Care UK Community Partnerships Ltd

Ferndown Manor

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Ferndown Manor is a residential care home providing personal and nursing care to 49 older people, some living with a dementia, aged 65 and over at the time of the inspection. The service can support up to 75 people.

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

Some people had cognitive and sensory impairments that limited their ability to identify risk. Staffing levels and staff deployment meant they were not always visible leaving people without staff nearby and at risk of avoidable harm. Risks to people from environmental hazards had not always been assessed to ensure people's safety.

Changes in leadership and the absence of a registered manager had impacted negatively on staff morale. Lack of consistent leadership had left staff feeling unsupported. Quality assurance processes had identified these issues and an improvement plan was in place which included additional staffing and the appointment of key senior staff, including a manager.

Staff understood their role in recognising and acting upon any concerns of abuse of poor practice. Recruitment processes were robust and included employment and criminal record checks to ensure employees were suitable to work with older people. People received their medicines safely.

The home were honest and open about any accident or incident that had caused or placed a person at risk of harm. People, their families and the staff team had opportunities through regular meetings to share ideas and be involved in developing the service.

People were supported by staff who had completed an induction and had on-going training and supervision that enabled them to carry out their role. Both care and catering teams understood and ensured people had their eating and drinking needs met. Working with other health and social care professionals ensured people received the best outcomes. People received appropriate healthcare for both planned and emergency events. The environment met people's needs for accessible space, inside and outside, and had space for both private and social time.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People had care plans that detailed their individual care needs and lifestyle choices. Staff were knowledgeable about people and how they were able to communicate which meant they were able to involve people in decisions about their care. A range of activities were organised that reflected peoples

interests and abilities. A complaints process was in place that people and their families were aware of and felt able to use and that they would be listened too. People had an opportunity to be involved in end of life care planning which reflected their cultural and spiritual wishes.

People and their families described the care as good and spoke positively about the staff. We observed people being involved in decisions about their day to day lives with staff enabling people to be as independent as they were able. People had their privacy and dignity respected.

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 2 May 2018).

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels and the management of the service. A decision was made for us to inspect and examine those risks.

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

We will continue to monitor information we receive about the service until we 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?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Ferndown Manor

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.

Inspection team
The inspection was carried out by two inspectors 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.

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

Notice of inspection
This inspection was unannounced.

What we did before the 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 reviewed information we had received about the service since the last inspection. We sought feedback from the local authority who work with the service.

During the inspection
We spoke with 12 people who used the service and four relatives about their experience of the care provided. We spoke with 14 members of staff including the regional director, manager, deputy manager, nurses, senior care workers, care workers and the chef. We spoke with a visiting health care practitioner about their experiences of the service.

We reviewed a range of records. This included 11 people's care records and multiple medication records. We looked at two staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures, were reviewed.

After the inspection
We looked at training data.

Requires Improvement

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 requires improvement. This meant some aspects of the service were not always safe. There was an increased risk that people could be harmed.

Staffing and recruitment

● Some people had cognitive and sensory impairments that limited their ability to identify risk. Staff were not always visible leaving people at risk of avoidable harm. Examples included our observations of a person struggling to mobilise around furniture in a lounge causing them to trip up, and another attempting to remove a secured picture frame from the lounge wall.

● Some people had cognitive and sensory impairments that limited their ability to use their call bell when they needed assistance. We observed one person shouting out for staff for ten minutes. No staff were in the vicinity to hear them calling so we spoke with the person who was cold and needed their windows closing. When people were able to use their call bells they were answered quickly.

● Staff consistently told us there were not enough staff. One care worker explained, "(People) with dementia need constant reassurance, you need to be constantly alert and when we do (personal care) there's no one else to look after the rest".

● The manager had identified staffing levels needed reviewing and taken some actions prior to our inspection. This included introducing an additional night carer in response to an identified increased number of falls in the suite that supported people with dementia. On the second day of our inspection they told us they had further increased staffing by one additional day time care worker.

● People were supported by staff who had been recruited safely. This had included employment reference and criminal record checks to ensure they were suitable to work with older people.

Assessing risk, safety monitoring and management

● Environmental hazards to people had not always been acted upon swiftly which meant people with a cognitive or sensory impairment where at risk of avoidable harm. We found a fire door, which was key pad operated and accessed a stairwell, was not closing safely. Maintenance visits had taken place but not been able to resolve the issue. No risk assessment had been completed to ensure people's safety. During our inspection this was prioritised by the regional director and actions taken to minimise the risks to people whilst the door awaited repair.

● Records showed us that equipment was serviced regularly including the boiler, fire equipment, and hoists. People had personal evacuation plans which meant staff had an overview of what support each person would require if they needed to leave the building in an emergency.

● People had their individual risks assessed, monitored and reviewed. Staff were knowledgeable about people's risks and understood and carried out the actions needed to minimise the risk of avoidable harm. This included risks associated with falls, skin damage, malnutrition, dehydration and wound care.

Systems and processes to safeguard people from the risk of abuse

● People received care from staff that had been trained and understood their role in recognising and acting on concerns of abuse or poor practice. Safeguarding information with helpline contact details was displayed around the building.
● People and their relatives described the care as safe. A relative told us, "When I drive home I know (relative) is warm, safe and seems to be loved". One person said, "This home is a very safe place for me to live".
● People were protected from discrimination. Staff had completed equality and diversity training and we observed them respecting people's lifestyle choices.

Using medicines safely
● People had their medicines ordered, stored, administered and disposed of safely. A nurse told us, "The pharmacist visits weekly and discusses any issues and reviews, they liaise with the GP; very efficient system". A relative told us, "My (relative) does get (their) medicines at the time that (they) should".
● Protocols were in place for medicines prescribed for as and when needed ensuring they were administered consistently and appropriately. A nationally recognised tool was used to assess whether people were experiencing pain who didn't have the cognitive ability to verbally express their needs.
● When people had been prescribed a topical cream body maps had been completed to ensure they were applied to the correct part of a person's body.
● People were supported to self-administer their medicines. Risk assessments had been completed with the person and regularly reviewed.
● Staff understood the actions needed should a medicine error occur, which included informing family and the persons GP. A visiting health practitioner told us, "They are vigilant about discrepancies with medicines".

Preventing and controlling infection
● People were protected from avoidable risks of infection as staff had completed infection control training and were following safe protocols.
● All areas of the home were clean and there were no malodours. One person told us, "They are always cleaning here, it sparkles".

Learning lessons when things go wrong
● Incidents, accidents and safeguarding's were seen as a way to improve practice and outcomes for people. An example included carrying out a trend analysis of falls and using the findings to increase staffing levels.

Good

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 remained the same. This meant people's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
- People and their families had been involved in pre- admission assessments to gather information about their care needs, lifestyle, spiritual and cultural choices. Information was shared appropriately with each department prior to admission. This meant that any equipment such as pressure mattresses were in place and the catering team could organise for any special diets.
- Assessments had been completed in line with current legislation, standards and good practice guidance.

Staff support: induction, training, skills and experience
- Staff had completed an induction and had on-going training and support which enabled them to carry out their roles effectively.
- Staff received regular supervision and had opportunities for professional development which included diplomas in health and social care.
- Nursing staff had completed clinical training courses which included end of life care, and the use of specialised equipment for administering medicines.
- Clinical staff meetings were used as an opportunity for learning and discussion and included topics such as dehydration and diabetes.

Supporting people to eat and drink enough to maintain a balanced diet
- People had their eating and drinking needs understood and regularly reviewed including referrals to the speech and language therapy team when people needed specialist swallowing assessments.
- People were supported with making choices and had their independence at mealtimes encouraged. When people needed assistance with their meals and drinks this was provided at the persons pace and was respectful of their dignity.
- People and their families spoke positively about the food. One person told us, "Very much enjoy the food here, they go to great lengths if you want something special. "Drinks when I want them, even a glass of Sherry before lunch". A relative said, "(Relative) eats everything, great menus, lovely food". We observed people being served a variety of home cooked, well balanced meals.
- Drink stations were situated around the home and fresh drinks were replenished frequently in people's rooms. One person told us, "Drinks are brought around in the morning and afternoon or you can or make one yourself".

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
- Records showed us that people had received support from other agencies when needed including nurses

that specialised in wound management and occupational health therapists. A visiting clinical nurse practioner told us, "Nurses talk to me and ask my opinion. Most of the time they don't need it but it's nice to bounce of somebody".

● When people were transferred to another agency such as hospital key information about their care and communication needs, medicines and key contacts was provided to ensure consistent care.

● Oral care assessments had been completed and included dentist input when needed. Records showed us people had access to a range of healthcare services including GP's, chiropodists, opticians and audiologists for both planned and emergency situations.

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

● The building met the needs of people. Corridors were wide and well-lit and hand rails included braille buttons to aid people who were visually impaired. People had access to specialist bathrooms if needed.

● A variety of communal areas provided places to meet and socialise with other people, including a café, bar, and cinema. A private dining area was available for family meals and celebrations.

● Signage was clear and enabled people to orientate about the building independently. This included signage for key places such as the toilet. People's bedroom signage included memory boxes with photographs and memorabilia to aid recognition of a person's own personal space.

● People had access to level, secure gardens that provided sitting areas and was wheelchair friendly.

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.

● Records and observations demonstrated that people were involved wherever possible in decisions about their care. One person told us, "(Staff) do seek my consent and they always knock on my door before coming in". Files contained copies of power of attorney legal arrangements for people and staff understood the scope of decisions they could make on a persons' behalf.

● When people had been assessed as lacking capacity to make a decision records showed us best interest decisions, had been made on their behalf and included input from both families and professionals who knew the person well. Examples included personal care, use of bed rails and administering medicines.

● Records showed us that DoLs applications had been made and when authorised any conditions were known by staff and had been met.

Good

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 remained the same. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity

- People and their families spoke positively about their care. One person said, "The Staff are very good here, caring, kind and supportive to me". A relative told us, "Staff are excellent, first class, whatever you need they are only too willing to help you". Another said, "With the regular staff (relative) has taken to knowing their voices and smiles up at them. They laugh and joke and have a great way with (relative)".
- We observed warm, friendly relationships between people and the staff team. Staff were knowledgeable about people's history, the family and friends important to them and respectful of people's lifestyle choices.

Supporting people to express their views and be involved in making decisions about their care

- People had their individual communication needs understood. Staff used appropriate non-verbal communication to demonstrate listening and to check people understood them. For example, talking with people at eye level and using hand gestures and facial expressions. A care worker explained, "A lot of people have Alzheimer's, you approach (communication) in a way that is comfortable to them".
- People felt involved in decisions about their day to day lives. One person told us, "The Staff do know how I like things done and they listen to me".
- People had access to an advocate when they needed somebody independent to support them with decision making.

Respecting and promoting people's privacy, dignity and independence

- People had their dignity and privacy respected. One person told us, "The Staff do treat me with full respect, they knock before coming into my room, they also protect my dignity". A relative told us, "They (staff) are always very careful to respect my (relative's) dignity.
- People were supported to be independent. One person told us, "I am encouraged to be independent, they let me make my own tea if I want to". A relative said, "They do encourage my (relative) to be independent, to the best of (their) abilities".
- Confidential data was accessed by electronic passwords or stored in a secure place ensuring people's right to confidentiality was protected.

Good

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 remained the same. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; 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 had care plans which reflected their personal care needs and lifestyle choices, were understood by staff and reviewed regularly. Care was responsive to people's changing needs. A relative told us, "(Staff) check on my (relative) every hour, but if (they) are unwell it's half hourly".
- Details of how a person's health conditions impacted on their wellbeing were included in care plans. A nurse told us, "It's important staff know the impact". They provided an example of a care worker noticing bruising on a person which indicated they needed a GP review of a blood disorder.
- People had opportunities to make friends and be involved in activities tailored specifically to their interests such as music, board games and quizzes, exercises and gardening. One relative said, "They get singers quiet often and the smile it brings to my (relatives) face is a joy to behold".
- People had been asked to write down a wish and staff had made them happen. Examples included a ride in a tank, romantic meal with a partner and a visit to a stable.
- Regular trips into the community took place and included local attractions such as an owl sanctuary and garden centres. Links had been made with the local community and included sharing an allotment with a local school and events with local churches.

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 clearly assessed and detailed in their care plans. This included whether people needed glasses, hearing aids or any additional support such as information provided in large print.

Improving care quality in response to complaints or concerns

- People were aware of the complaints process and felt if they raised a concern appropriate actions would be taken. One person told us, "When things have gone wrong it's been dealt with straight away".
- Details of the complaints policy was displayed in the foyer. The information included contact details for external agencies should people feel their complaint had not been dealt with satisfactorily. A relative told us, "There's a helpline to head office".
- Records showed us that when concerns were raised they were investigated, and appropriate actions taken to improve care quality.

End of life care and support

● People had an opportunity to develop care and support plans detailing their end of life wishes. These included any cultural requirements and decisions on whether they would or would not want resuscitation to be attempted.

● When people were receiving end of life care close working relationships had been maintained with health professionals ensuring people's changing needs were anticipated, maintaining a person's comfort and dignity.

● Bereavement support was available to staff. The deputy manager told us, "The first experience of death can be quite traumatic and a debrief is available if (staff) want it".

Requires Improvement

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 requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred 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

- Changes in leadership at key levels of management had impacted negatively on staff morale. Staff consistently raised concerns with us about staffing levels, staff retention and high agency usage. Records showed us that staff had raised concerns in supervision and at their last staff meeting.
- The regional director explained that staffing levels were calculated monthly based on people's dependency needs and reviewed weekly in response to any clinical risks.
- Quality assurance processes were multi layered and included feedback from people, their families and the staff team. The acting manager had identified staffing levels needed improvement and included this in the service improvement plan for discussion with the provider. They explained, "Through feedback from staff and relatives, and accident and incident trending, and also complaints, it's identified that the level of staffing on the floor doesn't meet the need of residents".
- The home did not have a manager registered with the Care Quality Commission. A 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 regional director told us a new manager had been appointed and would be commencing their role the following week with a plan to apply for registration.
- Lack of consistency of leadership and staff deployment meant staff didn't always feel supported. Two of the three suites had been without a unit leader. One care worker told us, "You are always being pulled in different directions as there's not enough staff". The regional manager told us, "The job (unit leader) includes staff deployment and oversight of allocation (of staff) on the floor. Both posts had been filled with new team leaders who had started their induction the week of our inspection.
- The service had made statutory notifications to CQC as required. A notification is the action that a provider is legally bound to take to tell CQC about any changes to their regulated services or incidents that have taken place in them.

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 manager understood the requirements of the duty of candour. This is their duty to be honest and open about any accident or incident that had caused or placed a person at risk of harm. Records showed us they fulfilled these obligations, where necessary, through contact with families and people.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People, their families and staff had opportunities for developing the service and sharing information and learning through regular meetings, quality surveys and social events.

● The staff team worked with other organisations and professionals to ensure people's care and support was in line with best practice guidance. This included national organisations linked with clinical and social care practice such as the Nursing and Midwifery Council and Skills for Care.

● Links with the local community included a partnership with a local school where children had shared reading, artwork and gardening with people.