Burwood Care Home Limited

Fern Hill House Care Home

Inspection report

2-8 Todmorden Road
Bacup
Lancashire
OL13 9BA

Tel: 01706873466
Website: www.fernhillhousecarehome.co.uk

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

Fern Hill Care Home is a residential care home providing personal care to 18 people aged 65 and over at the time of the inspection. Some people using the service were living with dementia. Accommodation is provided over three floors. However, during our inspection the top floor was not in use. The service can support up to 24 people.

People's experience of using this service and what we found
The service was not safe. We found significant concerns in relation to fire safety, resulting in us contacting the fire service. Risks to people's health and well being had not been sufficiently managed and staff were not always trained in line with the provider's timeframes. People were being put at risk from the risk of transmission of Covid-19 and other infectious disease because of inadequate infection prevention, cleaning and control processes.

Some of the fire safety and infection control issues were addressed subsequent to the inspection.

Whilst accidents and incidents had been recorded, there was no evidence that these were reviewed by management so appropriate action was/could be taken in response to risk. We reviewed training records and found multiple occasions when staff were working together without having undertaken the provider's mandatory training.

The service was not well led. The provider failed in their responsibility to ensure people using the service were protected by robust fire safety procedures, placing people at risk for a significant period of time. There was a new manager in place who had submitted their application to register with us. The provider did not always promote a person-centred culture that achieved good outcomes for people. Audits were not sufficiently robust to identify the issues we found during the inspection.

We have made a recommendation about engaging with people, staff and relatives.

Relatives spoken with felt their family members were safe from abuse. Records showed appropriate safeguarding referrals and notifications had been submitted to the relevant bodies. However, safeguarding training had not been completed by all staff, despite this being seen as a mandatory course by the provider.

We have made a recommendation about safeguarding training.

There was no evidence of lessons learned following accidents and incidents. However, the nominated individual took some action during our inspection to address this.

We have made a recommendation about lessons learned.

The service had robust recruitment systems and processes in place. Medicines were managed safely.

Equipment within the service, such as hoists had been serviced regularly. The service engaged with external professionals such as GP's and district nurses.

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 10 September 2018).

Why we inspected
This inspection was prompted in part due to concerns we received in relation to infection control, medicines, care practices and management of the service. 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 coronavirus 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 inadequate. This is based on the findings at this inspection.

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

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 Fern Hill House 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 monitor the service.

We have identified breaches in relation to risk assessment, infection control, fire safety and good governance.

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

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will request an action plan for 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it. And it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below.

Fern Hill House Care 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 carried out by two inspectors and an assistant inspector.

Service and service type
Fern Hill House 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.

According to our records, the service did not have a manager registered with the Care Quality Commission. This means the provider was legally responsible for how the service is run and for the quality and safety of the care provided. The new manager had submitted their application to us and was awaiting their interview.

Notice of inspection
We gave 48 hours' notice of the inspection due to restrictions in place during the COVID pandemic.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and the local Healthwatch team. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We also reviewed information from statutory notifications sent to us by the service about incidents

and events that had occurred at the home. A notification is information about important events, which the service is required to send us by law.

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 of this information to plan our inspection.

During the inspection
Due to restrictions the provider had in place to protect people from the risk of infection during the pandemic, we were not able to speak directly to people who used the service. However, we spoke with four relatives about their experience of the care provided. We spoke with seven members of staff including, the nominated individual, manager, senior care workers, care workers and the chef. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke with a visiting professional.

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

After the inspection
We continued to seek clarification from the provider and fire safety officer to validate evidence found.

Inadequate

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 inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management

- The risks to people's health and wellbeing had not always been appropriately managed. For example, we looked at two people's records which highlighted a risk of choking. However, there were no plans in place to evidence how this risk was being managed to keep the person safe. Another person was at risk of weight loss and dehydration, however, their risk assessment had not been reviewed since March 2020.
- We reviewed accident and incident records. We found no evidence to indicate the records had been reviewed by the manager and there was no records of any actions to mitigate risks. One accident and incident record showed a person who used the service had been found on the floor in the laundry in January 2020. On the day of the inspection we found the laundry was unlocked and accessible; it also contained detergents which could be harmful if ingested. The nominated individual and manager could not explain why action had not been taken to lock the laundry after a person who used the service accessed this space in January 2020. However, this matter was resolved by the end of this inspection.
- We reviewed training records and found multiple occasions when staff were working together without having undertaken the provider's mandatory training. For example, rotas evidenced that on three occasions, in the week leading up to the inspection, the two night staff on duty had not completed training in safeguarding, fire safety, infection control or health and safety. Further to this, one of them had not completed moving and handling training and the other staff training was out of date.

The provider had failed to ensure the safety of people using the service. This is a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- People were at risk of avoidable harm because fire safety precautions were ineffective.
- Fire escapes were dangerous and not fit for purpose. Firefighting equipment was inappropriately sign posted, an empty fire extinguisher had been left in a communal corridor and insufficient staff had had training on this area of safety. A fire risk assessment was out of date and did not cover essential areas of risk and the particular circumstances of the building of the home.
- An official fire service notice from November 2018 identifying a number of areas of concern had not been acted upon and most of the issues remained at this CQC inspection.

These failings placed people at risk of harm and was a breach of regulation 12 (1) (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We reported these concerns to the local fire service who took immediate steps to ensure people were safe. They have taken appropriate action and are working with the provider. An improvement plan has been agreed and monitoring of those improvements will be conducted by the fire service

Preventing and controlling infection

● People were being put at risk from the transmission of Covid-19 and other infectious disease because of inadequate infection prevention, cleaning and control processes. Training records evidenced not all staff had completed training in infection control. For example, five staff had not completed this training and one staff training was out of date.

● On the first day of the inspection we observed inappropriate practices for the disposal of Personal Protective Equipment (PPE). Bins for the disposal of such waste were not clearly identified and one was left open and did not have a lid.

● A piece of moving and handling equipment was in a communal area where people and staff frequented. It was very dirty and required immediate cleaning.

● A visiting professional said that on occasions when they visited, parts of the home could be dirty.

● We raised our concerns with the management team. On the second day of our site visit we found these areas of concern had improved.

We found no evidence to demonstrate people were affected by unsafe infection control practices. However, people were placed at risk of potential harm, as systems were not sufficiently effective to prevent the potential risk of infectious disease transmission.

This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The environment was clean, hygienic and pleasant smelling throughout.

● Staff demonstrated compliance with use of essential PPE.

Systems and processes to safeguard people from the risk of abuse

● People were not always protected from the risk of harm. Staff were required to complete the provider's mandatory safeguarding training on an annual basis. Training records showed only seven out of 15 staff had completed this and one staff member's training was out of date. One staff member we spoke with was not knowledgeable about safeguarding.

● Relatives spoken with told us they felt their family members were safe. Comments included, "I feel he is safe and they keep me updated if there are any issues or he won't take his medication. I know when they are consulting other professionals", "I think [name of person] is safe, but I cannot visit due to lockdown" and "I haven't seen [name of person] since March: as far as I am aware, she is safe."

● Records showed notifications had been completed for any safeguarding concerns and sent to the relevant bodies.

We recommend the provider ensures all staff have completed safeguarding training and are competent to safeguard people using the service.

Learning lessons when things go wrong

● There was no evidence of lessons learned. The nominated individual created a policy and procedure on lessons learned during our inspection. Accident and incident records and staff meeting records did not evidence discussions about lessons learned.

We recommend the provider consults best practice guidance on lessons learned to ensure this is implemented within the service.

Staffing and recruitment

● The service had safe recruitment systems and processes in place. We reviewed four staff files. Appropriate checks had been completed before staff started working at the home, to ensure they were suitable to care for the people living there.

Using medicines safely

● Medicines were managed safely. Staff administered people's medicines in line with current guidance and medicines records included all necessary information.

● Medicines were stored safely. Fridge and room temperatures were recorded daily, and action was taken where these were outside safe limits. Stocks of medicines were checked regularly and the ones we reviewed were accurate. 'When required' medicines were included on people's medicines records and information was available to guide staff about how and when to administer them. Medicines were dated on opening when appropriate.

● Relevant staff had received training in the safe handling of medicines. The provider had systems to regularly check the competence of staff to administer medicines safely.

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 good. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

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

- The provider failed in their responsibility to ensure people using the service were protected by robust fire safety procedures, placing people at risk for a significant period of time. The provider also failed to ensure risks to people's health and well-being were managed, as described in the safe domain of this report.
- There was no registered manager in post when we completed our inspection. However, there was a new manager who had submitted their application to register with us. The new manager had no previous experience of being in a registered manager role and did not appear to fully understand the regulations. The nominated individual told us the manager would need support and nurturing in this role going forward. There was an absence of evidence to support this had been provided before the inspection.
- One relative told us they did not know a new manager was in post initially. They commented, "I found out about the new manager by the social worker. The communication could be improved. They do not really keep me informed unless I ring up and ask." Another relative told us how they were made to feel uncomfortable (by staff) when they attended the home for a window visit during lockdown.
- The provider did not always promote a person-centred culture that achieved good outcomes for people. We have identified breaches of the regulations within the safe domains to evidence this. The manager had also not been made aware they could access extra training through the local authority or that IPC funding was available to support with staffing. This resulted in the manager working as a care assistant to cover for staff on a number of occasions.
- Audits were not effective and did not identify the issues we found during this inspection. We saw action plans had been created from audits, however, these had not been actioned. The nominated individual also completed audits, however, these were also not sufficiently robust and failed to ensure action was taken to mitigate the significant risks we found.
- The manager had established areas of concern around fire safety but these had not been acted upon and there was uncertainty around whether the registered provider and their representatives were acting towards making the home safer.

The provider failed to ensure people were safe from identified risks, to ensure people experienced good outcomes, and to ensure continuous learning and improvements. This is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

characteristics
● The service did not always engage and involve people. We saw evidence to demonstrate staff meetings had occurred since August 2020. However, there had only been two residents meetings, both of which discussed one topic. For example, the meeting in October 2020 just discussed the menu. There had not been any relatives meetings; the manager told us this had been attempted without success.
● We reviewed surveys that had been completed by staff. We found these had not been analysed for themes and trends. The ones we reviewed were positive. However, was no evidence that surveys had been given to people who used the service or their relatives.
● A relative told us, "We do not get any updates in writing or any newsletters or emails."

We recommend the provider takes action to ensure people, staff and relatives are communicated with effectively to drive improvements.

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 was open and honest with us throughout the inspection. Although, they had not been in post long enough to embed a culture of openness, the staff told us they were approachable.

Working in partnership with others
● The service worked in partnership with a range of professionals to ensure people received the care and support they needed. These included social workers, GPs, community nurses, hospital staff, dietitians, podiatrists and the local community mental health team.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment (1) and (2)(a) The provider failed to ensure the safety of people using the service. This included risk management and training needs of staff. (1) and (2)(e) People were at risk of significant fire safety issues. (1) and (2)(h) Systems were not sufficiently effective to prevent the potential risk of infectious disease transmission.

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 17 HSCA RA Regulations 2014 Good governance The provider failed to establish and operate effectively systems or processes to enable you to effectively assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity

The enforcement action we took:

Warning Notice