New Beginnings (Gloucester) Ltd

Fern Court

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
Fern Court is a residential care home providing accommodation and personal care to up to 13 people. The service provides support to people who may have a learning disability, mental health condition or autism. At the time of our inspection there were 12 people using the service.

Accommodation was divided between two areas; the annexe and the main house. Some rooms provide en suite accommodation. Everyone living at Fern Court had access to a communal living room, kitchen and dining area and had access to a shower and bathroom. The grounds around the property were extensive, accessible and secure.

People's experience of using this service and what we found
People were not always protected against avoidable harm. Incidents and accidents were not investigated in a robust way and learning from events was not used to prevent recurrence of the same issue. We saw people's care plans, risk assessments and positive behaviour support plans were out of date and contained inaccurate or conflicting information. Infection prevention and control was unsatisfactory. This placed people, visitors and staff at risk of infections. Service users were not always protected from the risks of their environment. The provider had not undertaken effective measures to ensure that service users would be protected from risks associated with fire safety and legionella.

Monitoring systems were not always effective as the records supporting the management of the service were not always reliable. There was an action plan in place for improvements which had been compiled by the local authority. The service had not always sent required notifications to the Care Quality Commission (CQC) without delay. The management and provider were working closely with the local authority and other partners to address failings.

We expect health and social care providers to guarantee autistic people and people 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 statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people.

Based on our review of safe and well led, the service was not able to demonstrate how they were meeting some of the underpinning principles of Right support, right care, right culture.

Right support: The provider was not always able to demonstrate how they met the needs of people with a learning disability in line with best practice guidance.

Right care: Care was not always person-centred and we saw examples where people's dignity and privacy were not promoted.

Right culture: The lack of effective quality audits had meant that the support provided was at risk of becoming a closed culture. A closed culture is one where people's needs are not placed at the heart of care practices and people not being involved in their support.

We sign posted the provider to the Right support, Right care, Right culture information on the guidance for providers page on our website.

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 20 February 2019).

Why we inspected
We received concerns from commissioners in relation to staffing and risks to people's safety. 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 COVID-19 and other infection outbreaks effectively. This included checking the provider was meeting COVID-19 vaccination requirements.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.
The overall rating for the service has changed from good to inadequate based on the findings of this inspection.
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.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Fern Court 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 monitor the service and will take further action if needed.

We have identified breaches in relation to safe care and treatment, good governance, person centred care and reporting incidents at this inspection.

Please see the action we have told the provider to take at the end of this report.

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 request an action plan from 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 continue to monitor information we receive about the service, which will help inform when we next inspect.

Special Measures
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.

Fern Court

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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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
Two Inspectors, a member of the CQC medicines team and an Expert by Experience carried out the inspection. 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
Fern Court is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Fern Court is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. The registered manager and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. The provider told us that they were in the process of recruiting a registered manager. Throughout the inspection we therefore spoke with other managers from within the organisation, who were overseeing the service in the absence of a registered manager.

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 considered the feedback from the local authority and professionals who work with the service. We used the information the provider sent us in May 2021 in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
The site visit was completed by two inspectors on 21 and 22 February 2022, and one medicines inspector on 21 February 2022.

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 spoke with one person who lived at Fern Court. We spoke with five relatives and one professional about their experience of the care and support provided by the service.

We spoke with the nominated individual about their oversight of the service. The nominated individual is responsible for supervising the management of the service on behalf of the provider.
We spoke with five staff including care managers from other services within the organisation, the deputy manager, one staff member and one agency staff member.

We reviewed a range of records. This included four people's care records, three staff personnel files and eight medicines administration 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 management team to validate evidence found. We looked at training data, monitoring records and quality assurance records. We spoke with three staff and three professionals who support people using 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 our last inspection we rated this key question good. At this inspection the rating has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong

- The provider had taken some action to minimise the risk of potential exposure to legionella bacteria by checking water temperatures throughout the service. However, as these were not reliably taken, they were not consistently monitoring the risk of exposure. A legionella bacteria risk assessment and a test to determine if legionella bacteria were present had not been completed. We raised this with the provider so they could implement a risk assessment to minimise the risk of legionella.
- People were not always supported safely. Where care plans identified people who displayed behaviours of distress which others might find challenging, there was an absence of clear guidance to ensure staff could manage this consistently and safely and in line with best practice guidance which increased the risk of people being exposed to harm.
- Systems and processes were not robust to protect people from the risk of abuse. The provider had failed to identify and mitigate practice that had the potential to expose people to harm. For example, there was a lack of clarity and guidance around the use of restrictive physical intervention. The management team verbally told us that restrictive intervention was no longer used, but this had not been updated in people's care records.
- The provider had completed a review of the incidents relating to behaviour at the service. However, this information had not been analysed or used to minimise the potential for future incidents. This meant that people were not protected from the potential of reoccurring incidents.
- People's care plans and risk assessments contained out of date documentation. Some information we saw contradicted other documents in use for the same people, meaning that staff did not have clear guidance about how people should best be supported.
- Service users were not always protected from the risks of their environment. The provider had not undertaken effective measures to ensure that service users would be protected from avoidable risk in the event of a fire. A fire audit had highlighted a number of concerns, but the actions taken as a result of these concerns were protracted and not always evident.

The provider did not always assess and do all that was reasonably practicable to mitigate the risks to people who received care. This placed people at risk of harm. This was a breach of Regulation 12 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Policies and guidance were available, and training had been provided to ensure that staff were supported to deal with allegations appropriately. The provider was reviewing their training matrix to ensure that all training was current and up-to-date.

Staffing and recruitment

● The provider was using agency staff on each shift to ensure people received appropriate levels of care and support. The provider told us that they were block booking agency staff whilst they recruited to ensure people had consistency. However, we saw, and people's relatives told us that when people were supported by staff that did not know them well they were not always confident they would receive personalised care. One relative said, "I don't know about the staff and training and so on – they're all new, they still don't know [my relative]."
● Staff were recruited safely. All required checks were made before new staff began working at the home. These included Disclosure and Barring Service (DBS) checks which provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Using medicines safely
● Prior to our inspection the provider had identified a high number of medicines errors and was taking action to resolve. The internal quality assurance process at the home had not identified the errors and so the provider was reviewing some errors retrospectively. They told us they had started a review of their administration and auditing process.
● Medicine administration records (MARs) confirmed people did not always receive their medicines as prescribed. For example, one person's MARs showed somebody was not receiving their medication as regularly as it had been prescribed.
● Staff had not always clearly documented where people had received 'as required' medication such as pain relief. This increased the risk for potential medication errors.
● The provider had identified that further staff training and competency checks were required and was working towards this with staff.

Preventing and controlling infection
● We were somewhat assured that the provider was preventing visitors from catching and spreading infections. We saw a form for screening visitors for symptoms of acute respiratory infection before being allowed to enter the home, but this was not being used reliably.
● We were not assured that the provider was meeting shielding and social distancing rules. The service had not recorded that they had formally identified which people were in the clinically extremely vulnerable group and therefore had no evidence they had supported people to socially distance or isolate when needed.
● We were somewhat assured that the provider was admitting people safely to the service.
● We were somewhat assured that the provider was using PPE effectively and safely.
● We were somewhat assured that the provider was accessing testing for people using the service and staff.
● We were somewhat assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were somewhat assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were somewhat assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

The provider told us that people had been supported to see their relatives safely throughout the pandemic. We saw that people had been supported to receive visits to the service or in the community.

From 11 November 2021 registered persons must make sure all care home workers and other professionals visiting the service are fully vaccinated against COVID-19, unless they have an exemption or there is an

emergency. We checked to make sure the service was meeting this requirement.

The Government has announced its intention to change the legal requirement for vaccination in care homes, but the service was meeting the current requirement to ensure non-exempt staff and visiting professionals were vaccinated against COVID-19.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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

- The registered provider had not evidenced that statutory guidance such as "Right Support, Right Care and Right Culture" had been considered in their care practices or values.
- The lack of effective quality audits had meant that the support provided was at risk of becoming a closed culture. A closed culture is one where people's needs are not placed at the heart of care practices and people not being involved in their support.
- People were not always supported in a person-centred manner. Whilst we did observe some positive interactions between staff and people, we also saw and read some examples where people were not engaged with positively. We raised this with the provider who told us that they were addressing poor interactions via a greater management presence and skill building amongst the staff.
- People were not always supported with their care and support in a way which promoted their privacy and dignity as staff were not following agreed ways of working with healthcare professionals.

People did not always receive appropriate, personalised care. This is a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; 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 failed to send some required notifications to the Care Quality Commission without delay. This impacted on the ability of the CQC to effectively monitor the safety of people as information was not available at the time of the events. CQC monitors important events affecting the welfare, health and safety of people living in the home through the notifications sent to us by providers.

The provider did not always notify the Commission without delay of the incidents which occurred as a consequence of the carrying on of the personal care to people. This was a breach of Regulation 18 (1) of the Care Quality Commission (Registration) Regulations 2009.

- The provider displayed their CQC rating within the service.
- Monitoring systems were not always effective as the records supporting the management of the service were not always reliable. The provider had not through their own monitoring systems identified that the information in complaints and health and safety audits was not always available, complete or accurate. The

provider therefore did not have all the information they needed to monitor whether staff and managers had followed the provider's policies.

● Care records, risk assessments and positive behaviour management plans required more detail to ensure information was clear and current for staff to refer to. The provider told us about they intended to review and update all care plan documentation and transfer these to a new online programme.

● The service had a substantial action plan in place which had been identified by the local authority. The provider told us they would now develop their own action plan so that they could prioritise and facilitate the improvements in a timely manner.

● At the time of the inspection, there was no manager registered with the Care Quality Commission. The absence of a registered manager meant that the service had been covered by different members of the management team across the organisation and oversight had not been consistent.

The registered provider had not ensured that the quality assurance and monitoring systems in place were robust and identified the breaches we have identified in this report. This placed people at risk of harm. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Continuous learning and improving care

● Relatives provided mixed feedback about their experience of communication at Fern Court. Some relatives told us they had shared information with the staff which had not been acknowledged or responded to. One relative said, "We're not officially told [when there is a change in manager]." Another relative said, "The communication should improve – what's happening?"

● There was limited opportunity provided to staff, people and their relatives to share their experience and have their say about the service. Staff, relative and residents meetings were not taking place regularly. They could therefore not monitor how people had been engaged, and whether action had been taken and any improvements made in response to the feedback.

●There was not a clear oversight of complaints at the time of the inspection. The management team told us they had gathered information but did not fully understand the system of the previous manager. The complaints file did not always highlight a clear overview of the concern and any subsequent actions taken.

● People living at Fern Court were subject to Deprivation of Liberty Safeguards (DoLS). The provider did not have an effective system of oversight of the legal applications had been submitted to the local authority..

Working in partnership with others

● Feedback received from health and social care professionals was mixed. One professional said, "The service seems chaotic; [but] I do think they are doing a great job under difficult circumstances."

● The service was working closely with the local authority and clinical commissioning group to develop safe care practices for people. Health and social care professionals were visiting the service and working with staff striving to achieve good outcomes for people.

● The provider was participating in regular progress meetings with stakeholders to discuss proposed and ongoing areas for improvement.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The registered person did not always notify the Commission without delay of the incidents which occurred whilst services were being provided, or as a consequence of the carrying on of the regulated activity service users.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People did not always receive care and support which was tailored to their individual needs. Staff did not provide care in accordance with people's choices and taken into consideration their wellbeing needs.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider had not ensured environmental risks had been appropriately assessed and managed. Risk had not been reviewed to protect people from harm.

The enforcement action we took:

We served a warning notice against the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person had failed to apply effective governance to ensure quality of care for people was appropriate.

The enforcement action we took:

We served a warning notice against the provider.