Fulford Care Home Limited

Fulford Care & Nursing Home

Inspection report

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09 July 2021

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Fulford Nursing Care Home is a residential care home registered to provide nursing and residential care for up to 74 people with a range of care needs including Parkinson's, frailty of age, specific health conditions and people living with dementia. At the time of our inspection, 65 people were living at the service. Accommodation was over three floors and divided into five designated units. The floors were accessible by a lift and stairway.

People's experience of using this service and what we found
Systems had failed to identify that people were not always protected from avoidable harm. People did not always receive safe support in relation to their medicines. Staffing levels were not effective in meeting people's care needs in a timely and person centred way.

Aspects of leadership and governance were not effective in identifying some of the concerns found. Medicine audits failed to identify some significant shortfalls in the management and administration of medicines. Care provided was not always recorded accurately within people's care records. There was an apparent discord between staff and the management team which was impacting on people's wellbeing.

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.

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 1 November 2018).

Why we inspected
We received concerns in relation to staffing levels and the management of medicines. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from good to requires improvement. This is based on the

findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to keeping people safe, medicines, the deployment of staff, and the way the service was managed.

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 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 well-led?

Inadequate

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 Care Act 2014.

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 undertaken by two inspectors and an Expert by Experience on day one and three inspectors on day two and three. Inspections were also undertaken at various times including out of hours. 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 Nursing Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service did not have a manager registered with the Care Quality Commission. This means that the provider is legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
Day one and day three of the inspection were unannounced. Day two was announced.

What we did before the inspection
We reviewed information we had received about the service since the last 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 used all this information to plan our inspection.

During the inspection
We spoke with seventeen people who used the service about their experience of the care provided. We spoke with sixteen members of staff including the chief operating officer, area manager, manager, clinical lead, registered nurses senior care staff, care staff and agency staff.

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

After the inspection
We continued to review information and sought clarification to validate evidence found. We looked at additional information requested and sought feedback from relatives and health and social care professionals about the service. Following our findings from the inspection, we made multiple safeguarding referrals to the local authority for them to consider as part of their safeguarding duties.

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 and there was limited assurance about safety. There was an increased risk that people could be harmed.

Using medicines safely; Assessing risk, safety monitoring and management

- There was a failure to ensure safe processes for medicines. Medicines were not always administered in line with the prescriber's instructions and there was a failure to follow National Institute of Health and Care Excellence (NICE) guidance for managing medicines in care homes.
- People did not always have access to their prescribed medicines. Prior to the inspection we had received concerns about the way medicines were managed at the service. We reviewed the medicine administration records (MAR's) for four people. There were 58 occasions between 19 June and 8 July 2021 when prescribed medicines were unable to be administered because they were not available. This included medicines to treat Parkinson's, cancer, asthma, constipation and gastrointestinal conditions. Due to the seriousness of the failure to make available and administer prescribed medicines, we raised four concerns to the local authority for their consideration under safeguarding guidance. Subsequent action taken by the provider ensured that on the 9 July 2021 people had access to all their prescribed medicines.
- Processes were not robust to ensure the safe management of medicines. This, and the lack of action taken by staff, exposed people to a risk of harm. One person was prescribed medicines to treat Cancer. Medication systems were not always effective, and staff had not acted to ensure the person received their prescribed medicines to help treat their condition. The person had been without their prescribed medicines for six consecutive days. This increased the risk the person's condition might not be well-managed and placed them at increased risk of harm. We shared this concern with the local authority for consideration under their safeguarding guidance.
- One person had not received enough of their prescribed medicines to treat their health condition. Accurate records were not maintained, and processes were not effective to accurately reconcile medicine stock. This meant staff had failed to identify administration errors and low stocks of medicines. The lack of effective reconciliation processes meant there had been a failure to identify the person had not always received the correct dose of prescribed medicine. We shared this concern with the local authority for consideration under their safeguarding guidance.
- During the inspection we were made aware of two medicine errors. One person told us the wrong medicines had been dispensed to them by a nurse. They had been administered their day and night medicines at the same time and had to alert staff to make them aware. The manager informed us of this near miss during the inspection. The person did not take their medicines because they were able to recognise they had been administered incorrectly. This raised concerns for people who were living with dementia and who might be unable to inform staff they had received the incorrect medicines.

There was a failure 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.

● Following our inspection, the provider arranged for a pharmacy advice visit. This took place on the 14 July. The pharmacy advice report identified areas of good practice and some areas where medicines processes could be improved upon. These were in relation to systems and processes for ordering, receiving and storing medicines.
● Staff demonstrated a good understanding of people's needs and were knowledgeable about people's individual preferences. Staff used an electronic care planning system to record care interventions in real time to provide assurances people had received the required support.
● Support plans provided guidance to enable staff to support people in a safe and consistent way. For example, the care plan for a person with Parkinson's contained detailed information about how this affected them and what support they required to assist the to achieve the best quality of life possible. There were up to date risk assessments regarding the management of complications of the condition such as choking, chest infections and gastric reflux.
● Risks to people were assessed, and measures were taken to mitigate these. We observed people received their fluids and meals at the correct consistency to mitigate their risk of choking. Skin integrity care plans had been effective in mitigating the risk of people developing pressure ulcers.
● Falls risk assessments had been undertaken and measures were in place to mitigate identified risks. This included how people moved and any equipment they needed to do this safely. Bed rails and pressure mats were in place for people who were at risk of falling, and people had falls prevention care plans. We observed people being supported to transfer using equipment such as hoists. Staff were competent with using the equipment and supported people to transfer in a safe and dignified way.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Systems and processes to protect people from the risk of abuse were not operating effectively. Processes for reporting and responding to concerns raised by staff were not robust to protect people from harm.
● Staff had completed safeguarding training and were aware of their responsibility to report any concerns they may have about people's safety. However there had been a failure by some staff to report concerns in line with the providers safeguarding policy and local authorities safeguarding guidance. This placed people at further risk of potential harm.
● Prior to, and during the inspection process, concerns were raised to CQC about unsafe practices at Fulford Care Nursing Home which had the potential to cause people harm. We have reported on these concerns further in the medicines and staffing headings of this Safe key question. There was evidence that people were not always protected from unsafe care. In response to the serious allegations about neglect and unsafe care we raised multiple safeguarding concerns to the local authority for their consideration under safeguarding guidance.
● Where people's care records documented failings in people's care that had the potential to cause harm, prompt action was not taken to mitigate a further risk of harm. For example, we identified a multiple example's of failing to administer prescribed medicines in line with the prescriber's requirements. Professional medical advice had not been sought to mitigate the impact on the person and there was a failure to act to prevent a further reoccurrence. This meant people were exposed to a continued risk of harm because there was a failure to identify the root cause to enable preventative measures to be taken.

People were not always 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. Safeguarding service users from abuse and improper treatment.

● People told us they felt safe and were supported to keep themselves and their belongings safe. Relatives told us they had no reason to feel concerned about their loved one safety.

Staffing and recruitment

● Prior to, and during the inspection, it was reported to CQC there were insufficient numbers of staff on duty to provide safe care. CQC undertook this inspection over three days. This included two unannounced visits and an out of hours inspection undertaken in response to concerns about unsafe staffing levels at night. Our findings showed staffing on these occasions was in line with the rota requirements.

● The provider used a staffing dependency tool to help align people's assessed needs to required staffing levels. The deployment of staff was not effective in meeting people's needs safely or in a timely way. People who required two members of staff to safely assist them, had only received support from one member of staff. This increased the risk of injury to staff and the person.

● People told us they did not always receive support in a timely way. For example, staff silenced call bells and failed to return. During the inspection, we observed people waiting for up to 30 minutes to have their personal care needs met. This increased the risk of people's care needs not being met in a timely way when they required assistance from staff.

● One person had been found by day staff in a urine soaked clothing and bedding. The person told us staff had failed to respond to their requests for support during the night. Checks undertaken by staff had failed to identify the person required personal care support.

● People were not supported by a consistent team of staff. A review of the rota identified occasions when staffing levels had fallen short of rota requirements and this had reduced staffing levels on some floors. The service relied heavily on agency staff and there were occasions when both registered nurses on duty were supplied by an agency. There had been a recent turnover of care staff, nurses and management. People told us they were worried about staff leaving and this was impacting on them receiving consistent care from a familiar team. The provider was actively recruiting to replace staff.

● Staff told us they did not regularly read people's care plans due to staffing levels and time constraints. They told us they relied on handover notes to inform them of changes to people's care needs. This, coupled with the reliance on agency staff who might not know people's needs, meant people were at increased risk of receiving inconsistent and inappropriate support to meet their needs.

There was a failure 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) 2014.

● Staff were recruited safely and in line with safe recruitment guidance. This included undertaking appropriate checks with the Disclosure and Baring Service (DBS) and obtaining suitable references. Checks were made with professional bodies such as the Nursing and Midwifery Council to check the fitness to practice status of registered nurses.

Preventing and controlling infection

● We were somewhat assured that the provider was admitting people safely to the service. People who were isolating due to being recently admitted from hospital had their bedroom doors open. However, the risk of spreading Coronavirus was mitigated due to people having had a negative polymerase chain reaction (PCR) test prior to admission. We have signposted the provider to resources to develop their approach.

● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

Inadequate

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. Records and information relating to people's care were not contemporaneous. At this inspection this key question has deteriorated to Inadequate. This meant that there was widespread and significant shortfalls in the way the service was led and that the delivery of high quality care was not assured by the leadership and governance and culture in place.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- At the previous inspection in October 2018, there were concerns about medicines, staffing levels and people's care records. We recommended the registered provider ensured care records and information relating to people's care were contemporaneous. At this inspection enough improvement had not been made and there were continued concerns in these areas.
- We found multiple medicine concerns which had not been identified through the providers monitoring and governance processes. There were inconsistencies within people's care records which meant it was difficult to tell if people received the care they needed. Staff deployment and shortages were impacting on the quality of care being delivered.
- There remained a failure to ensure care records and information relating to people's care were contemporaneous. We received feedback about inaccuracies in people's care records which meant they could not be relied upon as an accurate record of people's care. We reviewed people's care records and found inconsistencies with information. For example, where people's MARs recorded medicines were not administered, clinical progress and handover notes recorded "medicines administered as prescribed". This meant the provider could not be assured people were receiving appropriate care and support to meet their needs.
- Audit processes had failed to identify some of the concerns. Quality checks including nurses' daily checks had failed to identify, report or explore the concerns we found with people's medicines. The manager and area manager were not aware of the discrepancies in people's medicines until we shared the information with them. This is a demonstration of how the providers own processes were not effective in ensuring clinical and management oversight of people's care or for driving service improvement.
- Prior to the inspection process we received concerns about how the service was led. Some feedback was received prior to the new manager commencing in May 2021. During the inspection staff told us they were not happy and attributed this to the way the service was managed and insufficient staffing levels. Staff told us they were 'exhausted' and "unsupported". The manager told us that some staff had been resistant to change. This had contributed to some staff leaving and had made it difficult to implement measures to drive service improvements. There was a discord between staff and management and measures taken by the provider to address this had not been effective.
- People and visitors were aware of tensions between care staff and the management team. People told us

staff had openly shared information with them about poor management and unsafe staffing. We were provided with examples where staff had inappropriately shared aspects of our inspection process with people. The discord between staff and the management team impacted on people. People were concerned about the future of the service. We fed these concerns back to the provider during the inspection.

● The service did not promote a culture that empowered people to be equal partners in their care. Staff were committed to providing people with a good service. However, the culture of the service was task focused and we observed institutionalised practices. Language used amongst staff was not person centred and failed to demonstrate respect for people. New staff were being inducted into this culture.

● Provider led processes were in place to review accidents and incidents. These were not always effective in identifying concerns so any learning would be taken from them and the service would continue to develop.

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.

● The previous registered manager had left in April 2021; the new manager had started working at the service in May 2021. It is the managers intention to apply to register with CQC to be the registered manager of the service.

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 their responsibility to notify CQC of significant events, as they are required to by law.

● The provider understood their responsibility to be open in the event of anything going wrong. During the inspection they made us aware of an incident that required the manager to attend the service during the night. Processes were in place to respond and investigate complaints.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● People's views were sought of the care they received. Feedback was sought from people's relatives, friends, professionals and staff. People told us they enjoyed living at the care home and felt they had been looked after very well particularly during the difficulties faced with the global Coronavirus pandemic. People said they felt staff had protected them well and knew how hard the last year had been for them. One relative said, "staff go over and above" and another said, "staff work so hard and I am so grateful for all they do".

● Relatives and people were encouraged to make suggestions for improving the care offered and told us they were listened to. Relatives were complementary of the care and support provided to their loved one. Feedback included "I have my life back and know my relative is safe", and "I no longer need to worry and can sleep at night knowing my relative is well looked after".

● During the global pandemic the local community had provided messages of support and praise to people and staff. Staff told us they had really appreciated this. Children from the local school had sent letters which we were told had really boosted people's morale and cheered people up. When government restrictions allowed the local school, choir was going to provide a concert in the courtyard garden.

Working in partnership with others

●The service worked in partnership with healthcare professionals and services from a variety of disciplines. During the global COVID-19 pandemic there had been a reduction in professionals visiting the service. Provision had been made to enable telephone consultations to take place instead of face to face meetings.

Where practicably possible and where there was a need, healthcare professionals had visited the service.

● The service worked in partnership with the local clinical commissioning group (CCG). They had eight beds that were purchased by the local CCG for 'admit to access', this prevented people from having to remain in an acute hospital. People were able to receive re- enablement support from community healthcare professionals such as occupational and physiotherapists. This enabled people to prepare for returning home.

● Records showed staff had contacted a range of health care professionals. This enabled people's health needs to be assessed so they received appropriate support to meet their continued needs.

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 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from harm and improper treatment. There had been a failure to identify, report and respond to allegations of neglect and unsafe care practices.

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 There was a failure to ensure effective deployment of staff to meet the needs of the people using the service.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	There was a failure to ensure the proper and safe management and administration of medicines by trained nurses.

The enforcement action we took:

A warning notice was served on the 5 August 2021. The provider was required to be compliant with Regulation 12 by 2 November 2021

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	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.

The enforcement action we took:

A warning notice was served on the 5 August 2021. The provider was required to be compliant with Regulation 17 by 2 November 2021