

Caring Homes Healthcare Group Limited

Ferfoot Care Home

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?

Inadequate 

Summary of findings

Overall summary

About the service

Ferfoot Care Home provides personal care for up to 52 people, some of whom live with dementia. At the time of inspection there were 44 people living at the home. Accommodation is provided over two floors accessed by stairs and a lift. There are communal rooms such as lounges and dining areas. The home has a small secure garden for people to access from the ground floor.

People's experience of using this service and what we found

People were not supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice.

There were concerns about the culture at this service as it was not person-centred. The registered manager was not aware of how some staff were working. This placed people at risk of harm as the practice was undignified and unsafe at times. We observed that people were being woken at 6am to have medicines without any medical reason. We observed one person did not have their belongings in their room, staff had removed them and placed them on a different floor. We were not able to see why this action had been taken.

People's risks had been identified but management plans did not give detailed guidance on how to support people safely. Measures in place to mitigate risks were not always working, for example sensor mats were not plugged in and monitoring records were not being completed consistently and accurately. Behaviour support plans lacked details for staff to know what action was needed when people were distressed.

People's medicines administration records had not been checked for accuracy when handwritten by two members of staff. The provider could not be assured medicines needing cold storage were being stored safely as temperatures recorded were outside a safe range. People could see healthcare professionals when needed and referrals were timely.

Staff had not received the training they needed to support people effectively, safely and in a person-centred way. Staff told us there was not enough of them to support people safely. Whilst we saw there were enough staff deployed during our visits, we have made a recommendation about staffing numbers. People were being supported by staff that had been recruited safely.

Quality monitoring systems were in place but not routinely effective in identifying shortfalls. Care plan audits were not identifying conflicting information and medicines audits had not identified the shortfalls we observed. Accidents and incidents had been reviewed but there was limited evidence of learning across the providers services. There was a registered manager in place who was approachable. We heard mixed feedback about their management approach which we have shared with the provider.

The home was clean and domestic staff had schedules to ensure thorough cleaning was carried out. Staff were seen to be wearing appropriate PPE and following good infection prevention and control practice. Staff told us they had received training for using PPE safely and had good supplies throughout the COVID-19 pandemic.

There had been no cases of COVID-19 at the home and people and staff were being tested regularly following government guidance. Visiting was being supported indoors and outdoors. Systems were in place to screen visitors, complete an LFT test and supply them with PPE to use whilst at the home. We observed relatives indoors visiting people during our site visit.

The provider had kept people, relatives and staff updated throughout the pandemic and reviewed policies when needed to follow national guidance. People had been supported to stay in touch with relatives using different communication methods. Activity staff were employed and supported people to engage in activities they enjoyed.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update

The last rating for this service was requires improvement (published 10 December 2019) and there was one breach of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection enough improvement had not been made and the provider was still in breach of regulations. This service has been rated requires improvement or inadequate for the last six consecutive inspections.

Why we inspected

We undertook this focused inspection to follow up on specific concerns which we had received about the service. The inspection was prompted in part due to concerns received about the managers approach, people being woken up very early in the morning, unsafe medicines management, people not receiving care in a timely way and poor moving and handling practice. A decision was made for us to inspect and examine those risks.

We inspected and found there was a concern with supporting people who lack capacity to make their own decisions, so we widened the scope of the inspection to become a comprehensive inspection which included all of the key questions.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively

Enforcement

We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and we will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to staff training, supporting people with consent and provider and management oversight and governance.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

Following the inspection we met with the provider to discuss how they will make changes to ensure they improve their rating to at least good. We will request an action plan from the provider and we will work alongside them and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Details are in our safe findings below.

Requires Improvement ●

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement ●

Is the service caring?

The service was not always caring.

Details are in our caring findings below.

Requires Improvement ●

Is the service responsive?

The service was not always responsive.

Details are in our responsive findings below.

Requires Improvement ●

Is the service well-led?

The service was not well-led.

Details are in our well-led findings below.

Inadequate ●

Ferfoot Care Home

Detailed findings

Background to this inspection

The inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team

This inspection was carried out by three inspectors, a medicines inspector, an assistant inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type

Ferfoot Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

This inspection was unannounced. The first day of the inspection started at 6am.

What we did before the inspection

We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider was asked to complete a provider information return prior to this inspection. It was completed and returned during the inspection. This is information we require providers to

send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all of this information to plan our inspection.

During the inspection

We spoke with five people who used the service about their experiences. We spoke with five members of staff, the registered manager and regional manager. 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.

We reviewed a range of records. This included 13 people's care planning and support records and multiple medication records.

After the inspection

Following our site visit we spoke with 16 relatives about people's experiences of care received, a further 14 members of staff and the registered manager. We continued to seek clarification from the provider to validate evidence found. We looked at training data, quality assurance records and meeting minutes. We contacted four healthcare professionals for their feedback about the service.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has remained the same. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Using medicines safely

At our last inspection the provider had failed to have systems in place to make sure records gave staff guidance to manage risks. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

- At our last inspection people's risks had been identified but there were not always detailed management plans in place to give staff guidance on how to support people. At this inspection we found this had not improved. People we reviewed with epilepsy or who experienced seizures did not always have a care plan in place to help staff to manage the risks. Where there was a care plan it did not give staff sufficient guidance on how to support the person when they might have a seizure. It did not give staff guidance on what to do and when.
- At our last inspection people's topical administration records (TMAR) did not have the correct details on what creams people had been prescribed. At this inspection we saw this had improved however, staff had not recorded on people's creams when they had been opened. This meant staff did not know when creams had expired and were not as effective.
- Staff used Medicines Administration Records (MARs) to record when medicines had been administered. Although handwritten MARs had clear dosing instructions, were dated and signed; we were not able to see they had been checked by two members of staff for accuracy.
- Fridge temperatures were being monitored for medicines requiring refrigeration. However, the records showed that the maximum temperature was outside the recommend range. There was no recorded action to rectify this. It was not clear if staff had been resetting the thermometer. The records could not provide assurance that medicines were being stored at safe temperatures.
- At our last inspection we saw people's monitoring charts were not being completed contemporaneously. At this inspection we saw this was still the case. The first day of this inspection started at 6am. When we checked people's daily notes at 06.30am staff had recorded care had been given and people had been administered their medicines. They had timed the entries for 07.30am which was not correct.
- Behaviour support plans did not give staff clear guidance on what to do when people experienced distress. For example, one person's support plan stated staff were to work closely with the GP when the persons behaviour became unsafe. Whilst this may be one of the actions staff needed to follow there was no guidance on what to do at the time of the distress.

- Staff had sensor mats in place for two people. We were told they were at risk of going into other people's rooms so staff needed to monitor their whereabouts. On two occasions we observed the mats were not connected to the call bell system. This meant staff would not be alerted to their movements which placed people at risk of abuse. On one occasion we observed the person had moved out of their room and into the corridor without staff being alerted. We alerted staff to this shortfall at the time of inspection.
- Whilst accident and incident reports were completed by staff and reviewed by the management team, we were not assured of the learning shared within the organisation. We asked staff if they were aware of serious incidents that had occurred in other homes managed by the provider. Staff told us they were not aware of any.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate good governance. This placed people at risk of harm. This was a continued breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse

- People and relatives we spoke with told us people felt safe. Comments included, "[Relative] is settled and trusts everybody and is constantly monitored" and "[Relative] is safe. The doors are secure, it is a safe environment. [Relative] says the staff are all very nice."
- Staff had been trained on safeguarding and knew the signs of abuse. All the staff we spoke with were sure about how to report concerns and understood their responsibilities. One member of staff said, "I have done safeguarding training a couple of months ago, I know about abuse and I would always say something. I would go to the senior or deputy manager if concerned."
- Prior to our inspection we received concerns that safeguarding incidents were being covered up by the registered manager. We did not find any evidence to substantiate those concerns. Incidents had been reported to the local authority and notified to CQC when needed.

Staffing and recruitment

- Prior to our inspection we had received concerns that people were not being supported by sufficient numbers of staff. We observed during our inspection there were sufficient numbers of staff available.
- However, feedback about staffing from staff was mixed. Comments included, "They [provider] need to think about the wider picture and have more staff if they are taking people, other than those who have dementia, like learning disability or schizophrenia. They take a lot of time, need more staff to support them properly", "Shifts are often really stressful as you're rushing all day. People want things but you can't help straightaway as you're with another person. Some residents understand but others get really frustrated. You often don't have time to have a drink" and "Staffing is up and down. Can be busy. Have had lots of sickness, staff leaving, difficult to cover shifts, so sometimes short [of staff]." We shared the feedback with the registered manager at the time of the inspection.
- The registered manager told us they provided staffing number dependent on people's needs by using a dependency tool. This was reviewed regularly. The registered manager told us they had not decreased staff at the time of the inspection even though their numbers of people were reduced. They had no plans to reduce staffing numbers to reflect occupancy.

We recommend the provider takes into account the views from people, relatives and staff when reviewing staffing numbers.

- Staff had been recruited safely. The provider had carried out pre-employment checks to make sure suitable staff were employed.

Preventing and controlling infection

- We were assured that the provider was preventing visitors from catching and spreading infections.
- We were assured that the provider was meeting shielding and social distancing rules.
- We were assured that the provider was admitting people safely to the service.
- We were assured that the provider was using PPE effectively and safely.
- We were assured that the provider was accessing testing for people using the service and staff.
- We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
- We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance

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

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

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. We found staff were not working within the principles of the MCA.

- At our last inspection we found it was not clear in people's care plans who had been involved in making decisions for people and what options had been considered. The provider told us they were making changes to their documentation to make improvements. At this inspection we have found these improvements had not been carried out in all cases.
- One person did not have any of their belongings in their room. Staff had made a decision to remove all their belongings and place them in a cupboard on another floor. We were not able to see in the person's care plan how this decision had been made, who had been involved and whether this was the least restrictive option. We raised this with the registered manager and the regional manager during our inspection.
- Some people living with dementia were having some of their medicines at 6am. Staff were waking them up to administer medicine without any medical reason for doing so. We were not able to see in people's care plans how this decision had been made in people's best interests.
- We observed two people had sensor mats in place to alert staff to their movements. It was not clear in people's care plans why the mats were in place, who had been involved in the decision making and whether this was the least restrictive option.

The provider had failed to follow the principles of the MCA and make sure decision making was in people's best interests and the least restrictive. This placed people at risk of having their human rights breached. This was a breach of regulation 11 (need for consent) of the Health and Social Care Act 2008 (Regulated Activities)

Regulations 2014.

Staff support: induction, training, skills and experience

- Staff had not had training on supporting people with specific health needs or conditions. For example, staff had not been trained on epilepsy and how to support people who experienced seizures.
- The service had offered placements to some people who had a learning disability. Whilst people's needs were that of older people, there were also some behavioural needs which the staff were struggling to support. Staff had not received any training on working with people with a learning disability. One member of staff told us, "I haven't had any training on learning disability or mental health like schizophrenia. We do what we think rather than what we should be doing."
- Staff were concerned about newer staff not getting the training they needed during their induction. One member of staff told us, "Staff are thrown in without really knowing about people. They are not learning properly, especially if they haven't done care before. We need more training for staff if they [provider] are going to take people who don't have dementia. We have one person with a learning disability and another with schizophrenia. No real training about this just told about them and given a leaflet."
- Prior to our inspection we had been notified of a serious incident which was being investigated by the police. As part of the investigation the provider identified that moving and handling guidance given to staff had been incorrect. Since the incident we were not able to see that staff had received the correct moving and handling training. Whilst the incident occurred in February 2021 the provider had an e-learning moving and handling training course available for staff to complete at any time.

The provider had failed to provide staff with suitable training to enable them to carry out their role effectively and safely. This placed people at risk of harm. This was a breach of regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager responded immediately during and after the inspection. They confirmed they had contacted the head of learning to organise additional training for staff.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People's needs had been assessed prior to admission but during the pandemic this had been limited to virtual or telephone assessments. The registered manager told us this had been difficult as she was reliant on information shared by others and not able to see people face to face.
- People's health needs had been assessed using nationally recognised tools such as the Waterlow for risk of developing pressure ulcers. These had been completed monthly and assessed people's risks.
- Some people's care plans stated they were to have an assessment of pain using the Abbey pain tool. This is an observation pain assessment tool for people who are not able to communicate. It guides staff to know when people might be experiencing pain. We observed this was not always being completed which meant people might not have the support they needed at the time it was required.

Supporting people to eat and drink enough to maintain a balanced diet

- People and their relatives told us they thought people had plenty of food and drinks. Comments included, "If [relative] doesn't want to eat they will make a sandwich and drinks for [relative]. One member of staff gets on well with [relative], they respond to her when she feeds him. On visits [relative] looks well fed and hydrated. When [relative] is not drinking well staff will monitor drinks" and "The food is very good, we get a choice." One person told us they always had drinks to hand and were never thirsty.
- We observed mealtimes and saw they were relaxed and unhurried. People had support to eat when needed from staff who were sat down with them.
- People were offered choices and the food looked appetising. If people did not want what was offered, they

were given alternatives to choose from. There were drinks available throughout the home.

Adapting service, design, decoration to meet people's needs

- Improvements had continued with the environment. Flooring had been replaced, corridors looked bright and signs were available to help guide people.
- One of the quieter lounges was being used to support visiting. The room was accessible from the outside. This helped visitors come into the building without having to travel through other communal areas.

Supporting people to live healthier lives, access healthcare services and support; Staff working with other agencies to provide consistent, effective, timely care

- Staff referred people to healthcare professionals when needed. They worked in partnership with local GP's and community nurses. Relatives told us staff contacted them to keep them updated with changing health needs. One relative said, "[Relative] has had chest and water infections. Staff rang me to say [relative] was poorly. They [staff] always phone me immediately."
- Staff had daily handovers and meetings to make sure they were updated with people's changing needs. Handovers were an opportunity to share information about events, incidents and activities happening during the shifts.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence; Supporting people to express their views and be involved in making decisions about their care

- Prior to our inspection we received concerns people were not getting the care they needed, did not always have their call bell in reach and were being helped to get up at 5am which was not their choice. We did not find evidence to substantiate all of the concerns, however, we observed times where people were not treated with dignity and respect.
- We observed for one person on two occasions they did not have their call bell in reach. On one occasion they were calling for help so we activated their call bell for them and put it in their reach. We waited for staff to come and help this person.
- We observed for one person some undignified terminology in their care records which demonstrated staff did not have an understanding of people's needs.
- We observed one occasion whereby staff were supporting a person to use the toilet. They left the door wide open for a time so people walking past the door could see the person inside. This was not dignified. We raised all of the issues we observed with the registered manager and regional manager, at the time of the inspection, who assured us they would take appropriate action.
- On our first day of inspection we visited the service at 6am and found people were still in bed. Some people were up but this was their choice. Some staff we spoke with told us people were being helped to get up very early in the morning. One member of staff told us, "Some people get themselves up in the morning, but staff get some people up at 5am. It's those who don't know and are unable to verbally communicate. I'm not sure it's an instruction just a bad habit. The manager knows but it doesn't change." We shared this information with the provider during the inspection.
- People and relatives told us they thought staff were caring. Comments included, "The staff are very kind and caring", "Staff are very lovely, and [relative] is definitely getting care" and "Staff do an amazing job in very difficult circumstances. They know [relatives] little ways and are kind and friendly."
- People were being cared for by staff who enjoyed their jobs. Staff told us, "Residents are so lovely", "Absolutely yes I enjoy my job, there are difficult times but there are more enjoyable times" and "I like that every day is not the same, it is a very rewarding job."
- We observed some interactions that were kind and caring. We saw staff responding to people's requests for help, communicating with them sensitively. Staff were seen to be sat down with people talking to them about different topics.
- People had life history information in their care plans and rooms. Activities staff told us they had worked with relatives to get information and photographs for people to use for reminiscing and communication.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement. This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- Prior to our inspection we received concerns that people were not being repositioned when needed which placed people at risk of pressure damage. We observed people who were at risk with monitoring records in place, did not have accurate information recorded to demonstrate staff were repositioning when needed.
- People's repositioning records had gaps in recording and staff had recorded 'repo' when helping some people to move. This did not record what position the person was moved to which did not accurately record care delivery. Whilst we were not able to see evidence to substantiate the concerns in full, we could not see evidence to demonstrate people were being repositioned when needed consistently.
- Care plans contained information on a range of needs, but some lacked details. For example, one person was assessed as needing medicines to help them manage their bowel movements. Their care plan did not inform staff of this need and what action would be needed. For one person we observed they had anxieties about their cash. There was no care plan in place or system to give staff guidance on how to support them with their money. We raised this with the registered manager who told us they had put a system in place to make sure this person was supported to manage their money safely.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- People's communication needs were recorded in their care plan. We saw there was some pictorial documents which were easy read for people who had dementia.
- The provider was able to produce documents in a range of formats if needed.

Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- People were supported to take part in activities that they enjoyed. People's preferences were recorded in booklets which were reviewed by the activities team of staff. Comments from relatives about the activities included, "They [staff] know [relative] likes to sit in a place where they can see people going past. [relative] doesn't feel isolated" and "They do flower arranging. [relative] plays bingo. In the newsletter it says they [staff] have been planning for entertainments."
- Due to the pandemic opportunities to go out into the local community had been restricted however, people had been able to use the garden which was secure.
- People had been supported to keep in touch with their families via letters, the telephone and by

technology to have virtual meetings.

- People were able to have visits from named relatives following the government guidance. During our inspection we observed families visiting indoors wearing PPE. There was a designated room for visits which could be accessed from the front of the home.

Improving care quality in response to complaints or concerns

- The home had a complaints policy which outlined their process to deal with any complaints made. Complaints received had been logged and investigated by the registered manager. Outcomes were recorded and where needed letters of apology sent.
- Relatives told us they knew how to complain if they needed to. One relative told us, "I'm very pleased with [relatives] care. If I had any complaints the manager would listen to me."

End of life care and support

- Staff had supported people with end of life care. Where people had made decisions regarding their end of life wishes these were recorded in their care plans.
- The registered manager told us through the pandemic they had continued to support relatives to visit people for compassionate reasons at the end of their lives.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care

At our last inspection the provider had failed to have systems in place to make sure accurate, complete and contemporaneous records were in place. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

- At our last inspection we found improvement was needed to record keeping. The provider sent us an action plan to tell us what action they would take and by when to make the improvements. At this inspection we have found those improvements had not consistently been carried out.
- As we reported in the key question safe, people's daily notes were filled in by staff before they carried out the care delivery. Staff had recorded they had helped people with personal care and given people medicines. When we checked people's medicines records they had not been given their medicines so the daily notes were not accurate. We also observed hourly monitoring records were not completed contemporaneously. This meant the provider could not be assured records reflected an accurate and timely account of care delivery.
- Quality monitoring systems were not robust in identifying improvement required. During our inspection we have identified a number of shortfalls. These had not been identified by the provider as part of their monitoring.
- For example, care plans were being reviewed monthly using a system called 'resident of the day'. Whilst this system enabled the care plans to be checked it had not identified conflicting information or incorrect information in all cases. Medicines were being audited monthly but had not identified the issues we had found.
- Incidents of poor moving and handling practice which had led to serious incidents had occurred in another home managed by the provider. The provider informed us there were systems in place to cascade learning from serious incidents across their homes. We asked staff working at Ferfoot Care Home if they were aware of poor moving and handling practice and serious incidents in other homes managed by the provider. All the staff we asked said no they were not.
- We observed practice that was not person-centred and not in keeping with the provider values. People being routinely and unnecessarily woken up at 6am, one person not having their belongings in their room

and episodes of undignified practice. The service was not able to demonstrate a positive, person-centred culture.

- We were not assured the registered manager was fully aware of how staff were working in the home and that policies were being followed at all times. One member of staff told us, "The manager is supportive, but they don't know what's going on, on the floor. There's no discipline."
- Ferfoot Care Home has been inspected and rated requires improvement or inadequate for six consecutive inspections. The provider had not demonstrated there are systems and processes in place to achieve a good rating.

The provider failed to put into place robust systems to demonstrate good governance. This placed people at risk of harm. This was a continued breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff views of the registered manager's approach were mixed. Some felt well supported and thought she was approachable; some felt her style was not effective. Comments included, "I think [registered manager] is fine, she is very approachable. She is very busy, even if you make an appointment, she can be busy", "[registered manager] is really passionate, I quite like that, it is nice to see that", "[registered manager] is approachable. Sometimes she can flap about things, gets a bit stressed sometimes, she can take it out on the staff" and "Sometimes she [registered manager] can speak to staff wrongly, she comes out and have a go at staff on the floor. If she needs to speak to someone it needs to be confidential, not in front of residents and other staff."
- Prior to our inspection we received concerns that the registered manager had favourites amongst the staff team. Some staff we spoke with told us they had witnessed staff being treated more favourably which impacted on the team. We have shared these concerns with the provider.
- The provider informed us they had provided support to the registered manager to help them develop their style and approach. Management coaching had been provided and regional manager support had been available. There was a new regional manager in post who was visiting the home regularly to provide support.
- Despite the shortfalls we have found and the mixed feedback from staff, relatives told us they thought the home was well managed. Comments from relatives included, "The manager is [name of manager]. She will contact me if needed, brilliant manager. I've seen her during visits, and she says hello" and "[registered manager] is very nice. I've had discussions with her, and she reassured me. I feel she is a very genuine person."

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

- The provider had a duty of candour process in place and we saw this had been followed when appropriate.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People and relatives were able to attend meetings organised using technology. The provider had kept relatives updated throughout the pandemic with letters and emails.
- Staff were able to attend meetings and share their ideas. The provider organised a 'listening event' carried out by human resources colleagues. They visited the home to listen to staff and discuss any concerns.

Working in partnership with others

- Staff worked with local healthcare professionals to make sure people's health needs were being met.

Relationships had been maintained with local GP's who visited the home weekly and community nurses.

- The registered manager had accepted the support offered by the local authority during the pandemic. They had been able to attend support calls and webinars to help keep up to date with changes to working safely.

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 HSCA RA Regulations 2014 Staffing The provider failed to make sure staff had appropriate training and support to enable them to carry out their duties. Regulation 18 (2) (a)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The provider had failed to follow the principles of the MCA and make sure decision making was in people's best interests and the least restrictive. Regulation 11 (1) (2) (3)

The enforcement action we took:

We served a warning notice to the provider

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider failed to put into place robust systems to demonstrate good governance and provider and management oversight. Systems were not in place to assess and manage risks, assess and monitor the quality and safety and maintaining accurate and contemporaneous records for people. Regulation 17 (1) (2) (a) (b) (c) (f)

The enforcement action we took:

We served a warning notice to the provider