisions for themselves, had their legal rights protected because best interest decisions were made in these situations. This involved people's representatives and health care professionals. For example, a best interest's decision was made to use bedrails to keep a person safe in their bed. A best interest decision is made about a specific issue and involves people who know the person and takes into consideration their previous views and beliefs.

People required some restrictions to be in place to keep them safe. The home had been granted the right by the local authority to deprive some people of their liberty in line with the Deprivation of Liberty Safeguards (DoLS) and the home was waiting for the outcome of other applications. The staff in the home were complying with the conditions of these authorisations. For example, the home was secured with a key pad to ensure their safety. These safeguards aim to protect people living in care homes and hospitals from being inappropriately deprived of their liberty. The safeguards can only be used when there is no other way of supporting a person safely. Staff were aware of the authorisation and the implications for this person's care and when these safeguards were to be reviewed. The provider kept up to date with changes in legislation to protect people and acted in accordance with changes to make sure people's legal rights were protected.

Requires Improvement

Is the service caring?

Our findings

Staff were not always caring and respectful towards people. During our inspection some staff spoke about people in front of other people that did not always seem respectful. Two health and social care professionals told us they had observed some interactions that had not been caring or respectful. They said they had observed some staff being inpatient with people and talking about them in front of others. For example, saying "he is very aggressive." They told us they had raised these concerns with the registered manager who said they would talk to the staff. One person's communication care plan used language which was disrespectful, such as describing the person as "trying and whining" and "manipulative". We raised this with the registered manager during our inspection.

People and their relatives told us the staff were kind, caring and always there to help. One person told us staff were, "lovely and talk to people respectfully". Another person told us, "Carers are brilliant and very dedicated." One relative told us, "I have nothing but praise for the staff, they have been wonderful, and nothing is too much trouble for them." Another relative told us, "The staff here are second to none, first class, they are attentive and kind which is just what people need. They seem to know what people need before they need it, this is a wonderful home." Three health and social care professionals told us staff spoke to people respectfully and in a caring way. One professional told us, "Staff language is appropriate and they always check what they are saying with the resident." Another healthcare professional told us when someone first moved into the home that a person required lots of reassurance and "staff provided this".

Staff were supporting people in a caring way that reassured and demonstrated their awareness of people's needs and preferences. For example, staff were aware of what could cause distress for some people and we observed staff supporting people to feel reassured and cared for. One member of staff told us how staff supported people who could become distressed due to their mental health needs. They said, "We always reassure." Another member of staff told us one person did not like to receive too much assistance from staff with their personal care as they became distressed. They told us how staff provided care to minimise the distress to the person. The person's care plan supported this approach. We saw staff reassuring people when supporting them to move using equipment and explaining what they were doing.

People and relatives were involved in making decisions about their care. People told us that staff involved them daily in their care and how they spent their day. People's representatives were involved to support people to make decisions. One person told us, "The chef comes around every day and ask what you like." Comments from people's relatives included, "The home contact me straight away if there is a problem." and "It is the best dementia home in the area, they are good at keeping families involved."

People's privacy was respected. Some people chose to spend all or part of the day in their own room and this was respected by staff. It was clear that people had been supported to personalise their bedrooms with their belongings, such as photographs and pictures, to help people to feel at home. Bedroom doors were always kept closed when people were being supported with personal care.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive personalised care that was responsive to their needs. Some care plans and records did not provide personalised information for staff to follow to meet people's needs. For example, there were gaps in three people's records. One care plan lacked detail about how staff should support the person with their mental health needs. We saw the person was distressed during our inspection and staff were unable to console them. The care plan lacked guidance for staff about how they should support the person. Staff did not know how to support this person to meet their needs. However, we also saw some care plans detailed how people should be supported to move safely, receive support and care to maintain their personal hygiene and to prevent pressure sores from developing. We observed that staff followed these plans. For example, staff responded to some people quickly who became distressed and provided support to ensure people didn't fall.

People's representatives were involved in the assessment and planning of their relative's care. One relative told us, "We have got the annual meeting today." Another person's relative told us they were involved in the planning of their relative's care. Staff contacted people's representative in response to people's changing needs. Care plans contained personalised information about people and families had been involved to share information to help staff get to know the person. One member of staff told us, "Families are part of the care." One health care professional told us they had previously been part of care review meetings and they felt people were being looked after.

People received support to take part in activities and people were supported individually according to their needs and preferences. For example, people were visited by staff in their rooms, supported to play games and staff read to people. People were also supported to go out of the home on trips and to places of their choice. One person's relative told us, "The home encourages all residents to get involved in activities. The trips out are interesting and well planned. Any safety issues are thought through." The home employed activity staff to focus on meeting people's social needs. One health care professional told us that staff had identified that one person was at risk of social isolation and had started to visit them in their room to provide social support to respond to this need. One member of staff said, "We identify people who are declining or not going out of their room. We have asked about getting more staff as we have so many people who require one to one (social care) support." They told us an additional member of staff was working as a social carer on a temporary basis to meet people's needs. A senior manager told us there were plans to make this a permanent arrangement.

People and their representatives were able to raise concerns and complaints and these were responded to. People and relatives told us that they would be happy to raise any issues or complaints and they did. One person's relative told us they were, "confident that any concerns raised would be listened to and acted upon". People's representatives were encouraged to give their feedback in relative's meetings and by completing surveys. Meetings took place with relative and residents every three months. We saw that improvements identified had been actioned. For example, all new or agency staff worked with experienced staff in the home and care reviews had been arranged with relatives.

Requires Improvement

Is the service well-led?

Our findings

Staff gave us mixed feedback about how well the home was managed and the approach by the registered manager. One member of staff told us, "The home has a really good manager; they often come to see people and are always accessible." Another member of staff told us, "Both the manager and senior staff are supportive." However half of the staff that we spoke with raised concerns with us that the registered manager was not approachable to all staff, did not listen to all staff and they did not feel confident that action would be taken in response to concerns. They also raised that they felt the registered manager was not transparent in how they treated staff which made them feel they had "favourites". The registered manager told us they were introducing changes to shift patterns and to where staff worked in the home to improve the skill mix and to improve the way the home met people's needs. They acknowledged that some staff had difficulty with these changes. A senior manager told us they would provide support to the registered manager to improve relationships with the staff team.

There were systems to assess the quality and safety of the service provided in the home, however, these were not always effective. Staff carried out audits each month of accidents, weight loss and incidents in the home to ensure people's needs were being met. A senior member of staff told us, "The audit identified that weight loss was a problem." However there was no analysis of staffing levels in relation to the care provided in supporting people at risk of poor nutrition.

Incidents and accidents were reviewed at the end of the month. This meant there was a risk that any changes required to someone's care would be delayed. Other incidents had not been reviewed to ensure people were protected from inappropriate or unsafe care. For example, we saw records that one person had sustained substantial bruising but there were no records to account for this bruising and no checks of what had happened. One person had fallen during inspection. The person had experienced a high number of falls and was known to be at a high risk of falls. There was no review that day or the following day into how the fall happened or what care the staff had provided when it occurred. The care plan had not been evaluated so that it was relevant and up to date.

There was an action plan in place that the registered manager and head of care were working on to make improvements to the care provided. A senior manager told us the management team were introducing improvements to the retention of staff, as turnover rates were too high, in order to improve continuity of care. We did not see evidence of what action had been taken.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010,which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 .

There were systems in place to identify improvements required to the service and to the systems that assessed and monitored the service. An overall audit of the home had been carried out in September 2014 by a senior manager responsible for monitoring the quality of care. This audit identified where there were some areas that required improvement. This included monitoring the types of accidents and incidents each month that occurred. This was to identify any trends including times of falls and where they occurred so that any action required could be taken to reduce the risks to people. The registered nurses were now more involved in clinical audits. All of the nurses that we spoke with were aware of this and confirmed this was now being implemented. One member of staff told us, "Clinical audits were not happening regularly but they are now."

There were arrangements for unannounced night visits to ensure people received a good standard of care during the night. The last night visit was in September 2014 and a senior member of staff told us they had not observed any concerns.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care People who use services were not protected against the risks of receiving inappropriate care or treatment that does not meet their individual needs and ensures their welfare and safety. Regulation 9 3 (b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People who use services and others were not safeguarded against the risk of abuse by means of responding appropriately to any allegation of abuse. Regulation 13.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA (RA) Regulations 2014 Meeting nutritional and hydration needs People who use services were not always supported, where necessary, for the purposes of enabling service users to eat and drink sufficient amounts for their needs. Regulation 14.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance People who use services were not protected against the risk of unsafe care as the systems in place to manage risks were not effective. Regulation 17.