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# The Ferns

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Inadequate |

| | |
|---|---|
| Is the service safe? | **Inadequate** |
| Is the service well-led? | **Inadequate** |

# Summary of findings

## Overall summary

About the service
The Ferns is a residential care home providing accommodation and personal care to five people living with a learning disability. A maximum of six people can live at The Ferns.

The Ferns is a large terraced home over three floors and has a cellar. Three people had their own bedrooms and two people shared a large bedroom. There was a shared lounge, dining room, kitchen and two bathrooms. Staff used a downstairs room as an office and sleep-in room. This room could also be used by people living at the home during the day.

People's experience of using this service and what we found
The service was not well managed; quality audits were not acted upon and repairs to the property had not been completed. Risks to people's health and wellbeing were not always assessed and managed, for example fire risk assessments. Staff had not received the training or supervision to support them in their role.

The service was not person-centred in its approach; people were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests. The service had decided people could not go out on their own during the COVID-19 pandemic. People had not been involved in this decision or supported to make their own choices. This was legally authorised for two people through Deprivation of Liberty Safeguards (DoLS). Staffing was insufficient to support people to go out into the community during the COVID-19 pandemic.

Records reflected a lack of person-centred care and dignity. Risk assessments and care plans emphasised the negative; things people were not able to do, rather than detailing what they could do and where they needed support.

People received their medicines as prescribed.

We expect health and social care providers to guarantee autistic people and people living with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the guidance CQC follows to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

The service was not able to demonstrate how they were meeting the underpinning principles of Right support, right care, right culture.

Right support:
During the COVID-19 pandemic the service had taken a blanket decision that people could only go out with staff support. A Deprivation of Liberty Safeguards (DoLS) had been authorised for two people which legally

allowed the service to prevent people from going out on their own. A DoLS was not in place for three people. Additional staffing had not been provided during the COVID-19 pandemic to enable people to be regularly supported to go out of the home if the chose to do so. Whilst there were some leisure opportunities within the home, such as craft items, board games and computer games we found they were not frequently used.

Right care:
People did not receive person centred care and support. Care plans and risk assessments focused on things people were not able to do rather than on their strengths and skills. The home was in need of maintenance work to be undertaken so it was suitable for people to live in.

Right culture:
The management lacked oversight of the home and did not promote a person-centred culture where people were involved in making choices and decisions about their own lives.

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

Rating at last inspection
The last rating for this service was Good (published 17 October 2019).

Why we inspected
This inspection was prompted by concerns found during an inspection at the provider's other service on 27 November and 1 December 2020. These included a lack of person-centred care, the environment, staffing and management of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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 coronavirus and other infection outbreaks effectively.

We have found evidence that the provider needs to make improvements. Please see the safe and well-led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.
The overall rating for the service has changed from good to inadequate. This is based on the findings at this inspection.
You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for The Ferns on our website at www.cqc.org.uk.

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 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 the governance and auditing, risk management and maintenance of the property at this inspection.

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
We will meet with the provider and request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

**Is the service safe?**

Inadequate

The service was not safe.

Details are in our safe findings below.

**Is the service well-led?**

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

# The Ferns

**Detailed findings**

## Background to this inspection

The inspection
We carried out this focused 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
The inspection was completed by two inspectors.

Service and service type
The Ferns 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 two managers 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. For the purpose of this report, we will refer to the managers as 'registered manager one' and 'registered manager two.'

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We used the findings from the CQC inspection at the provider's other home to identify areas to enquire about during this inspection.

The provider was not asked to complete a provider information return prior to this 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 experience of the care provided. We spoke with four members of staff including the provider, registered manager one, senior care worker and one care worker.

We reviewed a range of records. This included two people's care records and five medication records. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at external servicing reports and quality assurance records. We spoke with one professional who was regularly involved with the service.

Inadequate

# 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 good. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- The provider had not ensured the home was safe and free from risks which may cause harm to people. Urgent repairs identified on the electrical installation report, dated February 2020, had not been completed. The cellar had a large amount of paper records stored which increased the fire risk. The fire risk assessment had not been completed by a competent person and did not address the hazards we found.
- Personal emergency evacuation plans lacked detail and did not provide sufficient information about how people would respond in an emergency such as a fire.
- Water temperature checks showed two bathroom sink taps were over 50 degrees, which posed a risk of scalding. The bath water temperatures were also above the recommended temperature. No action had been taken to manage or reduce this risk.
- The back yard of the home was cracked and uneven. Two fence panels were missing and it was being used to store household waste. This made the yard unsuitable for people to use safely.
- Radiators did not have radiator covers. No risk assessment had been completed to assess the level of risk posed by hot radiators.
- Risks people may face had been assessed and information provided for staff to follow. However, not all known risks had been assessed. For example one person had epilepsy. There was no care plan or risk assessment to support the person in the event they had an epileptic seizure.

The provider had not ensured the home was safe and free from risks which may cause harm to people. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- Records showed staff had not completed safeguarding training since November 2018. The records stated this training should be refreshed annually.
- The records in one person's care file detailed an incident where one person hit another person living at the home in October 2019. This was not raised as a safeguarding concern with the local authority as per current best practice guidelines. There was no evidence of any actions taken to resolve the issue and prevent a re-occurrence. Following the inspection the provider told us they had informed the person's social worker and the incident had been discussed with both people involved.
- One person told us how they had had an accident three years ago when they fell down the cellar stairs. The cellar door was locked, with the staff having the key. However, the door would be left unlocked when the staff member was in the cellar completing the laundry. This meant alternative arrangements for securing the cellar door at all times had not been implemented following the person's accident. Following the inspection we were told that a door leading to the dining room where the cellar door is located now has an

alarm to alert staff if it is opened during the night.

The lack of safeguarding training for staff and not responding to safeguarding concerns was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Preventing and controlling infection

● Staff had access to personal protective equipment (PPE), including visors. However, one member of staff was wearing a cloth mask that was not water repellent as required by the COVID-19 PPE guidelines. We were told they struggled to wear a surgical mask for health reasons, however were not using a visor as an alternative. This meant there was a higher risk of the member of staff contracting COVID-19 or passing it on to other people whilst in work.

● Due to the repairs the home needed it was not possible to thoroughly clean all the home due to the cracks in walls and ceilings.

● The cellar had a locked wooden door leading to steps into the back yard. This door was old and not well fitting. There was a risk that vermin could enter the cellar from the back yard of the property.

The building had not been properly maintained which was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● A cleaning schedule was followed for communal areas.

Staffing and recruitment

● There were insufficient staff on duty to meet people's needs during the COVID-19 pandemic. Prior to the pandemic most people went out into their community on their own or attended day services. During the pandemic, the service had decided that people should only go out with staff support. However, there was only one member of staff on duty at The Ferns, which meant people did not have the opportunity to go out when they wanted to.

● We were told that the senior member of staff was available to support people to attend appointments or go out if they wanted to. People told us, and records showed, people were not going out regularly. One person said, "I don't go out really, I am a bit fed up. I always need to have staff with me, so I can't go out alone."

The provider and registered managers had not adapted the staffing at the home to enable people to go out on a regular basis. This contributed to a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● There had not been any new staff recruited at The Ferns since 2017. Therefore we did not look at any staff recruitment files at this inspection.

Using medicines safely

● Registered manager one said staff had completed training for medicines administration and were observed to ensure they were competent. However, records showed medicines training had not been refreshed since 2017 and competency checks had not been completed. Also they did not check the staff knowledge of what to do if something went wrong whilst administering people's medicines, for example if a tablet was dropped or a person was too ill to take their prescribed medicines.

● People received their medicines as prescribed. Medicine Administration Records (MARs) were fully completed.

● The service used homely remedies which are used to treat minor ailments and do not need to be

prescribed. They were kept as stock to give people access to medicines that would commonly be available in any household. Balances were checked each month to ensure they were being managed appropriately.

The lack of training in medicines management and competency checks contributed to a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Inadequate

# 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 good. 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.

Continuous learning and improving care; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The quality assurance system in place was not robust. Audits were completed for health and safety and infection control. The same issues were repeatedly identified in the audits; however no action was taken. For example excessive waste stored in the cellar and back yard and a large crack in one person's bedroom.
- Action had not been taken to rectify defects identified in an electrical installation report. Water temperatures were routinely recorded as being at a temperature that posed a risk of scalding.
- Action had not been taken to secure the cellar door at all times after an accident three years ago. Following the inspection registered manager one told us an alarm had been fitted to alert staff if people got up early and entered the dining room where the cellar door is located.

The quality assurance systems were not robust and action was not taken to rectify the issues identified in the audits completed. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

- The building had not been well maintained; there had been a large crack in one bedroom, extending into the roof space for in excess of six months. Another bedroom had a large stain from an old leak and cracks across the ceiling, the hinge on another person's wardrobe door was broken so the door could not be used.

The building had not been well maintained which was a breach of regulation 15 (premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- People were not involved in their care and support. The service had made a decision that everyone at the home was not to go out without staff support during the COVID-19 pandemic. A generic risk assessment was used to justify this. The registered managers had not completed individual assessments with people of their capacity and understanding of the rules around preventing COVID-19 transmission to assess what support, if any, they needed.
- People had not been asked about their wishes at the end of their lives. End of life discussions record people's wishes for their care and support at the end of their lives and also any wishes following their death, for example their funeral. Registered manager one and the provider said that people would move from the

home for end of life support as the home would be unable to meet their needs, however this had not been discussed with the people living at the home.
● The service had not ensured sufficient staff were available to support people when they wanted to go out, resulting in people having little to do. The local authority told us the home had reported to them they had used some of the COVID-19 infection control grants provided by the government for additional staffing to support individuals on a one to one basis. We saw no evidence of this in the rotas or daily records we viewed.
● Care plans were not person centred. They highlighted what people could not do. For example, an assessment of daily living document rated people's ability for a range of tasks as 'poor, average or good'.
● Records were not written to uphold people's dignity and choice. Daily records for one person noted, "Despite seeing me once this morning with the mop bucket, [name] announced they were going for a bath. Lots of huffing and tutting when informed the floor has been mopped."
● Staff had not received up to date training and ongoing supervision to support them in their role.

The service was not person-centred and people were not involved in decisions about their lives. This was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

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
● There had not been any notifications to CQC since November 2018. Registered manager one explained the types of events that needed to be notified to CQC.
● However, a Deprivation of Liberty Safeguards (DoLS) had been authorised for two people in August 2020. The CQC had not been notified of this as required. As described in the safe domain an incident when one person hit another had not been reported as a safeguarding incident.

Not notifying the CQC of the DoLS authorisation and safeguarding incident was a breach of regulation 17 (good governance) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Working in partnership with others
● The home worked with the local authority commissioning team who monitor the service.