Sanctuary Care Limited

Fernihurst Nursing Home

Inspection report

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31 August 2018
11 September 2018
14 September 2018

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced responsive comprehensive inspection took place on 30 and 31 August and 11 and 14 September 2018. This inspection was undertaken because of safeguarding concerns which had happened at the service. At our last comprehensive inspection in July 2017 the service was rated good overall and in all domains.

Fernihurst Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. They
provide care and accommodation for up to 50 people. The majority of people at this service live with dementia or have mental health needs. The service is a purpose-built care home providing accommodation over three floors, with two lifts between floors and with communal facilities on each floor. There were 46 people using the service on the first day of our inspection.

There was a new registered manager who registered with the Care Quality Commission (CQC) in February 2018. They had previously worked as the deputy manager at the home. A registered manager is a person who has registered with CQC 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.

Staff and relatives said at times the staff levels at the service were too low. The provider had a system in place to assess people's dependency to determine the number of staff and range of skills required in order to meet people's needs. During the inspection people were wandering in and out of other's rooms. This was normalised behaviour at the home and action was not being taken by staff to try and prevent this. The provider increased the staff levels during the inspection.

People were placed at risk because of poor staff response times to call bells. This posed a risk to people because when pressure mats were activated setting off an alarm by people wandering into other's rooms. There was confusion at the service about which people required regular checks. The provider took action to address this concern.

There was not a robust system at the service to ascertain if staff were responding to call bells promptly. During the inspection process the call bell system was serviced to ensure it was working correctly. The management team held a staff meeting and made staff aware of concerns found at the inspection which included call bell response times and that call bells would be monitored.

Staff did not always have the information they needed to support people with complex behavioural needs receiving emergency one to one support. Staff were not ensuring they stayed with people requiring one to one support at all times. This posed a risk to the person, others and staff. The registered manager and regional manager took action regarding these concerns.

The provider was not always ensuring people were protected against the risk of abuse. There had been a delay on two occasions of the management team informing the local authority safeguarding team of safeguarding concerns. This placed people at risk of further abuse. The management team were working with the local authority safeguarding teams regarding these concerns and to mitigate further risks.

Improvements were needed to the way people's medicines were managed and recorded. Medicines were not always administered or recorded correctly. Some people's medicine administration records (MARs) had one or more gaps for regularly prescribed medicines where it was not clear of a dose had been given or not. It was not possible to be sure if peoples' external products were being applied in the way prescribed for them. Medicines had not been re-ordered in a timely way to prevent people's doses being missed.

The provider had quality assurance processes in place and a service improvement plan (SIP) to continually develop the service. We identified areas of concern during the inspection which had not been identified by the provider's quality assurance systems. During the inspection the provider took action to resolve some areas of concern and added further actions to the SIP.

Recruitment procedures were thorough and all necessary checks were made before new staff commenced employment. New staff had received an induction when they started working at the service. There was a system to ensure staff received training to ensure they had the right skills and knowledge to meet people's needs. Supervisions and appraisals had been completed. It was not always clear that the registered nurses at the home always recognised their roles and responsibilities particularly in relation to staff allocation re monitoring checks. The registered manager was working with them through supervisions to ensure they knew what was expected of them.

Staff recorded accidents promptly in the accident book and the actions they had taken at the time. However, staff were not recording accidents and incidents where they had been placed at risk or injured. Therefore, there was no oversight monitoring of these incidents by the management team to support staff and put in place measures to prevent further incidents. The provider took action regarding this concern.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. The registered manager and nurses demonstrated an understanding of their responsibilities in relation to the Mental Capacity Act (MCA) 2005. They understood where people lacked capacity, a mental capacity assessment needed to be completed with best interest decisions made in line with the MCA. They had submitted applications where required to the local authority Deprivation of Liberties Safeguarding team (DoLS) to deprive people of their liberties.

People were supported to have regular appointments with their GP, dentist, optician, chiropodist and other specialists. Each week a GP undertakes a visit to the service to review their patients. Health professionals said staff followed their guidance and called them promptly.

The provider recognised the importance of social activities and ensured people's social needs were being met. There was a designated activity person supporting people with activities. They were very passionate about delivering activities and were always looking to further develop the activities at the home.

Staff knew people well and were aware of people's needs and supported them as individuals. Care plans were in place for people's every day personal needs which guided staff how to support people. However, there were no care plans to meet people's specific health needs and dealing with behaviour that challenges. The regional manager was aware of this and was working to have them implemented on the computer

system. Care plans and risk assessments were reviewed on a regular basis and when a change in their needs was identified. The registered manager and staff were committed to ensuring people experienced end of life care in an individualised and dignified way.

Staff were kind, friendly and caring towards people, they treated people with respect and dignity. People were supported to eat and drink sufficient amounts to maintain their health. People said they liked the food provided.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. The registered manager held regular meetings with staff and actively sought their views. The premises and equipment were on the whole managed to keep people safe. Except for the call bell system which was serviced during the inspection.

The provider is required by law to send CQC notifications about important events at the service. For example, deaths, serious injuries or safeguarding concerns. We received notifications as required from the provider.

We found three breaches of regulation. You can see what action we told the provider to take at the back of the full version of this report.

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.

People were placed at risk because of poor staff response times to call bells and monitoring checks not always taking place.

Improvements were needed to the way people's medicines were managed and recorded.

People were not always protected from abuse. Staff were aware of the signs of abuse and would report concerns internally. The management team had not reported some concerns promptly to the local authority safeguarding team and put in place measures to protect people.

There were adequate staff levels to meet people's needs.

Accidents and incidents were recorded in the accident book by staff and the actions taken at the time. However, there was not a clear system for staff to record incidents where they had been injured or placed at risk.

People were protected by a safe recruitment processes.

Is the service effective?

Good

The service was effective.

Staff received appropriate training to meet people's needs.

Staff had received an induction when they started work at the service.

Staff had had supervisions and felt supported.

Staff understood their responsibilities in relation to the Mental Capacity Act (MCA) (2005) and Deprivation of Liberty Safeguards (DoLS). Appropriate applications had been made to the DoLS team and best interest decisions were being made where people lacked capacity.

Staff were quick to refer people to health professionals and followed their advice.

People were supported to maintain their health and wellbeing and their nutritional needs were met.

Is the service caring?

Good

The service was caring.

Staff treated people with dignity and respect when helping them with daily living tasks.

Staff relationships with people were strong, caring and supportive. Staff knew people well and how they liked to be supported.

Relatives were welcome to visit at any time and were involved in planning their family member's care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans were in place for people's every day personal needs. However, there were not care plans for people's specific health needs and dealing with challenging behaviour.

People and relatives had been involved in the development and reviews of their care plans.

People's social needs were met and they were encouraged to follow their interests.

People experienced end of life care in an individualised and dignified way.

There were regular opportunities for people, and those that mattered to them, to raise issues, concerns and compliments.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had quality monitoring arrangements at the service. However, people were at risk because these did not always identify areas of concern and therefore action was not taken.

Staff views were sought and taken into account in how the

service was run. Staff spoke positively about the management team.

People's views and suggestions were taken into account to improve the service.

Fernihurst Nursing 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 checked 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.

Following concerns, we had received about the service, two adult social care inspectors planned a focussed inspection and visited on 30 and 31 August 2018. The first day was unannounced, the second day the provider knew we would be visiting. Due to the concerns we found on these two days, we converted the inspection to a full comprehensive inspection and returned on 11 and 14 September 2018 to collect further evidence to complete the inspection process. The visit on the 11 September 2018 was unannounced and the inspection team consisted of an adult social care inspector, an assistant inspector, a specialist advisor and an expert by experience. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service. We announced the visit to the service on 14 September 2018 to feedback our findings to the registered manager and the regional manager.

Prior to the inspection we reviewed the previous inspection reports and information we held about the service and notifications we had received. A notification is information about important events which the service is required to send us by law.

We met the majority of people who lived at the service and received feedback from four people who were able to tell us about their experiences. We also spoke with five visitors/relatives to ask for their views on the service. The majority of people using the service were unable to provide detailed feedback about their experience of life at the home. We spent time in communal areas observing the staff interactions with people and the care and support delivered to them. We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people living with dementia.

We spoke with 17 staff, including the registered manager, deputy manager, nurses, senior care workers, care workers, a cook, activities person, housekeeper and the administrator. We also spoke with the provider's regional manager, the provider's maintenance manager and two agency workers working at the service.

We reviewed information about people's care and how the service was managed. These included six people's care records and 15 medicine records and the systems in place for managing and administering medicines. We also looked at two staff files, staff training records and a selection of policies, procedures and records relating to the management of the service.

We sought feedback from health and social care professionals, commissioners and the local authority safeguarding team to obtain their views of the service provided to people. We received feedback from two professionals.

Inadequate

Is the service safe?

Our findings

The service was good at the last inspection. It is now rated as inadequate because people were at risk of receiving inappropriate and unsafe care. Improvements were needed to the way people's medicines were managed and recorded. Staff recorded the administration of medicines on Medicine Administration Record (MAR) charts. A sample of 15 people's MARs showed that medicines were not always administered or recorded correctly. Two people's records showed they had preparations applied more often than prescribed for them, for two or more days.

Seven people's MARs had one or more gaps for regularly prescribed medicines where it was not clear if a dose had been given or not. One person had a hand-written MAR chart where allergies had been recorded as 'none known'. However, on this person's cover sheet that was kept with their MAR chart there were several allergies recorded. Another person's current MAR showed that they had missed nine morning doses of two of their medicines because they were asleep. Staff told us that their GP had been asked to change the form of one of these medicines in to a liquid form to make it easier to take. They had not discussed changing the times of the medicine to make sure doses were not being regularly missed.

Creams and other externally applied preparations were recorded on an electronic recording system. There was information available in people's care plans to detail which preparations should be used and where to apply them. However, the records recorded that 'cream' or 'lotion' had been applied and didn't specify which products had been used. Therefore, it was not possible to be sure if peoples' external products were being applied in the way prescribed for them.

Some people had medicines prescribed to be given 'when required'. The home's policy specified that administration plans for these medicines should be kept with their MAR charts. This was to guide staff as to when it would be appropriate to give doses of these medicines. We saw these plans in place for some people's medicines, but for seven people these plans were not present for all their 'when required' medicines.

The systems for ordering and receiving medicines into the home did not make sure that people's medicines would be available for the whole cycle. Two people had missed several days doses of one of their regular medicines as they had been out of stock. When medicines had been received at the beginning of the cycle, it had not been identified that supplies had not come in, or would run out before the next ordering date. Therefore, these had not been re-ordered in a timely way to prevent doses being missed. The registered manager was aware there had been concerns about missing medicines. They told us the pharmacist from the supplying pharmacy had come to the service on the 20 August 2018 because not everybody's medicines had been sent and worked with the GP to get medicines required.

There were suitable arrangements for storing and disposal of medicines, including medicines requiring extra security. Storage temperatures were monitored to make sure that medicines would be safe and effective. People received their medicines in a safe way at lunchtime. They were asked if they needed any 'when required' medicines such as pain relief.

We checked records for two people receiving covert medication (disguised in food or drink without their knowledge or consent). Policies and procedures were followed to make sure that their mental capacity had been assessed. 'Best interest' decisions were recorded with the involvement of healthcare professionals and family members. Pharmacy advice had also been recorded on the best way to administer these medicines safely.

There were policies and information available to guide staff on looking after medicines. A system of updated training and competency assessments was in place to make sure they gave medicines safely. The registered manager told us that there were plans to update all staff competency checks over the next few weeks. Regular monthly medicines audits were completed, however the issues that we found during our inspection had not been identified and actions taken to correct them. There was a system for reporting any errors or incidents and actions identified to help reduce the chance of them happening again.

The provider was not always managing risks to people. Concerns were raised by a relative about not feeling their relative was safe. This was because of poor staff response times when pressure mats were activated and people wandering into other's rooms. There had been a few safeguarding concerns where people had accessed other's rooms. This had resulted in the staff putting in place pressure mats next to vulnerable people to alert staff if they were at risk of other's entering their room. During the second day of our inspection we activated a pressure mat with the regional manager present. It took staff four minutes to respond to the call. This delay placed the person at risk of potential abuse. The provider wrote to us after the inspection to advise us that staff had observed the regional manager in the doorway of the person's room and assumed they were in attendance.

The regional manager was disappointed by this response by staff. By the third day of our inspection the registered manager had added an audit of call bell response times to their daily review. A staff meeting had been held to make staff aware of the concerns regarding call bell response times. The management team demonstrated and staff confirmed that since this meeting staff response times had improved. This was also confirmed by staff. Comments included, "Answering call bells a lot quicker…more staff alertness…less incidents definitely" and "Staff are responding to call bells a lot quicker…less incidents."

Before the inspection emergency one to one support at all times had needed to be put into place for two people. These people had complex behavioural needs which had escalated and placed them and others at risk. Staff were recording the people's presentation each hour. These contained evidence where the people had displayed challenging and inappropriate behaviours to others. We found the provider's own staff, and staff from local agencies designated to support these people, did not have any guidance about how to support these people to keep the person, themselves or other's safe. There was also no oversight by the management team regarding the concerns recorded on the behavioural charts and no actions had been taken to mitigate further risks. On the second day of inspection the regional manager put in place a care plan for each person. This gave staff guidance how to support them and to call for assistance if behaviours escalated.

Staff were not ensuring they stayed with these two people at all times. We observed an incident where one of these people was left unattended while the staff member took a comfort break. This placed the person and others at potential risk of harm. Action by the management team was taken to guide staff about getting cover when they needed to take a refreshment break.

Monitoring checks were not always taking place as required to ensure people were safe and comfortable. At the beginning of this inspection the registered manager said three people were having 15-minute checks as they had been assessed as at risk. They said people in their rooms were having hourly checks. At the last

inspection July 2017 staff had completed checks and recorded them on comfort rounding paperwork. The provider had implemented a new computerised system at the service on the 8 August 2018. The new system had not been set up to guide staff to undertake these checks. After the second day of the inspection the provider's information technology team visited the service to support staff to record hourly checks.

The registered manager and regional manager said the nurses were allocating staff to people to provide care and undertake regular checks to ensure people were safe. This was not happening so regular checks were not taking place. A care worker told us staff used to be allocated three or four specific people to support on each shift. When we spoke to staff there was confusion about who required regular checks. Several staff said the timings were changed because of reduced staff levels rather than reduced risk. For example, one staff member said that close observations for some people used to be every 15 minutes but it was "impossible" with the variability of staffing levels on some shifts.

Known risks were poorly managed and therefore put people at risk of harm. For example, ineffective monitoring of people's whereabouts in the home. We observed a couple of people wandering in and out of other's rooms. This was a normalised behaviour at the home and action was not being taken by staff to try and prevent this. Staff described how some people became distressed when people intruded into their private space, for example their room. This could result in a physical or abusive confrontation between people. We saw these were recorded on the home's electronic record system but action had not been taken to reduce the risk of a similar event occurring again. We saw one person throwing food and one person banging on the office door for snacks; this was accepted as normal behaviour and no consideration on the impact of other people living at the home.

The call bell panel was not working outside of the lounge on the second floor. This panel identifies for staff when and where a call bell has been activated. This meant that staff had to leave the communal area on the second floor and walk down the corridor to establish which bell was alerting. This left people alone in the lounge when staff left to check the call bell panel. Two staff said this had not worked for over a year. However, the registered manager and regional manager said this was not the case. During the inspection the provider acted and ensured the call bell system was working effectively and the panel repaired.

The above concerns were examples of a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

People were protected from some potential risks. Staff had undertaken risk assessments about each person which identified measures taken to reduce risks as much as possible. These included risk assessments for the risk to each person if they left the service, eating and drinking, skin integrity, falls, mobility, medication and physical dependency. Staff had completed a risk assessment for a person with inappropriate behaviour. They identified the hazards associated with the person's behaviour and the practice required to decrease the risks to a manageable level. For example, letting a person know their behaviour was inappropriate. However, these were not in place for all people with inappropriate behaviour.

An individual risk assessment for evacuation of people in the event of a fire was in place. This provided information about each person's mobility and communication needs and the support they would require in case of an emergency evacuation of the service.

The provider did not always ensure people were protected against the risk of abuse. Staff had witnessed some incidents of abuse and had alerted the most senior person on duty at the time of the incidents. However, there had been a delay on two occasions of the management team informing the local authority safeguarding team of these significant events at the service. This placed people at risk of further abuse. As a

result of these safeguarding issues the local authority and commissioners had held individual safeguarding meetings with the provider's management team.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The management team were working with the local authority safeguarding teams regarding these concerns and to mitigate further risks. As part of this process emergency one to one support had been put in place for two people, funded by the commissioners. The management team had put in place more robust systems for future safeguarding issues which need to be fully embedded at the service. They had also agreed to ensure all staff received safeguarding update training.
The provider had a system in place to assess people's dependency to determine the number of staff and range of skills required in order to meet people's needs fully. The registered manager said when there was full occupancy the staff levels were nine care staff and two nurses or support nurse assistant during the day and six at night. Staff said "a few" people's behavioural needs had increased at the home. This had added additional challenges which placed the staff under increased pressure. Staff expressed concern that current staffing levels impacted on the safe running of the home. This potentially put them and people living at the home at risk of physical harm or emotional distress.

Staff told us morale had been low and it was a constant struggle. They felt people did not always receive the level of personal care they required. For example, frequency of showering. One staff member told us sometimes they had to work alone. Other comments from staff and relatives included, "Can't watch everyone and can't keep everybody safe", "We are seeing that we are not giving what we can, it's not nice, it doesn't feel right" and "Not enough staff to help with all the complex needs of the people at the home." Two staff told us they had raised their concerns with higher management but they had not seen a difference. The management team said they had not been made aware of staff concerns.

Staff were allocated the areas they were required to work at the beginning of their shifts. The registered manager said the registered nurses could redelegate staff to areas where there was a need. Staff said this did not happen. For example, one staff member said, if someone has fallen. This requires a nurse and a care worker to support the person, give first aid and reassurance. This leaves the area short staffed and people not being closely monitored. They said staff from other areas are not delegated to that area to support and keep people, safe. Another staff member said a person's behaviour had become very unpredictable and required very close monitoring. Additional staff support had not been delegated to support staff. This added additional stress and pressure on staff to provide the support required.

We asked to look at call bell response times. We were told the call bell computer with these recordings was not working, therefore we were unable to check call bell response times. The management team said they did not regularly monitor call bell response times to ascertain if staff were responding to call bells promptly. This meant they could not reassure themselves staff were responding promptly to call bells in order to keep people safe or highlight a staff level concern.

The provider uses a dependency assessment tool. The purpose of this type of tool is to help providers regularly assess the staffing levels based on people's individual needs. On the first day of our visit the management team increased the staff levels to six at night. On the third day of inspection the provider had increased the staff level on days by one trained nurse. This was in addition to one to one support which had been put into place before our inspection for two people with complex needs who may provide a challenge to others. This was funded by their commissioning body. Staff said this had made a difference. After the inspection, the provider sent us a copy of their 'informing staffing levels report' which had been completed

on 30 and 31 August 29018. The provider has written that they provide above average direct hours without taking into account people receiving one to one care and without accounting for support staff or management.

There were effective recruitment and selection processes to help ensure staff were safe to work with vulnerable people. The registered manager was actively recruiting to fill three vacant positions, two care staff and one night registered nurse. They had recruited one new registered nurse and were awaiting employment checks before they took up their post.

Accidents and incidents were reported and appropriate action taken. They were reviewed by the management team to identify ways to reduce risks as much as possible. Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses and to report them internally and externally when required. However, staff made us aware there had been incidents where they had been harmed by people's actions. One staff member said they had never been asked to formally fill out an injury form. We raised this with the management team that staff were not recording incidents where they had been placed at risk or harmed. We were assured that the provider had a system for staff to record these. Staff were reminded at the staff meeting about the process they needed to follow if they were placed at risk or harmed.

Premises and equipment were managed and maintained to keep people safe. There was a designated maintenance person supported by the provider's higher maintenance management team. They undertook regular checks. These included effectiveness of window restrictors, hot water temperatures and routes of escape, checks on fire door. They also undertook weekly fire bell checks and drills. One relative said "I always seem to come in when there is a fire drill. The alarms go off and all the doors shut."

External contractors regularly serviced and tested moving and handling equipment, fire equipment and lift and stair lift maintenance. Staff recorded repairs and faulty equipment. All tasks undertaken by the maintenance person were recorded to ensure there was an audit trail of work carried out. The provider had systems in place to check the water quality at the service annually against the risk of legionella.

The home was in the process of undergoing a redecoration programme. Corridors had been painted and were awaiting local art work to be put up. At the time of the inspection one of the two lifts was undergoing scheduled servicing and one of the nurse's stations was being refurbished. There were areas within the home with unpleasant odours. The management team told us that six bedrooms were scheduled for new carpets and staff worked to minimise odour.

Staff had access to appropriate cleaning materials and to personal protective equipment (PPE) such as gloves and aprons. The provider had an infection control policy in place that was in line with best practice guidance. The housekeeping faced difficult challenges due to the complexities of the people supported at the home. For example, people with continence issues. They used a cleaning schedule to try and ensure all areas of the home were kept clean.

Good

Is the service effective?

Our findings

The service was good at the last inspection. It remains good. Staff had received the training they required to support people safely. Staff had regular opportunities to update their knowledge and skills. Staff had completed the provider's mandatory training. When staff first came to work at the home, they undertook a period of induction and completed an induction checklist. This included working alongside experienced staff to get to know people and their care and support needs. One staff member said, "Shadow for two weeks, complete training such as manual handling and then work alone but checked."

New staff employed who were new to care completed the Care Certificate, which is a nationally recognised Skills for Care training programme for newly recruited staff. Relatives were confident the staff were well trained to looked after people well. Comments included, "I have witnessed regular training. They all seem to be off doing their NVQs or whatever they do these days" and "I think, and I have suggested, that they should do a video of the work in here to train other people. There are good examples of where staff have been trained well."

There were designated staff champions who provided knowledge and expertise for other staff. These included a champion for infection control, tissue viability, continence, medicines, dignity, diabetes, new computerised care system and end of life care. This meant people were supported by staff who had developed additional skills and knowledge in these areas and worked alongside staff to ensure best practice was carried out.

Staff and records confirmed they received supervision on a regular basis and annual appraisals. This was an opportunity for staff to meet with their line manager, reflect on recent work and their own wellbeing as well as discuss any support and training they might need. Staff said they found the supervisions useful and were positive about the support they received. One staff member commented, "I can talk to them, anytime I like." Another said, "I discussed what I would like to do…continue to learn."

People were supported to have regular appointments with their dentist, optician and chiropodist. People were also supported to access other health services when necessary. For example, GPs, older people's mental health team (OPMT), speech and language therapist (SALT) and opticians. People and relatives said they felt well cared for and staff got a GP when needed. Comments included, "They get the doctor if I need one" and "The doctor visits regularly." Each week a GP undertook a visit to the service to review their patients. Health professionals said staff followed their guidance and called them promptly.

Care plans showed staff had called relevant health care professional in a proactive way to seek advice or help for ensuring the best care was provided. For example, a request for medicines to be changed from tablet to include liquid preparation, because the person was struggling to swallow their medicines. Where one person had been tearful and upset a G.P was called. Relatives confirmed they were informed about any changes to people's health. Comments included, "My father had a bruised hand and they called me."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Where people lacked the mental capacity to make decisions the registered manager and staff followed the principles of the MCA.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are 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 were being met.

We found the home was meeting these requirements. The registered manager understood their responsibilities in relation to DoLS. Appropriate applications had been submitted to the DoLS team to restrict people's liberties at the service. Staff had completed best interest decisions where people lacked capacity. Staff had received training on the MCA and demonstrated an understanding of people's right to make their own decisions. Where people did not have anybody representing them they had involved the Independent Mental Capacity Advocate (IMCA) to ensure that the home was meeting the person's needs and legal rights.

People were supported to have sufficient to eat and drink and maintain a balanced diet. Staff gathered information about people's dietary requirements and their likes and dislikes when they first arrived at the home. This information was available in the kitchen for the catering team to inform them about people's requirements.

People at risk had their weight monitored regularly and further action was taken in response to weight loss and appropriate referrals made. The cook said they fortified foods with additional calories where needed. Where people had swallowing difficulties, they had been seen and assessed by SALT. Where the SALT had assessed a person as requiring a special diet and recommended a pureed food, these meals were provided in the required consistencies for people.

There was a varied four week menu containing well balanced nutritious options with at least two main meal choices and desserts. People were shown two sample meals by staff and able to choose what food they would like to eat. People and relatives were happy about the food and said they were offered a choice if they did not want what was on the menu. Comments included, "The food is marvellous…and the service is like a first class hotel", "All my father's food is pureed. It's nice…I'd eat it", "She always cleans her plate – she loves it", "the food is very good – there's a lot of it" and "You get what you want. If you want something you like, they get it for you."

Snacks and drinks were available if people required them. Warm milky drinks were offered throughout the day, fortified foods were also available for those who need enriched meals or snacks. One relative said, "My wife gets drinks and snacks at will if she wants them".

Good

Is the service caring?

Our findings

The service was good at the last inspection. It remains good. Staff were kind, friendly and caring towards people. People were seen positively interacting with staff, chatting, laughing and joking. People and visitors said staff were kind and compassionate. Comments included, "This is a beautiful home. It's a lovely life in here. I would recommend it to anyone", "I can have a laugh and a joke in here", "The staff are very, very good…excellent in fact", "The staff treat my mum very well indeed" and "I'm delighted she's here."

People and relatives said staff treated them with respect and ensured their privacy. One person said, "They always knock before entering my room and then ask to come in." Staff said they maintained people's privacy and dignity when assisting with intimate care. One commented, "If giving personal care, I shut the door, close the curtains, tell them what I am going to do."

However, people's dignity was sometimes undermined by poor monitoring of people's location in the building. For example, we saw one person going into another person's room uninvited and looking around the room. A person was in bed and looked frail, this intrusion undermined their dignity. Another person was described as a "magpie" collecting other people's belongings; this undermined people's dignity and privacy as their personal belongings were not being protected from being lost or damaged. This was being addressed by the management team as they had taken action to increase the staff levels, monitoring checks and guidance to staff.

During our inspection, we saw many examples of the staff being kind and patient with people. For example, one person repeatedly and loudly asked a question regarding the time of the day. Staff reassured them and tried to use their answer in a way to move the person onto another topic as other people were becoming distressed by the person's circular conversation. This was unsuccessful and one person was supported to move to another room to reduce the risk of a confrontation. Staff remained patient and good naturedly answered the person each time they sought reassurance about whether it was night or day.

On another occasion, a staff member gently assisted a person to eat their meal. Their tone of voice was soft and gentle. They explained what the meal was and checked with the person when they were ready for the next mouthful. The person often gazed at the staff member and held the staff member's hand. They looked at ease and they both laughed at various incidents during the meal. There was a good rapport between the staff member and the person, with the staff member ensuring the person was involved in decision making where possible. They took into account the person had little verbal communication and so took time to read their body language and facial expressions.

One person appeared restless and distressed; they were agitated and could not appear to sit comfortably. Their form of communication aggravated other people in the room, including one person who shouted at them. Staff took time to try and establish the reason for their distress, offering them different meals and trying to establish if they were in pain.

A person told us they had been so grateful because they had told the registered manager they loved the

little posies of flowers they had seen in the home. They said, "(Registered manager), a short time afterwards appeared with a little bunch of flowers in a pot especially for me at my table."

The staff referred to people by name were often seen hugging and comforting people and ensuring they had what they needed. For example, "Can I get you something?"

People confirmed they were always asked for their consent before care and support was provided. One person commented, "They always ask if I'm ready". Staff involved people in decisions about the care they received. Examples included, staff knew people's preferred bathing/showering choices. Another example was a person who liked to get up at 6.30am and have a cooked breakfast. Staff arranged this person had their breakfast early as it suited them.

Staff respected people's preference of gender of staff member supporting them. A care worker confirmed that, as a matter of routine until they got to know people's preferences, they checked, especially with females, if they would prefer female staff to attend to their personal care.

People's relatives and friends were able to visit without being unnecessarily restricted. Throughout our visits there were many visitors who said they were made welcome. One said, "They look after us very well." Another said, "We trust mum's carers … we see them a lot."

Relatives had sent thank you cards to the team for the care the staff had given their loved one. One of these said, "We would like to express our enormous thanks. (person) was treated by you all with such understanding and affection, for which we are very grateful… could not have had a better-quality life at a time when she needed increasing help." Another said, "Thank you each one of you for everything you did to make mum feel as happy and comfortable as possible…You were all so kind and considerate…I have a lot of happy memories of (person) time at Fernihurst. It's been a difficult couple of years, but made easier by the support you gave me and everyone's positive, caring approach; nothing too much trouble."

Requires Improvement

Is the service responsive?

Our findings

The service was good at the last inspection. It is now rated as requires improvement because there were not care plans in place for people's specific health needs and challenging behaviour. For example, one person had Parkinson's. This was referred to throughout the person's care plans but there was not a clear guide how to support this person in relation to their Parkinson's disease. Another person had Alzheimer's, there was no care plan to support this person with how to live with this illness. The regional manager was aware of this deficit and was working with the provider's computers team to add these to the new system. The provider wrote to us after the inspection and told us their aim was to "Help people live well with their dementia, rather than treat the diagnosis as an illness. The associated symptoms of Alzheimer's are addressed in core care plans, such as communication and behaviours, activities, mobility, continence and so on."

Staff knew people they supported well and looked out for them and their vulnerabilities and supported them as individuals. Relatives comments included, "They know about them, and they look after him brilliantly…I am happy he is being checked regularly and he is kept clean".

Before people came to the service a member of the management team undertook a comprehensive pre-admission assessment of need of people looking to move to the service. The regional manager said the registered manager closely reviewed potential people's needs to ensure they would fit within the home and they could meet their needs. Care plans were in place on the new system for people's every day personal needs. For example, care plans were in place for medicine, continence management, eating and drinking, night time and resting and personal care and hygiene. The care plans guided staff how to support people. For example, continence management; it set out the equipment needed to support the person to manage their continence. Another care plan looked at communication and wellbeing. It identified the person's needs in relation to sight, speech, hearing, memory and anxiety and the goals they had to maintain them.

The provider had started using their new computerised care record system at the home on 8 August 2018. This had been trialled at other services operated by the provider. Staff at Fernihurst had worked to ensure information from people's paper care records had been transferred onto the new system. The new system had monitoring charts for staff to complete specific to individuals. These included charts for bowel elimination, night checks, weight and personal care and hygiene. Staff carried handheld devices which looked like mobile phones which were linked to the computerised system while on duty. This enabled them to access information and input tasks on the device when they had undertaken. Staff were also advised on the systems noticeboard about what was happening at the home so they could be informed and share information with people. For example, menu's and activities.

One relative was most impressed that staff they spoke with always knew about how their relative had been that day. They had been concerned about their relative's hydration. So, spoke with a staff member who was immediately able to reassure them by telling them the person had been given 250 mls of water "and she's drunk 200 mls so far."

Care records contained information about people's activities and interests and things they enjoyed. For example, information about preferred music, socialising, hobbies, celebrations, pets and life history. Staff had recorded people's goals in relation to these. For example, maintain good family relationships. Nurses and senior care workers reviewed people's care plans and risk assessments monthly and more regularly if people had a change in their needs. A relative confirmed they were involved in the care plan review process. They said, "I am consulted on any changes."

We looked at how the provider complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. People had information about their communication needs in their care plans to guide staff how to ensure they had the information required. Staff ensured people had their hearing aids in place and had their glasses cleaned. The registered manager said they ensured people had information in accessible formats where needed, to help them understand the care and support available to them.

The registered manager and staff were committed to ensuring people experienced end of life care in an individualised and dignified way. There was nobody receiving end of life care at the time of our inspection. People had Treatment Escalation Plans (TEP) in place that recorded people's wishes regarding resuscitation in the event of a collapse. During our visit a relative of a person who had passed away at the service arrived. It was evident by the way they were greeted with lots of hugs and tears they had developed strong relationships with the management team and staff.

The provider recognised the importance of social activities and understood meaningful activities formed an important part of people's lives. People's social needs were being met. There was a designated activity person supporting people with activities. They were very passionate about delivering activities and were always looking to further develop the activities at the home. They knew people's preferences and interests. Notice boards were in place so people and relatives were kept informed about changes and what activities were on offer. These included theme days and visiting pets. The activity person had the support of three volunteers each week and used the services of external entertainers to regularly visit the home to entertain people. A lay preacher visited the home regularly and communion was available, at least once a month.

People and relatives were happy with the activities that were offered at the home and spoke highly about the activity person. The activity person looked at people as individuals and completed a Pool Activity Level (PAL) assessment for each one. This assessed what level of support each person required to undertake social activity. For example, people who might not be able to actively engage in an activity might benefit from sensory support. They allocated time to visit people who chose not to or couldn't leave their rooms because of a health issue.

The provider had a complaints procedure which made people aware of how they could make a complaint. The complaint procedure identified outside agencies people could contact if their complaint was not resolved to their satisfaction. This included the local government ombudsman, local authority and the Care Quality Commission (CQC).

People and relatives said they would feel happy to raise a concern and knew how to. Comments included, "If I had a complaint and anything was wrong I would talk to the manager." The registered manager and regional manager had dealt with four concerns and complaints in 2018 in line with the provider's policy; they had made changes as a result. They had undertaken an investigation and responded to the complainants to let people know the outcome of their findings and the actions they had taken. For example, poor selection of desserts; the registered manager had spoken with the cook and changes to the menu had

been made as a result.

Requires Improvement

Is the service well-led?

Our findings

The service was good at the last inspection. It is now rated as requires improvement because we identified areas of concern during the inspection. These had not been identified by the provider's quality assurance systems. For example, improvements were needed in the way people's medicines were managed and recorded. Pressure mats were used to alert staff if people were up and about. Staff were not always responding to these promptly. Regular monitoring checks of people in their rooms or deemed at risk were not taking place. One call bell panel on the second floor was not working so staff needed to leave the lounge and walk down the corridor to find out which call bell was ringing.

The above examples are all a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During the inspection the provider took action to resolve some areas of concern. After the second day of the inspection the provider's computer team went to the home to improve the computerised system re monitoring checks and care planning. Door sensors were being installed where the management team felt they would be more effective for people. The whole call bell system had been checked and where needed mended, staff levels had been increased, changes made to deputy manager's supernumerary duties, care plans put in place for one to one people to guide staff, a staff meeting to inform staff, improved monitoring of call bells, staff advised how to record incidents/abuse towards them.

The service had a registered manager in post as required by their registration with the Care Quality Commission (CQC). People and relatives were positive about the registered manager, deputy manager and regional manager. They said they were approachable and always available if they wanted to talk with them. Comments included, "She's (registered manager) a darling – she's better than any manager in any care home I've been in" and "I like her a lot." A relative was keen to tell us that the registered manager and her deputy were always "hands on" and visibly engaged in the minute by minute home affairs. One comment included, "Deputy is very good".

Staff said the registered manager was approachable and they felt confident their views would be listened to. Comments included, "(Registered manager) takes things seriously… likes to know the residents and takes an interest in staff", "Very supportive, will not take any nonsense, ensure we do the job right, she treats residents, staff, and families with respect and dignity" and "Doing really well, if I had a problem I could go to her."

The registered manager said she was supported by the provider's regional manager and higher management team. They said they were "always on the end of the phone" and had regular conversations, although these were not formally recorded. The registered manager was scheduled to undertake the provider's management and leadership programme in October 2018.

During the inspection the provider's management team reviewed the deputy manager's duties and made changes to ensure they worked supernumerary. The deputy manager was contracted to undertake a clinical

shift each week with the rest of their duties as supernumerary. Due to staff shortages they had needed to undertake more clinical shifts and in the registered manager's absence manage the service. This had impacted on them completing their role. For example, they had not completed the deputy manager's daily audits for the two weeks before our inspection.

The provider had quality assurance processes in place and a service improvement plan (SIP) to continually develop the service. The registered manager and deputy manager undertook regular audits which were sent to the provider's higher management team to be reviewed. These included, information about people's weights, pressure damage, medicine errors, accidents and incidents, premises management, care plan audit and staff feedback.

The provider's higher management team undertook regular quality performance and compliance reviews to monitor that the service was providing care that people required. The regional manager's audits looked at complaints, fire drills, accidents, people with a low body mass index (BMI), medicine audits, spoke to staff, reviewed staff files, received feedback from people and their visitors and observed the dining experience. Examples of actions taken as an outcome of audits included a mattress and pump checklist was implemented and the sluice room to be kept locked.

The regional manager said the staff had worked well to input information on the provider's new computerised care record system. They said they had identified there were tweaks which were required to make the system have the required information and checks for the home. During the inspection the provider's computers team had been to the home to discuss computer issues with the regional manager and care system champion. They had also demonstrated where information could be found and added on the system.

It was not always clear the registered nurses at the home always recognised their roles and responsibilities particularly in relation to staff allocation and monitoring checks. The registered manager was working with them through supervisions to ensure they knew what was expected of them. There was an out of hours on call system for staff on duty to call the registered manager, deputy manager or regional manager. This meant staff had managerial contact if they required additional support during their shifts. However, staff were not always contacting the out of hours manager for guidance. For example, when there was no availability of staff for one to one support. During the inspection process the registered manager re issued guidance around the home to remind staff about the on-call arrangements.

There were accident and incident reporting systems in place at the service. The registered manager and deputy manager monitored all accidents in the home and ensured staff had acted appropriately regarding untoward incidents. They checked the necessary action had been taken following each incident and looked to see if there were any patterns in regards to location or types of incident. Where they identified any concerns, they acted to find ways so further incidents could be avoided. They completed a monthly analysis to identify trends about, time of day/night and the frequency of accidents. These were also monitored by the provider's management team at the provider's head office. They looked at trends and patterns to identify where there were concerns and what action needed to be taken.

People and those important to them had opportunities to feedback their views about the home and quality of the service they received. A survey for people living at the home and relatives had been sent out in April 2018. The results had not been collated by the provider at the time of our visit. The regional manager confirmed the results had been positive. The results would be collated by the provider's head office team and a poster with the statistics would be produced to share with people. Residents and relatives' meetings were regularly held. This provided an opportunity to discuss concerns and suggestions and changes at the

service.

Staff were actively involved in developing the service. Full staff meetings were held regularly as well as meetings with individual departments. For example, nurses, kitchen staff and housekeeping. Between each shift there was a handover to give staff key information about each person's care and any issues brought forward. There was also a mid-morning meeting referred to as '10 at 10 meeting'. The registered manager met with heads of departments and senior staff on duty, including the nurses, to discuss what was happening at the service and any issues which needed to be addressed. However, these meetings had not always taken place when the registered manager was not working. During the inspection the management team held a meeting to advise staff of the concerns found. Staff were positive about the meeting. One commented, "There has been a higher staff presence, staff are starting to appear. It helped everybody settle down a bit."

In October 2017 the service was inspected by an environmental health officer to assess food hygiene and safety. The service scored the highest rating of five, which confirmed good standards and record keeping in relation to food hygiene had been maintained.

The provider had displayed the rating of their previous inspection in the main entrance of the home and on the providers website.

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 had not ensured people's medicines were managed safely. They had not managed risks to ensure the health and safety of people using the service and not done all they could to mitigate risks. 12 (1)(2)(a)(b)(g)

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 The provider had not ensured that people using the service were protected from abuse. 13 (1)(2)(3)

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's quality assurance system had not identified issues at the service which put the health, safety and welfare of people using the service at risk. 17 (1)(2)(a)(b)