

Mariposa Care Limited

Ferndene Care Home

Inspection report

Parksprings Road
Gainsborough
Lincolnshire
DN21 1NY

Tel: 01427810700

Website: www.executivecaregroup.co.uk

Date of inspection visit:
19 July 2017

Date of publication:
04 September 2017

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?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection took place on 19 July 2017 and was unannounced. Ferndene Care Home provides care for older people who have mental and physical health needs. It provides accommodation for up to 48 people who require personal and nursing care. The service provides care on two floors and is divided into two units. At the time of our inspection there were 42 people living at the home.

There was not a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated regulations. There was a manager in post who was applying to become registered as the manager?

On the day of our inspection staff interacted well with people. People and their relatives told us that they felt safe and well cared for. Staff knew how to keep people safe. The provider had systems and processes in place to keep people safe.

Medicines were not consistently administered and managed safely.

We saw that staff obtained people's consent before providing care to them. Where people could not consent, staff worked in ways that protected their rights.

We found that people's health care needs were assessed and care planned and delivered to meet those needs. People had access to healthcare professionals such as the district nurse and GP and also specialist professionals. People had their nutritional needs assessed and were supported with their meals to keep them healthy. People had access to drinks and snacks during the day and had choices at mealtimes. Where people had special dietary requirements we saw that these were provided for.

There was not sufficient staff consistently available to meet people's needs. However at the time of inspection the provider was using agency staff to maintain staffing levels. Staff responded in a timely and appropriate manner to people. Staff were kind and sensitive to people when they were providing support. People were treated with respect.

Staff were provided with training on a variety of subjects to ensure that they had the skills to meet people's needs. The provider had a training plan in place. A plan was in place to provide staff with supervision. People were encouraged to enjoy a range of social activities. They were supported to maintain relationships that were important to them.

Staff felt able to raise concerns and issues with management. Relatives were aware of the process for raising concerns and were confident that they would be listened to. Regular audits were carried out and action plans put in place to address any issues which were identified. The process had failed to identify some of the

issues we found at inspection. Accidents and incidents were recorded and investigated. The provider had not consistently informed us of notifications. Notifications are events which have happened in the service that the provider is required to tell us about.

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 consistently safe.

Medicines were not always administered safely.

Risk assessments were completed.

There was not sufficient staff consistently available to provide safe care.

Staff were aware of how to keep people safe. People felt safe living at the home.

Is the service effective?

Requires Improvement ●

The service was not consistently effective.

The provider did act in accordance with the Mental Capacity Act 2005.

Staff had not received regular supervision but arrangements were in place to address this.

Staff had received training to support them to meet the needs of people who used the service.

People had their nutritional needs met.

People had access to a range of healthcare services and professionals.

Is the service caring?

Requires Improvement ●

The service was not consistently caring

People did not have their dignity consistently considered.

Care was not provided in an appropriate manner.

Staff responded to people in a kind and sensitive manner.

People were involved in planning their care and able to make

choices about how care was delivered.

Is the service responsive?

Good ●

The service was responsive.

Care records were personalised.

People had access to activities and leisure pursuits.

The complaints procedure was on display and people knew how to make a complaint.

People were aware of their care plans.

Is the service well-led?

Requires Improvement ●

The service was not consistently well led.

There were some systems and processes in place to check the quality of care and improve the service however checks had not identified the issues we found on inspection.

Staff felt able to raise concerns.

The manager created an open culture and supported staff.

Ferndene Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19 July 2017 and was unannounced. The inspection was completed by an 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.

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.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We used this information to help plan our inspection.

We looked at notifications which we held about the organisation. Notifications are events which have happened in the service that the provider is required to tell us about. We also considered and information that had been sent to us by other agencies when making our judgements.

During our inspection we spoke with the manager, a senior manager, two nurses and two members of care staff. We spoke with 11 people who used the service and six relatives. We also looked at five people's care plans and records of staff training, audits and medicines.

Is the service safe?

Our findings

We observed the medicine round in the upstairs unit. We saw that medicines were administered safely. However at lunchtime we found medicines in a cup in a person's bedroom in the downstairs unit which had not been taken. We spoke with the person who said they did not realise they were there. We did not see the member of staff return to the person to check they had taken their medicines. However when we looked at the medicine administration records (MARS) we saw the medicines had been signed for. This meant the member of staff had signed that the medicines had been taken when they could not be sure they had. They could not be sure the person was not storing their medicines rather than taking them. Risk assessments had not been completed to assess the risk of the person being left with their medicines. We checked in their care plan and it stated, '[Person] is unable to manage their medication independently'. In addition we saw that medicines for this person prescribed for 5pm had been signed as given. This was checked by us at 4pm. There was a risk that people did not receive their prescribed medicines and that other people could access inappropriate medicines.

The morning medicine round in the upstairs unit did not finish until 11.45am and the lunchtime round commenced at 12.35pm. Records did not indicate the actual time people received their medicines and it was not clear how staff ensured there was sufficient gap between doses. This meant there was a risk the gap between doses was not according to recommended times and medicines were not given according to the times stated on prescribed medicines.

We looked at all the MARS for people living at the home. We found in six records protocols for medicines which are given 'as required' (PRN) such as painkillers, were not consistently in place. These are important because they indicate when these medicines are required and whether or not people could request and consent to having their medicines. People were therefore at risk of receiving medicines inappropriately. People were asked if they wanted their PRN medicines during the medicine round.

In one MARS which was handwritten, a medicine had been overwritten in order to correct the spelling. However this had made the record illegible and the correction had not been countersigned as detailed in the provider's medicine policy. There was a risk the person would not receive the correct medicine because staff would not be able to read the corrected record.

In another record a person was prescribed Paracetamol every four to six hourly, however this had been given as a PRN and consistently recorded as not required. The person was not receiving the medicine as prescribed and there was a risk they would experience pain.

Where people received their medicines without their knowledge (covertly) arrangements had been put in place to ensure this was in their best interests. However the provider's policy did not specify that a pharmacist should be consulted before using this method to ensure the medicines were not affected by the method of administration. This is recommended in NICE national guidance.

We saw that the MARS had been fully completed. However, this was not always according to the provider's

policy and guidance as we observed medicines being signed for without assurance that people had taken them.

Medicines were stored in locked cupboards according to national guidance. Processes were in place to ensure that medicines were disposed of safely and records maintained regarding stock control.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Policies and procedures were not followed to ensure medicines were administered safely.

Individual risk assessments were completed on areas such as nutrition and skin care. Risk assessments had also been completed on issues specific to individual people. For example, a person retained a key to their bedroom and a risk assessment had been completed to ensure this was safely managed. Accidents and incidents were recorded and investigated to help prevent them happening again. For example, falls were monitored and actions had been put in place on an individual basis to reduce the risk of falls to people. Individual plans were in place to support people in the event of an emergency such as fire or flood.

People who used the service told us they felt safe living at the home and had confidence in the staff. Relatives told us that they felt their family member was safe. However people and relatives told us that they did not think there was usually enough staff to provide safe care to people. A relative said, "Often when I am here the buzzers are going for ages and ages before they are answered." During our inspection we observed call bells were answered promptly and staff responded to people in a timely manner. However during the inspection we observed long periods of time when there were no staff available to people in the upstairs lounge area. We also observed a person on two occasions attempting to get out of their chair and nearly falling as there was no staff in the area.

Another relative said, "The regular staff are good but there are so many agency and relief staff here, they don't know the resident or their needs. They don't have time to sit and read through the care plan all the time. That then leads to a lack of continuity."

Another relative told us, "They respond when you say something, but you shouldn't have to get to that stage. One day I came and they had forgotten to put [my family member's] knee brace on. It's just basic caring surely, that's what they should be good at. There are big signs and messages in my [family member's] room for the staff to remember to do all the bits and pieces but still they forget to do some of them. Having said all this I do believe things are so much better now than they were with the previous manager. Things are getting better. My [family member] is very happy here and generally they do care about them, it's just about time I think and there's not enough staff to do the things and take the time that's needed."

At the time of our inspection the home was having to use agency staff in order to fill gaps in the rota due to staff vacancies. We spoke with the manager about this who told us they tried to use the same agency staff in order to provide continuity of care to people. They also told us they were currently in the process of recruiting to vacant posts.

Care staff said that they thought there was sufficient staff but it depended on people's needs. They said if they required support both the nurses and manager would provide assistance in order to meet people's needs. We observed staff responded to people promptly. The manager told us that staffing levels varied according to the needs of people. However with reference to people being without a staff presence for long periods of time they said they had discussed this with staff previously but would raise again to ensure this would not happen.

The registered provider had a recruitment process in place which included carrying out checks and obtaining references before staff commenced employment. They also carried out Disclosure and Barring Service (DBS) checks to ensure that prospective staff would be suitable to work with the people who lived in the home. These checks ensured that only suitable people were employed by the provider.

Staff were aware of what steps they would take if they suspected that people were at risk of harm. They were able to tell us how they would report concerns, for example, to the local authority. Staff told us that they had received training to support them in keeping people safe. The registered provider had safeguarding policies and procedures in place to guide practice and we had evidence from our records that issues had been appropriately reported.

Is the service effective?

Our findings

The provider acted in accordance with the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The 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. We checked whether the provider was working within the principles of the MCA. We saw that best interests decisions had been carried out and were specific as to what decisions these related to. For example, a person required bed rails to be in place and a best interests decision had been completed.

We observed that people were asked for their consent before care was provided. Records included completed consent to treatment forms. Where people were unable to consent this was detailed in the care records.

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. The application procedures for this in care homes and hospital are called the Deprivation of Liberty Safeguards (DoLS). If the location is a care home the Care Quality Commission (CQC) is required by law to monitor the operation of the DoLS, and to report on what we find. At the time of our inspection there were 29 people subject to DoLS, DoLS provides legal protection for those vulnerable people who are, or may become, deprived of their liberty. When we spoke with staff and manager about the MCA and DoLS they were able to tell us about it and how it applied to people within the home.

One person told us, "I think they [staff] are all very good here especially the nurses, and the manager." Staff told us they were happy with the training that they had received and that it ensured that they could provide appropriate care to people. We saw from the training records that most staff had received training on core areas such as fire and moving and handling.

There was a system in place for monitoring training attendance and completion. It was clear who required training to ensure that they had the appropriate skills to provide care to people and that staff had the required skills to meet people's needs. Staff also had access to nationally recognised qualifications. New staff received an induction and when we spoke with staff they told us that they had received introductory training and found this useful. The induction was in line with the Care Certificate which is a national standard. The provider was in the process of changing training provider in order to facilitate more face to face training. In addition a member of staff had been trained to provide training and the manager and this member of staff were planning to provide local training relevant to people living at the home.

Staff were happy with the support they received from other staff and the manager of the service. However staff had not received regular supervision to review their skills and experience. We saw that supervision and appraisals were in the process of being planned. Appraisals are important as they provide an opportunity to review staff's performance and ensure that they have the appropriate skills for their role.

We observed lunchtime in both units and saw staff assisting people with their meal to ensure that they received sufficient nutrition. Staff sat alongside people and chatted as they supported them. The lunchtime meal was relaxed with staff serving the meals and engaging in conversation with people. People were offered a choice before the meal. We observed a member of staff asking people in the afternoon what they would like for tea. However at lunchtime we observed people were not offered a choice of juice.

People had been assessed with regard to their nutritional needs and where additional support was required appropriate care had been put in place. For example, people received nutritional supplements to ensure that people received appropriate nutrition. Where people had allergies or particular dislikes these were highlighted in their care plans. Staff were familiar with the nutritional requirements of people and records of food and fluid intake were maintained appropriately. This is important to support staff to monitor whether or not people receive sufficient nutrition.

We found that people who used the service had access to local and specialist healthcare services and received on-going healthcare support from staff. Where people had specific health needs such as diabetes information was available to staff to ensure that they provided the appropriate care. Care plans were also in place for short term health issues such as infections. One person said, "They got the GP to me yesterday without any hesitation." A relative said, "They do keep me well informed and I know that if my relative is poorly, they will get the GP and let me know what's happening."

Is the service caring?

Our findings

People who used the service and their families told us they were happy with the care and support they received. One person said, "Oh they are very nice staff, most of them anyway. Very kind and courteous to us." People who used the service told us that staff treated them well and respected their privacy. One relative said, "Yes the staff always tap on the door before entering, and come and turn and see to my [family member] regularly and record it all in that book over there. The staff are very good." People told us and we observed that staff usually knocked on their bedroom doors. We did however observe where a person had their bedroom door open two members of staff failed to knock before entering the room although they did address the person before entering. We also observed two occasions when people received their treatment in an inappropriate environment. For example a member of staff applied cream to a person's knee in the dining area during lunchtime in front of other people having their lunch. They also applied eye drops whilst people were sat in communal areas such as the dining area during lunchtime. We raised this with the manager.

A relative told us, "Yes I know our loved one is well cared for here. I think the food varies a bit, but [family member] hasn't got a big appetite anyway. We live away and they keep us well informed." Another relative said, "Yes I feel the staff have good training in moving people and that they always take good care when doing so. My [family member] doesn't like having to be in a hoist but the staff always try and reassure her when they are using it." Staff supported people to mobilise at their own pace and provided encouragement and support. For example, we saw a person walking with a staff member and the staff had a supportive arm on their back to give reassurance whilst they were walking. We saw when staff assisted people to mobilise by using specialist equipment they explained what they needed people to do and explained what was happening.

We observed staff chatting with relatives' in a friendly and respectful manner. All the people we spoke with said that they felt well cared for and liked living at the home. Staff explained to people what they were going to do before providing care and asked people if that was alright. We observed a person was reluctant to take their medicines. Staff spent time with them explaining why they needed to take them and offering them options of how they could take the medicine. We observed the staff member was calm and reassuring and did not rush the person. This resulted in them taking their medicines.

We observed that staff were aware of respecting people's needs and wishes. We observed a staff member asking a person whom they were supporting to move into the lounge area where they would like to sit. Care records detailed people's choices. For example a care record stated, 'Likes to have a hot drink and something to eat prior to going to sleep.'

We saw that staff interacted in a positive manner with people and that they were aware of people's needs. For example, a person required a specialist beaker for drinking and we observed staff consistently provided this to the person. We observed when people were distressed staff were aware of how to support them in order to reduce their distress. For example we observed a person in the dining room getting impatient and staff calmly reassured them.

People who used the service told us that staff treated them well and respected their privacy. One relative said, "Yes the staff always tap on the door before entering, and come and turn and see to my [family member] regularly and record it all in that book over there. The staff are very good." People told us and we observed that staff usually knocked on their bedroom doors. We did however observe where a person had their bedroom door open two members of staff failed to knock before entering the room although they did address the person before entering. We also observed two occasions when people received their treatment in an inappropriate environment. For example a member of staff applied cream to a person's knee in the dining area during lunchtime in front of other people having their lunch. They also applied eye drops whilst people were sat in communal areas such as the dining area during lunchtime. We raised this with the manager.

The provider had introduced a new process for recording people's care on a daily basis, including food and fluid intake. These were kept in people's bedrooms to protect their privacy and also to enable staff to be aware of the care people required.

Is the service responsive?

Our findings

Activities were provided on a daily basis. Staff told us they felt there was a good level of activities for people. Records included when an individual had been visited by the co-ordinator on a one to one basis and had a manicure, chat, walk, or participated in a group activity as well. We saw evidence of previous activities such as a clothes party and musical entertainment. During our inspection we observed people taking part in craft activities and a game of carpet bowls. People also had access to church services within the home and we saw that any specific cultural wishes were recorded in care records and provided for according to people's wishes.

A relative told us, "It's an amazing activities programme here. Whenever we come and visit there's always something happening and there's a monthly programme given to us all. The lady who runs it is amazing, so enthusiastic and full of energy. They had Zoo lab here recently. She gets them all involved somehow no matter what. Even the residents who don't want to join in group wise, she visits them and sits with them when she can. She takes some out walking in their chairs, and arranges fetes and fundraising things." Another relative said, "The activities are good and there's plenty for them all to take part in if they want to or just do one to one things which they often do as well. My [family member] has friends up here which is nice."

The activities co-ordinator told us they had been responsible for fund raising for the home, raising £700 last year which enabled people to go to the seaside on two occasions. They said this year they had already raised £400 for outings. The fundraising events included people who lived at the home, their relatives and staff. The manager told us the care staff were encouraged to help with activities when they had available time. In order to encourage this suggestions of activities had been put into a jar and staff were directed to take a slip and carry out an activity with a person when they were able to.

The provider was in the process of introducing a new format for care records. The care records we looked at were in the process of being revised. We found that that the new care records were incomplete but information was available in the old format. Both sets of records were kept together to ensure staff had access to the information. Care records were personalised and included information about what practical support people required. Care records included details so that staff could understand what things were important to people such as information about people's past life experiences and their preferences. Information such as this is important because it helps staff to understand what is important to people and why. When individual care plans had been written for specific health issues these contained information about the physical care required.

Care plans had been reviewed and updated with people who used the service. The home operated a resident of the day system which meant that on a daily basis one person had their care reviewed to ensure it was relevant and updated accordingly. A person told us, "It [resident of the day] means much more than cleaning my room. It means I get special treatment and attention from the staff and manager, they come and spend extra time with me chatting and things like that to make me feel special."

Where people were unable to communicate verbally we saw staff understood how to communicate with

them. For example, we observed a person banged their cup on the table when it was empty and staff knew they wanted more juice and responded which settled the person. However one person told us they used to have hearing aids and these had been lost and not been replaced. They told us this meant they were unable to join in activities or watch the TV.

Relatives told us that they felt welcome at the home and that they were encouraged to visit so that relationships were maintained. We observed staff offering visitors a drink and chatting with them and their family member.

A complaints policy and procedure was in place and on display in various areas around the home, for example in the lift and in people's bedrooms. People told us they would know how to complain if they needed to. At the time of our inspection the provider was dealing with one ongoing complaint in line with their complaints procedure. The complaints procedure was available in a written and picture format to aid understanding. Complaints were monitored for themes and learning.

Is the service well-led?

Our findings

There was not a registered manager in post. However the provider was in the process of applying to register a manager with the CQC.

Arrangements were in place for checking the quality of care on a range of areas including infection control, care records and medicines. We saw action plans had been put in place where further action was required to make improvements. However, we found that these arrangements did not always ensure that appropriate care was provided. For example, a medicine audit was carried out in June 2017 which identified the need for PRN protocols to be put in place. The July 2017 audit did not identify any gaps in the medicine records regarding PRN protocols. However, at this inspection we identified gaps in six records with reference to PRN protocols.

People felt the home was well run and told us all of the management team were approachable. The manager was walking the floor throughout the day and appeared to know the residents well. The manager told us that in order to understand first hand how care was being delivered they regularly worked with staff to provide care and staff confirmed this. When we spoke with the manager they were familiar with the needs of people who lived at the home.

Staff understood their role within the organisation and were given time to carry out their tasks. They said they felt supported in their role and that staff worked as a team in order to meet people's needs. A staff member told us they were able to ask the nursing staff for advice and assistance. They told us that staff meetings were held and if there were specific issues which needed discussing additional meetings would be arranged.

Staff and relatives told us that the registered manager and other senior staff were approachable and supportive. Staff said that they felt able to raise issues and felt valued by the manager and provider. The provider had introduced an award scheme for staff where relatives could vote for individual members of staff. Two members of staff had already received the award.

Resident and relatives' meetings had not been held on a regular basis. However the manager had a meeting planned. In addition surveys had not been carried out with people. The manager told us the provider was in the process of producing these so that people were able to have a say on how the home was run. However the manager told us that they encouraged people and staff to come and speak with them at any time. They told us they worked on shift particularly at weekends because this gave them an opportunity to meet with relatives who were unable to visit during the week.

The service had a whistleblowing policy and contact numbers to report issues of concern, were displayed in communal areas. Staff told us they were confident about raising concerns about any poor practices witnessed. They told us they felt able to raise concerns and issues with the manager.

The provider had informed us about accidents and incidents as required by law.

