Partnerships in Care Limited

Fern Lodge Care Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an unannounced inspection of Fern Lodge on the 12th November 2018.

Fern Lodge is a care home with nursing registered to accommodate seventeen people who are experiencing mental health issues. It is managed and operated by Partnerships in Care. Fern Lodge is a Victorian, three-storey semi-detached house near Chester City Centre. At the time of our visit; twelve people were living there.

At our last inspection we rated the service good. At this inspection we found the evidence continued to support the rating of good and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection.

People told us that they were happy with the service they received. They told us that the staff team were caring and supportive. They told us that they felt listened to and were fully involved in the support they received and had control of their daily lives.

Staff were aware of how to best protect vulnerable people. Systems were in place to report any concerns.

The premises were clean and hygienic.

Medication management was robust. Steps had been taken to enable people to be in control of managing their medication.

Staff were available at all times to provide advice to people who used the service.
Assessments were in place to identify the risks people faced. These were regularly evaluated.

Staff received the training and supervision they required to carry out their role. New staff received a structured induction to their role to ensure that they were able to carry out their responsibilities.

The registered provider operated within the principles of the Mental Capacity Act 2005.

The nutritional needs of people were met. Consideration was made to the dietary needs of people as well as lifestyle choices.

The design of the premises met the needs of people and the usage of facilities was being reviewed to ensure that they best served the people who used the service.

The health needs of people were met.

Staff interacted with people in a caring and helpful manner. The confidential information of people was protected.

Activities were available in line with the individual preferences of people. The registered provider was aware of the risks of social isolation that could be experienced by people.

Care plans were very person centred and contained all the information to successfully support people. People were involved in their care plans.

A robust complaints procedure was in place.

The registered manager was aware of the needs of people and adopted an inclusive approach to the running of the service.

The views of people were sought to influence the running of the service.

Audits were in place to enable an oversight of the quality of the service to be gained.

The registered provider met their legal responsibilities to notify CQC of any incidents and to be transparent in the displaying of their most recent inspection rating.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Fern Lodge 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 the 12th November 2018 and was unannounced.

The inspection was carried out by an Adult Social Care inspector

Before our visit, we reviewed all the information we had in relation to the service. This included notifications from the registered provider, comments from people who used the service, concerns and safeguarding information.
Our visit involved looking at four care plans and other records such as two staff recruitment files, training records, policies and procedures and complaints files.

As part of our inspection, we ask registered providers to complete 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 improvements they plan to make. A PIR was returned to us when we asked.

We checked to see if a Healthwatch visit had taken place. Healthwatch is an independent consumer champion created to gather and represent the views of the public. They have powers to enter registered services and comment on the quality of care provided. Healthwatch visited on 1st August 2018 and found positive support for people who used the service.

Prior to the inspection we contacted a number of organisations for their views on the service. These included the local authority's commissioners and the safeguarding team.

During the inspection we spoke with five people who used the service. In addition to this we spoke with the registered manager, two registered nurses, one support worker, kitchen staff and a student nurse. We also spoke with a representative of the registered provider who was responsible for quality assurance within the

service.

Good

Is the service safe?

Our findings

People told us that they felt safe living at Fern Lodge. These comments related to their physical and emotional safety. They felt as though they could express themselves. Staff understood the types of abuse that could arise and were clear about the reporting systems in place to raise any concerns. They were confident that the registered manager and nursing staff would report any concerns that they had. The registered provider had a dedicated whistleblowing team they could contact but they were also aware of the role CQC had as an external point of contact. Procedures for reporting safeguarding concerns were in place and staff had received recent training in this.

Assessments were in place outlining the risks faced by people in their everyday lives. This related to environmental risk assessments as well as aspects of support which potentially could expose them to harm. All people had been consulted about their risk assessments with people choosing to sign them to agree their contents and others preferring not to in line with their personal choice. Risk assessments had been appropriately completed to ensure people were supported in the safest way., ensuring that their financial interests were protected and an assessment of any potential deterioration in their mental health and the impact this could have on people in their daily lives. Risk assessments provided a clear indication of the level of risk and how this could be mitigated. All risk assessments were up to date and regularly evaluated. Two people self-administered their medication. Risk assessments were in place to ensure this was safe and arrangements were in place to ensure that this system worked.

People told us that there were enough staff to support them. The nature of the support provided focussed on giving advice and guidance to people rather than necessarily supporting them directly with personal care tasks. We found that staff were always available to people to offer help and guidance. A staff rota was available outlining that staffing levels were maintained during the day and night. Other ancillary staff were also available providing domestic and catering support. Since our last visit; the registered provider had employed an administrator to deal with clerical issues. We were told this had been beneficial in freeing up nursing staff to concentrate on clinical work. Staff told us that they considered there were enough staff on duty. New staff had been recruited appropriately with checks carried out to ensure that they were suitable to support vulnerable people.

Medicines were managed appropriately. All medicines were stored within a locked facility. Consideration had been made to storing individual medicines in lockable facilities within people's rooms but people who used the service had preferred the current method of administration.
Medication administration records (known as MARS) were appropriately signed following administration. Records also indicated when medicines had been received and by whom. Medicines when needed (known as PRN medication) had been prescribed for some people to alleviate pain or to be used as a last resort if people were experiencing distress. These were accompanied by PRN care plans which clearly outlined those occasions on when these medicines should be used. Guidance was in place for nursing staff to offer PRN painkillers as people had been assessed as being able to relay when they were in pain. Other PRN medicines assisted people who experienced agitation. The use of these was not common and demonstrated that other techniques to alleviate people's distress had been utilised. People told us that they always received their

medicines on time and that these were never missed. Nursing staff had received training in medicine administration and had had their competencies to do so checked.
The premises were clean and hygienic. Domestic staff were employed to carry out general cleaning tasks within the building. They used personal protective equipment such as disposable gloves and aprons to ensure that the spread of infection was minimised. There was an expectation that people should take responsibility for cleanliness standards in their own rooms. This was in line with the need to ensure that people were not de-skilled. Staff supporting people with these tasks were mindful of the need to ensure that hygiene standards were still maintained during these tasks.

We looked at how the registered provider took action when things went wrong. One person at the service could have their needs appropriately met by the service and as a result no longer lived there. The registered manager had identified that a more robust assessment process was needed showing that the service learnt from events that went wrong.

Good

Is the service effective?

Our findings

People were positive about the staff team and told us that they were knowledgeable about their needs and "they know what they are doing". People enjoyed the food offered within Fern Lodge. They said, "It is very good and we always get a choice of what we want." People told us that they felt well and that, "We can always get any health problems sorted." And, "They [staff] look after us." People also commented about changes to the usage of some rooms within the building; in particular a downstairs bedroom that now was being used as an activities room and an informal lounge area. People told us that they were pleased with this room as it was somewhere they could do arts and crafts and other activities.

Staff confirmed that they received a wide range of training. Staff received training that meant they could be effective in their role. This had included mandatory health and safety topics as well as training linked to the needs of individuals they supported. Staff had received training in safeguarding and mental health awareness. Training had also been received in the Mental Capacity Act. Staff told us that training had been varied and was ongoing. Nursing staff confirmed that they received support in ensuring that they could develop their professional practice. Staff also received regular individual supervision enabling their performance to be discussed. Group supervision was achieved through staff meetings. New staff received a structured induction into the service with a period of shadowing and training. One staff member told us that this had prepared them for their role.

The creation of the activities room had enabled people to gather informally, with a small kitchen area within this room which enabled people to make drinks. It was intended that this may be utilised for people to cook their own meals in the future. The registered manager was clear that there were limitations due to the size of the building as to how adaptations could be made to best serve people who use the service and staff alike. The registered manager was looking at the usage of each room and how additional facilities could be introduced to assist all. The design of the building was suitable for the need sof people who lived there. People who had any support needs with their mobility had a room on the ground floor. The health needs of people were closely monitored by the staff team. People received regular reviews from other health professionals to deal with physical needs. Appointments for doctors, physiotherapists and opticians were routinely made when needed. The nature of the needs of people were such that there were strong links to psychiatrists and other mental health professionals. Records outlined the reviews and appointments people had attended to ensure that their mental health was optimised. Records clearly outlined the points discussed during each appointment and progress noted. Any recommended actions were always followed up by the staff team. Risk assessments were clear about the risks people faced from a deterioration in their mental health. Where people's health had deteriorated, appropriate action had been taken to enable people to be admitted to hospital for a period of time until they felt able to return to Fern Lodge. Once they returned, the staff team undertook close reviews of the person to ensure that their health was promoted.

We looked at how the nutritional needs of people were met. Care plans included reference to the preferences, likes and dislikes of people relating to food. Specialist diets were in place relating to assisting people who had health issues such as diabetes. The cook was clear about the requirements of this condition and how meals should be prepared. The cook was aware of the preferences of people, for example, some

people preferred a vegetarian diet and this was clearly respected.

Meals were prepared in a well-equipped and hygienic kitchen. The kitchen had received a 5 star rating from the local authority food hygiene department earlier this year. 5 stars is the maximum rating that can be awarded. Food stocks were plentiful. Records were maintained indicating the temperatures of prepared hot food and a cleaning schedule was in place. The cook commented that the budget for meals had increased of late and that this had been a positive step.

We did not observe lunch directly as the size of the dining room was such that any observations would be obtrusive. A dining room was available. This was a pleasant room with tables set out for lunch. A written menu was available for the day with details of alternatives and vegetarian choice on display. A winter menu had been devised. Hot drinks were available for people at all times.

People's weights were monitored on a monthly basis. Records we saw demonstrated that people's weights generally remained stable.

People were routinely asked if they consented to certain arrangements as part of their care. All people had been offered to sign a form to consent to the treatment and support they received. Not all had signed the consent form mainly because they did not feel comfortable in signing documents. In those instances, verbal consent was obtained from people. Consent ranged from agreements to take photographs of people to assist with identification on documents to consent on how their financial interests were to be safeguarded and actioned.

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met. We found that the registered provider was acting within the principles of the MCA. The capacity of people to make decisions had been assessed and these assessments were reviewed periodically to ensure that the right outcome had been identified.

Where assessments had determined people lacked capacity in certain areas of their lives; steps were made by the registered provider to apply for a deprivation of liberty safeguard. Two had been applied for and these related to concerns about people leaving the building unescorted and issues relating to their finances. These had been granted and were current.

Good

Is the service caring?

Our findings

People told us "I feel that [staff] care about me" and "they [staff] are very good, they make sure I have my privacy and they reassure me".

Interactions with people and staff were friendly and informal. Interactions included jokes and banter which people responded well to. Staff were very aware of the communication needs of people and had identified those people who needed to be communicated with in a more gentle and reassuring manner. Staff approach was very person-centred and geared to the needs of individuals. We saw many examples of staff responding to people's requests for information in a timely and helpful manner.

People gave us examples of how staff reassured them especially during the administration of medication. One person told us that an occasional medical intervention they had was not pleasant but they understood the need for it to help them keep well and told us that staff reassured them and took their wishes into account in respect of the gender of the staff member giving support.

Staff ensured that those experiencing degrees of distress were supported appropriately. We witnessed one person clearly concerned about a situation and this had the potential to escalate into a period of distress for this person as recorded within their care plan. Staff intervention ensured that the person was reassured and in the end, was laughing and joking with staff. Care plans provided clear information on how people's anxiety could be alleviated by staff intervention and this had proved to be successful. PRN medicines were available to assist as a last resort but staff interventions were used primarily. This had resulted in PRN medication being given sparingly.

People's views, ideas and plans were sought. People were free to express their views on their aspirations. This was used to influence care plan documentation as to how people wanted to progress in the short term as well as their long-term goals. Individual sessions between people and staff were held to review their care. This provided the opportunity for people to be given information and to express their views. People told us "if there is something I don't agree if in my care plan, they [staff] will not put it in".

Confidential information was stored securely and protected in line with General Data Protection Regulation (GDPR). People's personal information was appropriately protected and sensitive information was not unnecessarily shared with others.

People were encouraged to be as independent as possible. This extended to people being responsible for cleaning their rooms or managing their own laundry to prevent them becoming de-skilled. People were encouraged to manage their own medication. This had been planned to ensure that it was effectively done but also in line with people's wishes. This was being planned for other people but done carefully to ensure that the person could cope with this responsibility.

Good

Is the service responsive?

Our findings

People told us that they were involved in their care plans. They told us "I feel involved with it and get the chance to change it". They were aware of how to make a complaint if they felt things were not going well. They were confident that they would be listened to and their concerns acted upon.

People were keen to present us with evidence of activities that they had undertaken or were planning for the lead up to Christmas. The availability of an activities room had been welcomed by people and they now had a dedicated space in order to pursue their interests. Other people preferred to pursue their own activities in the wider community, for example, through voluntary work or trips to Chester. Planned events were on display for people to refer to including trips out and other activities. The service had held a "Macmillan coffee morning" to raise funds and a substantial amount of money had been raised as a result. People told us that they had enjoyed it and were looking at planning more fund-raising events in the future.

Care plans were very person centred and contained all the information needed to enable the successful support of individuals. These included a one-page summary of people and then more detailed information about their needs. Plans included details of all aspects of people's daily lives and their preferred routines. Information was included relating to the aspirations of people in the short term and longer terms. This had been done in conjunction with individuals. People were further involved in the reviews of care plans through one to one sessions with people were their decisions were considered. When people's needs change, care plans were altered as a result. Care plans included detailed instructions about the preferences of people, how they wished to be supported and the ways in which communication with people would be most effective.

Reference was made in care plans to the cultural or spiritual needs of people. The religion of people was recorded and in most instances, these were recorded as being a denomination of the Christian faith. One other religious preference was recorded and recognised. The heritage of people was recorded and in one instance the background of a person was such that English was not used by this person as a first language but another language was preferred and this was recognised by the staff team.

We checked whether the service was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand and receive any communication support that they need.

The communication needs of people were such that people could understand written information. Information was available to people with the availability of notice boards with information on staff members on duty, activities planned, how to keep and feel safe and other relevant information. People were reminded to ensure that the security of the building was maintained through the front door being closed at all times. Menus were available in written form and no difficulty was experienced by people in understanding the information available to them.

A complaints procedure was available. This contained the information needed to raise any concerns about the support provided to them. A complaints log was available. One complaint had been raised of late and the registered manager was in the process of investigating this.

No one was receiving end of life care and it was not anticipated that anyone would experience this in the near future. Details of the future wishes of people were recorded in line with their preferences.

Good

Is the service well-led?

Our findings

People did not comment specifically on how well run the service was but were positive about the approach of the staff team and how they had their needs met. They told us, "We feel listened to." People told us their views were listened to and used one to one meetings, residents' meetings and surveys.

The service had a registered manager. They were registered with us in July 2018.

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 about how the service is run. The registered manager was present during our visit.

The registered manager maintained a presence within the service and demonstrated an awareness of the needs of people who used the service. There were clear lines of communication between the registered manager and the nursing team to enable the progress of people to be discussed. Staff considered the registered manager as supportive and approachable. The registered manager had a vision of how the service could develop in future to best serve people who lived there.

The registered provider had a series of audits in place to monitor the quality of the support provided. These included environmental checks and infection control. Other audits included checks on care plans and medication systems. The registered provider employed a representative to focus on quality checks within the service. This person was present during our visit and outlined how the quality of the service was checked. Visits had been conducted by this person and checks made on all aspects of the service to determine how the service was operating and how it could further develop in the future. The audits identified small areas of improvement with a clear vision to enhance the environmental standards of the building and review the usage of the available space to best serve individuals.

The registered provider had systems in place to ensure that the views of the people who used the service and others were captured as part of the measurement of the quality of the service provided. People who used the service confirmed that regular meetings were held with the staff team and that this provided the opportunity for them to express their views on the service provided as well as looking at suggesting improvements. The minutes to these meetings were available for people to refer to on a notice board. Individual meetings with keyworkers also enabled people's views to be heard.

Recent surveys had been sent out to people who use the service and their relations. These had only just been returned to the registered manager and were yet to be analysed. We were able to look at these and saw that people were satisfied with the service they received.

The registered provider sought to work with other agencies. There were close links with social workers and other health professionals such as psychiatrists. These links were made to ensure that the needs of people could be met as well as to maintain positive mental health. The registered provider also offered placements

to student nurses and worked closely with the local university in order to achieve this. A student nurse was present during our visit. They told us that the service had been supportive to their studies and came across as a personalised service in contrast to more clinical settings they had been used to.

The registered provider always notified us of any events within the service as legally required.
Ratings from the last inspection were on display within the home. From April 2015 registered providers were legally required to display their CQC rating. The ratings are designed to improve transparency by providing people who use services, and the public, with a clear statement about the quality and safety of care provided. The ratings tell the public whether a service is outstanding, good, requires improvement or inadequate.