Fulford Care Home Limited

Fulford Care & Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Fulford Care and Nursing Home is a residential care home providing personal and nursing care to up to 74 people. The service provides support to people living with a range of care needs including Parkinson's disease, age related frailties and dementia. At the time of our inspection there were 60 people using the service.

People's experience of using this service and what we found
Quality assurance systems remained ineffective in monitoring the quality and safety of medicine administration. The provider's auditing of medicines was not robust enough to continually identify and address concerns around the storage, administration and risks to people in relation to medicines. Where internal processes had highlighted areas for improvements, necessary improvements were not always addressed and sustained.

The management structure had been under a recent review and there had been a shortage of office and senior clinical staff. Deputy managers covered the duties of these staff which impacted managerial oversight of the quality and safety of the service.

People, their relatives and staff told us there were times of staff shortages. There were enough staff to meet people's needs, however, we observed staff were not always deployed effectively. A relative told us, "Mum said sometimes she has to wait for the toilet. Sometimes she can get a bit annoyed but it's not their fault, her walking isn't that brilliant now."

People's support and associated health risks were mostly assessed. Care planning considered people's health needs and provided clear guidance to staff in how to support people, for example, with moving and positioning equipment and eating and drinking. Checks of the environment were completed, staff were trained and followed hygiene practices to keep people safe from the spread of infection.

People were protected from risk of abuse; staff received training and knew how to recognise and respond to safeguarding concerns. People and their relatives told us they would feel comfortable to speak with management or staff if they had concerns of safety. A person said, "I couldn't have stayed by myself in my house any longer. I came here determined to settle in, and the atmosphere is safe and caring. It really is very nice here; I can have visitors anytime."

People, their relatives and staff were invited to share their feedback with the management team. Staff morale had improved since our last inspection. We saw examples of where people and staff had voiced their opinion and had been listened to by the management team.

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 access to healthcare services and staff supported them to attend appointments. Professional guidance had been recorded in people's care documentation and staff were further informed of changes at staff handover.

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. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 1 October 2021) and there were breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. The service remains rated requires improvement. This service has now been rated requires improvement for the last 2 consecutive inspections.

At this inspection we found the provider remained in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 30 June, 5 July and 9 July 2021. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safeguarding, staffing, safe care and treatment and good governance.

We undertook this focused inspection to check they had followed their action plan and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

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.

For those key questions not inspected, we used the ratings awarded at the last comprehensive inspection to calculate the overall rating. The overall rating for the service remains requires improvement. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Fulford Care and Nursing Home on our website at www.cqc.org.uk.

Enforcement
We have identified breaches in relation to medicines, staffing and governance at this inspection.

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

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.

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 well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Fulford Care & Nursing Home

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 was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was completed by 2 inspectors, a medicines inspector, an observer, 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.

Service and service type
Fulford Care and Nursing Home 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. Fulford Care and Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was not a registered manager in post. There was an interim manager in post. The provider was in the process of recruiting a permanent manager who would become the registered manager

Notice of inspection
The inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service including the action plan submitted following the inspection in 2021. We used the information the provider sent us 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 contacted Healthwatch, Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all this information to plan our inspection.

During the inspection
We spoke with 12 people who used the service and 5 relatives about their experience of the care provided. We spoke with 15 members of staff including the regional operations manager, interim manager, clinical deputy manager, care deputy manager, registered nurses, an agency registered nurse, care workers, administrator, activity co-ordinators and catering staff. We approached 6 health and social care professionals who have regular contact with the service for their feedback.

We reviewed a range of records. This included 19 people's care records and 10 people's medication records. We looked at 3 staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including quality assurance processes, training records, policies and procedures were reviewed.

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 our last inspection we rated this key question requires improvement. At this inspection the rating for this key question has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment
At our last inspection, the provider failed to ensure effective deployment of staff to meet the needs of the people using the service. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvements had been made and the provider remained in breach of regulation 18.

● The deployment of staff did not always ensure people's needs were met in a timely way. Staffing levels were higher than the provider's calculated staffing levels, but people's needs were not always met in a timely way. For example, we observed 8 staff had a break at the same time during the busy morning period, which meant people had to wait for support from staff. A staff member said, "In the mornings it's most busiest because people are up and dressed into their chairs or going out. When there are less staff it's difficult to get everyone's needs met in a short amount of time."
● We observed some people did not always receive personal care in a timely way and at mealtimes there were not always enough staff deployed to ensure people's needs were met. People told us staff were no longer available to take them out for walks outside of the service. A relative told us, "I don't think there are always enough staff, [person] had pressed the buzzer and they haven't come. I think they are understaffed; it does upset my relative."
● Calls bell analyses were completed by the management team. This included the response time of when calls were answered, the analysis identified calls which were not responded to within 3 minutes, however, further investigation did not conclude how much longer the person needed to wait before receiving support.

The provider failed to ensure effective deployment of staff to meet the needs of the people using the service. This is a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

● Staff were recruited safely. Pre-employment checks such as, references, the right to work in the UK, and Disclosure and Barring Service (DBS) checks were completed prior to new staff employment. DBS checks 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; Assessing risk, safety monitoring and management

At our last inspection, the provider failed to ensure the proper and safe management and administration of medicines by trained nurses. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, not enough improvement had been made, the provider remained in breach of regulation 12.

● Medicines were not always safely managed and associated risks were not always assessed. Medicines were not always stored, administered and documented safely. Medicines were not always administered in a timely way. Medicine rounds were completed throughout the morning until 11:30am. This meant people who required pain relief did not always receive their medicines when they needed them. An agency nurse was unable to locate a key for a cupboard for medicine which required additional storage, the key was located after 15 minutes, this could cause a delay should a person require these medicines. A person told us, "Although the meds come regularly, there is such a large window of time that they come, if I'm at the end of it I am sometimes left in pain."
● The medicines room temperature exceeded safe recommended ranges despite air conditioning units running. People's medicines were at risk of becoming unstable and ineffective. The medicine room, trolleys and medical oxygen were not secured safely. Where medicinal oxygen was stored or used, signage was not clear to highlight the risk in the event of a fire. Following the inspection, we were sent confirmation of storage and signage arrangements for medicinal oxygen.
● Risks in relation to medicines were not always assessed. People who were prescribed anticoagulants (blood thinners) did not have an assessment of risk for the event of a fall, injury or excessive bleeding. Risks relating to the use and storage of creams and ointments had not always been assessed. There was insufficient planning for people who were prescribed medicines which required close monitoring and specialist supply; plans did not include action for staff to take in the event of a missed dose or how to obtain a supply in an emergency.
● Staff did not always follow prescribing instructions and the provider did not assess the risk to staff for administering certain medicines. For example, a person's medicine required a specific risk assessment to include additional PPE to protect staff of a childbearing age, a risk assessment had not been completed. The same medicine required to be swallowed whole, however, the person chewed the medicine. Staff did not recognise this as a concern. We fed this back to the management team who advised they would contact the prescriber for a review.

The provider failed to ensure the proper and safe management and administration of medicines by trained nurses. This is a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Risks to people's health and specific conditions were mostly assessed and managed safely. For example, Parkinson disease care plans contained details of how the condition affected the person with their mobility and ability to swallow. Assessments had been completed for people who required equipment, such as catheters and hoists, to help them move and position. We observed staff followed the guidance in people's care plans.
● People who required their diets prepared to a specific consistency had clear risk assessments and care plans to inform staff how to mitigate the risk of choking. Catering staff were kept up to date with changes to people's conditions and dietary requirements. We observed meals were prepared to people's correct assessed diets.

● Environmental risk assessments had been completed. This included the risk of legionnaires, fire and seasonal changes, such as, actions to take during hot weather. People had personal emergency evacuations plans (PEEPs), for the event of an emergency.

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

At our last inspection, the provider failed to ensure people were protected from harm and improper treatment. There had been a failure to identify, report and respond to allegations of neglect and unsafe care practices. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection enough improvements had been made and the provider is no longer in breach of regulation 13.

● People were protected from the risk of abuse and lessons were learned from incidents. Staff were aware of their responsibilities to safeguard people and report any concerns. Staff received training and had access to the local safeguarding policy. A staff member told us, "I've learned that things from a safeguarding point of view, it's not a bad thing, it's to protect people in our care."
● People and their relatives told us they felt safe and if they had concerns, they could speak with staff or management. A relative told us, "[Person] is happy, she said she doesn't want to leave, she said she feels safe as the staff are very nice to her. I feel she is safe and well looked after."
● The management team had oversight of incidents which required reporting to the local authority. Safeguarding concerns had been appropriately investigated and escalated to the local authority where needed.
● Lessons were learned and shared with staff when things went wrong. Root cause analyses had been completed for accidents and incidents with actions to prevent reoccurrence. For example, a person had experienced a scald from a hot drink. Staff meetings, additional training and further education was provided to staff to mitigate similar incidents. The provider had purchased cups with anti-spill lids and posters were displayed in staff areas to act as reminders.

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 MCA 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 Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

Preventing and controlling infection
● We were assured the provider was preventing visitors from catching and spreading infections.
● We were assured the provider was supporting people living at the service to minimise the spread of infection.

● We were assured the provider was admitting people safely to the service.
● We were assured the provider was using PPE effectively and safely.
● We were assured the provider was responding effectively to risks and signs of infection.
● We were assured the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured the provider's infection prevention and control policy was up to date.
● People welcomed visitors inside of the service and went out with loved ones as they pleased.

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

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

At out last inspection, the provider had not ensured there were adequate systems to monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people. Accurate and contemporaneous records were not always maintained regarding people's care. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, the provider remained in breach of regulation 17.

● The provider did not always ensure continuous learning to improve the quality of care and systems in place had not identified the issues we found during the inspection. We found continued concerns in relation to medicines, staffing levels, people's care records and quality assurance processes.
● Managers and staff were not always able to perform their roles and regulatory responsibilities. There was a lack of management and clinical oversight within the service. The deputy care manager and deputy clinical manager were providing cover for duties usually completed by senior clinical staff and office staff. This impacted on people not always receiving their support and medicines in a timely way. There was a lack of senior clinical support and oversight, the provider had block booked an agency nurse to provide this, however, oversight was not sufficient.
● Improvements to the quality of care provided, following concerns, were not always demonstrated. Where staff had identified concerns, these continued to reoccur indicating quality assurance processes were not effective. There was little evidence of monitoring for the action taken to ensure effectiveness and action had been embedded.
● Processes were not always effective. For example, a person was admitted to the service with no written hospital discharge information. Staff had received verbal information in respect of medicines which had resulted in errors and omissions to their care and medicine records.
● The service did not have a manager registered with CQC. During our inspection we were informed of some further managerial changes. There had been 3 changes of managers since January 2023 which had impacted on the oversight of the quality of care and people receiving a good service.

The provider had not ensured there were adequate systems to monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people. This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Other quality assurance processes were effective, there were a vast number of audits completed, these included health and safety, accidents and incidents, dignity and infection prevention and control. Where concerns were identified, they were included on the service development plan. The provider's senior management team provided oversight of the findings.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

At out last inspection, the provider had not ensured there were adequate systems to monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people. Accurate and contemporaneous records were not always maintained regarding people's care. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, improvements had been made and the provider was no longer in breach of regulation 17 in relation to the culture at the service.

● There had been some improvements made to staff morale, however, there remained a disharmony between some staff and the management team. Some staff told us they felt unsettled with the recent changes to the management structure. A staff member said, "I've been through two new managers. Now we have another new manager. It feels like both have come in to make big changes, and it's finding your feet again and each manager wants to do things differently."
● There had been improvements made to the culture of the service. Staff spoke to and about people with kindness and compassion. People and their relatives told us staff were caring. A person said, "I've got to know the staff, they are good and kind, all sorts - a nice mix. Very motherly and very sweet."
● Staff responded to people's needs in a person-centred way. We observed people being offered choices and staff anticipated people's needs. A relative told us, "My relative's actions (body language) denote what she wants and they [staff] interpret it to exactly what she needs."

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 management team understood their duty to be open and transparent when something went wrong. They described how they would provide an apology, explain how things would be done differently, and they would speak with all parties concerned, notify CQC and document actions taken.
● Safety incidents such as, falls, and the development of pressure ulcers had been considered alongside the duty of candour. Letters of apologies had been extended to people and their relatives where appropriate.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and their relatives were involved and engaged by the management team. Resident and relatives' meetings were held at the service. A person told us they were able to give suggestions at meetings and said, "I do go to the resident's meetings, and things are acted upon if they can be."
● Most staff spoke highly of the engagement provided by a member of the management team whilst they held the manager's position. They prioritised staff morale and had initiated ideas such as 'positive pants Wednesday' which they said had lifted the morale of staff. Employee of the week and month further increased positivity and engagement. The regional operations manager arranged 'staff surgeries' for employees to speak with them directly and confidentially.
● Staff surveys had been distributed and key findings were addressed and shared on a 'you said, we did' poster. Examples of staff feedback included additional face to face training and an increase of coaching and

supervisions.

Working in partnership with others

● Staff and management worked in partnership with external agencies and within the organisation. A variety of professionals including community matrons, occupational therapists and the older people's community mental health team had been involved to provide advice and enable staff to support people.

● Staff worked with health care professionals to enhance the quality of people's lives and well-being. A visiting health care professional told us, "The home do follow my advice and will notify me generally of any concerns with my patients. From what I have observed people are treated with dignity and respect."

● The management team met regularly with other managers of the organisation to share knowledge and mutual support. The regional operations manager gave examples of the management team's contribution to the organisation. Clinical managers meetings were further held amongst clinical leads to share evidenced based best practice.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the proper and safe management and administration of medicines by trained nurses.

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 Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not ensured there were adequate systems to monitor and improve the quality and safety of services provided, including risks to the health, safety and welfare of people.

The enforcement action we took:

Served a Warning Notice

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to ensure effective deployment of staff to meet the needs of the people using the service.

The enforcement action we took:

Served a Warning Notice