Care UK Community Partnerships Ltd

# Ferndown Manor

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

The inspection took place on the 26 March 2018 and was unannounced. The inspection continued on the 27 March 2018 and was announced. This was the services first inspection since registration on 27 February 2017.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Ferndown Manor 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. The home is registered to provide care for up to 75 people.

People described the care as safe and were supported by staff who understood how to recognise signs of abuse and the actions needed if abuse was suspected. There were enough staff to meet people's care and support needs. Staff had been recruited safely including full employment history and disclosure and barring checks. Induction and on-going training provided staff with the skills needed to carry out their roles effectively. Staff were supported and had opportunities to meet with senior staff and discuss their role and professional development.

People had their risks assessed and actions were in place to minimise the risk of any avoidable harm. This included risks associated with swallowing, falls, skin damage and malnutrition. Staff were able to explain to us how people's needs and choices were met and their role in reducing risks people lived with. Staff had completed infection control training and demonstrated practice that reduced the risk of avoidable infections. When things went wrong lessons were learnt and actions put in place to improve safety.

People had their medicines ordered, stored, administered and recorded safely. When people self-administered their medicines risk assessments were in place which were regularly reviewed to ensure safety.

Pre admission assessments were completed and formed care and support plans that were reviewed regularly. The plans were individual and reflected people's individuality. Staff understood people's care and support needs and how they chose to spend their day. People had their eating and needs understood by both care and catering staff which included special diets, allergies, and likes and dislikes. Menus were varied, offered choices and provided well balanced meal options. Positive relationships had been developed with other professionals such as district nurses and chiropodists enabling effective health outcomes for people. People were supported with both planned and emergency access to healthcare when it was required.

The environment had a range of public and private areas for people to spend their time. The design promoted independence with braille buttons on hand rails to alert people the rail was ending to wheelchair accessible raised garden beds. Outdoor space provided a secure environment with lots of sitting areas. People had opportunities for social gatherings at a café and bar area, cinema and a lifestyle room with a range of equipment.

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. People felt involved in decisions about their care and every day life's. Staff were kind and had friendly, fun relationships with people and demonstrated a good understanding of how people were able to communicate. They cared for people whilst respecting their dignity and privacy and supported people to live as independently as they were able. People had opportunities to discuss their end of life wishes and care and support plans reflected people's spiritual and cultural needs.

If people needed to make a complaint they were aware of the process and felt the registered manager was a good listener and would put things right. A complaints log was kept and records showed that when complaints had been received they were investigated in a timely way and outcomes shared with the complainant.

A range of activities were provided seven days a week and included one to one events, group activities in the home and trips out into the community. People past history, hobbies and interests were known to staff and used to provide meaningful activities.

The management team promoted an open door culture were visible around the home and knowledgeable about people and the service. Staff spoke positively about their roles and the organisation and felt appreciated. Staff were well informed about changes as they happened as there were structured communication processes that were effective. A range of meetings with staff, people and their families provided opportunities for engagement and involvement in service development. Quality assurance systems were robust and effective in identifying areas of service delivery that required improvement. Partnerships with other agencies and organisations enabled appropriate sharing of information that in turn provided seamless care for people.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

People were supported by staff that had been trained to recognise signs of abuse and the actions needed if abuse was suspected.

People had their risks assessed and regularly reviewed with actions in place to minimise avoidable harm.

People were supported by enough staff to meet their needs and choices that had been recruited with checks in place to ensure they were suitable to work with vulnerable adults.

Medicines were ordered, stored, administered and recorded safely.

People were protected from avoidable infections.

When things went wrong lessons were learnt and changes introduced to improve safety.

### Is the service effective?

Good

The service was effective.

Assessments were completed of people's care and support needs and choices which respected people's individuality and diversity.

Staff had completed an induction and on-going training that enabled them to carry out their roles effectively.

People had their eating and drinking needs understood and met.

Working relationships with other health professionals enabled positive outcomes for people.

People had access to healthcare for both planned and emergency treatments.

The environment and design provided opportunities for people

to independently have access to both private and social areas including outside space.
People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible

## Is the service caring?

Good

The service was caring.

People received kind, compassionate care and had their communication needs understood and met.

People were involved in decisions about their care and support.

People had their privacy, dignity and independence respected.

## Is the service responsive?

Good

The service was responsive.

Care and support plans were person centred reflecting a person's diversity, reviewed regularly and followed by the staff team.

A complaints process was in place which people and their families felt able to use if needed, felt they would be listened to and appropriate actions taken.

Activities reflected people's past history, hobbies and interests.

## Is the service well-led?

Good

The service was well led.

The management team provided a positive, open culture that empowered people, their families and staff to share ideas and concerns.

Systems and processes were in place that enabled effective communication with the staff team keeping them abreast of changes.

Systems and processes were in place to promote engagement with people, families, staff and the community.

Quality assurance systems were effective in driving continual improvements.

Partnerships with other agencies and sharing of information

appropriately ensured positive seamless care for people.

# Ferndown Manor

**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.'

The inspection began on the 26 March 2018 was unannounced and the inspection team consisted of an inspection manager and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who used this type of care service. It continued with one inspector on the 27 March 2018 and was announced.

Before the inspection we looked at notifications we had received about the service. A notification is the means by which providers tell us important information that affects the running of the service and the care people receive. We also spoke with local commissioners to gather their experiences of the service.

The provider was asked to complete a Provider Information Return prior to our inspection. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make..

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

During our inspection we spoke with 13 people who used the service and one relative. We spoke with the regional director, registered manager, customer relations manager, unit leader, two nurses, four care workers, the chef and two housekeeping staff. We also spoke with two community nurses who had experience of the service. We reviewed six peoples care files and discussed with them and care workers their accuracy. We checked three staff files, care records and medication records, management audits, staff and resident meeting records and the complaints log. We walked around the building observing the safety and suitability of the environment and observing staff practice.

Good

# Is the service safe?

## Our findings

People and their families described the care as safe. One person told us "It's my home and I feel safe here." People were supported by staff that had completed safeguarding training and understood how to recognise signs of abuse and the actions needed if abuse was suspected. People were protected from discrimination as staff had completed training in equality and diversity. We observed interactions between staff and people that respected people's individuality and religious practice. One care worker explained "We covered equality and diversity in our induction. It covered the Equality Act and ensures people are able to have their own opinions, choices and lifestyles".

Assessments had been completed that identified risks people experienced. When a risk had been identified actions had been put in place to minimise the risk. Some people were at risk of skin damage and had specialist mattresses and cushions in place to reduce pressure on their skin. One person had a risk of choking and a referral had been sent to the speech and language therapist team. People had their weight monitored and any loss of weight led to a review of their eating and drinking and food being fortified to add additional calories. One person faced risks due to behaviours they demonstrated. Staff had a good knowledge of the person and used this to provide distraction and activity which successfully reduced the behaviour. People were involved in decisions about how risks they lived with were managed. An example included the use of bed rails when a person had a risk of falling from bed. We spoke with staff who had a good knowledge of the risks people lived with and their role in reducing risk. Risk assessments were reviewed monthly with people.

People had personal evacuation plans which meant staff had an overview of what support each person would require if they needed to leave the building in an emergency. Systems were in place to ensure equipment such as hoists, slings, fire equipment and lifts were in good order and serviced appropriately.

People told us they were supported by enough staff to meet their needs. One person said "When you use the bell the girls (staff) always come quickly to help you". We observed staff supporting people in a timely way. The registered manager told us "We use a staff dependency tool and are over on nursing and care hours. We use a staffing ladder which guides us on staffing levels as we increase admissions. Staffing is not an issue and if somebody needed one to one support we would be responsive". We spoke with a visiting nurse who told us "There seems a good number of staff to people". Staff had been recruited safely. Relevant checks were undertaken before people started work. For example references were obtained and checks were made with the Disclosure and Baring Service to ensure that staff were safe to work with vulnerable adults.

People had their medicine ordered, stored, administered and recorded safely. When people self-administered their medicines a risk assessment was in place that included a monthly review and a weekly medicine audit. When people had medicines prescribed for as and when required (PRN) a protocol was in place to support decisions about administration. An example was paracetamol for pain management. The protocol included the dosage and minimum time between further doses being given. Medicines administered were recorded electronically. The system had in-built safety systems which alerted staff to

when people needed medicine, recording the effectiveness of medicines and ensuring correct time gaps were adhered to between medicine doses. When people had been prescribed controlled drugs systems were in place to ensure the additional storage and administration safeguards were met.

Some people required topical creams to be applied. Body maps had been completed for each person indicating where each cream need to be applied and how often. Medicine administration records showed us that people were having their topical creams in line with their prescriptions.

People were protected from avoidable risks from infection as staff had completed infection control and food hygiene training. We observed staff wearing gloves and aprons appropriately and hand sanitizers and moisturisers available at points throughout the building. Staff understood actions to take if someone is suspected of infectious disease and required barrier nursing. All areas of the home were clean and odour free.

Lessons had been learnt when things went wrong. Prior to our inspection records informed us that there had been a medicine error. The registered manager explained how this had led to improvements. They told us "The error was self-reported by the nurse. They had been interrupted when administering and gave the wrong medicine to a person". They went on to explain "As a result nurses now wear a tabard which asks staff not to disturb them". We observed this happening throughout the course of our inspection.

Good

# Is the service effective?

## Our findings

Assessments had been completed before a person moved into the service and this information had been used to form their care and support plan. The plans contained clear information about people's assessed needs and the actions staff needed to take to support people. Care plans had been developed in line with current legislation, standards and good practice guidance. This meant people had their rights, equality and diversity protected. Assessments included any equipment that was required to provide effective care such as specialist mattresses.

Staff had completed an induction and on-going training that provided them with the skills to carry out their roles. Training had included person-centred care, emergency first aid, health and safety and moving and handling. One person told us "I need help and I trust the carers to do it properly". A care worker told us there induction had included completing the care certificate. The Care Certificate is a national induction for people working in health and social care who did not already have relevant training.

Training had also been completed which was specific to people living at the home. One care worker had completed dementia training and explained how it had positively affected their approach. They explained "If somebody isn't happy I look for the reason why; look at the underlying issues, hunger, pain, anything really". Nurses were supported to keep their clinical skills up to date. Nurses have to re-register with the Nursing & Midwifery Council every three years in order to be able to continue to practice. This is called re-validation. The registered manager told us "Currently we're running courses for re-validation. Things like diabetes, epilepsy and sepsis".

Staff received monthly supervision; felt supported and had opportunities for professional development. We spoke with staff that had completed health and social care diplomas at level 3 and level 5. Another told us they were completing team leader training. One care worker told us "I love this job, it's very different from what I was doing before but I get lots of training and the chance to develop my knowledge and skills".

People had their eating and drinking needs met. The chef knew people by name and was knowledgeable about their allergies, likes and dislikes cultural requirements and special diets. They told us "On admission we get a diet notification for each resident. On 'Resident of the Day' each month we visit people in their rooms and spend half an hour with them. We discuss what they enjoy on the menu. Find out their favourite thing and then prepare it for them later in the day". One person told us "The kitchen are happy to make an omelette as some foods don't suit me". We observed people being offered a choice of food and drinks throughout the day. People were able to have a meal in their room or one of the dining rooms. We observed one person sharing a meal with a relative. Food was well presented, nutritious and well balanced. One person told us "I have very high standards, and so far, they have easily met them; I'm a bit of a foody but the meals have been excellent". In reception there was a café which provided hot and cold drinks, cakes and biscuits for people and their families. A bar provided pre-lunch drinks and we saw people enjoying a sherry or a glass of wine before their lunch.

Working relationships with other organisations supported effective care outcomes for people. Examples included working with district nurse teams, physiotherapists, dieticians and community mental health teams. A team leader explained "A course has been planned specifically to look at community health issues such as cellulitis and chest infections; how to recognise the signs". We spoke with two visiting nurses who described the service as responsive to health changes. Records showed us that people had planned and emergency health situations dealt with effectively.

The environment provided opportunities for people to access communal areas, private areas to meet with family and friends and accessible secure outside space. A private dining room was available for people to use with families and friends. A care worker told us how one family had booked it for Mothering Sunday. Social meeting places included a bar area and a café. A visiting nurse told us "It's always lovely seeing people using the coffee shop". Bedrooms had been personalised and people had been involved in colour choices before moving in to the home. The design had been created to aid independence of people with sensory impairments. Examples included braille buttons on hand rails to indicate count down to the end of the rail and raised wheelchair accessible flower beds in the garden.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application 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 that the service was working within the principles of the act. Mental capacity assessments had been completed for people and DoLs applications had been submitted to the local authority. We checked one person's records that had conditions attached to their DoLs which included activities inside and outside the home. Records showed us these conditions were being met. Most people living in the home were able to make decisions about their care and they did so throughout our inspection. Staff provided care in people's best interests when they could not consent. This was recorded as having been decided within the framework of the Mental Capacity Act 2005. Files contained copies of power of attorney legal arrangements for people and staff understood the scope of decisions they could make on a persons' behalf.

Good

# Is the service caring?

## Our findings

People and their families described the care as good. One person told us "We tease each other but basically very respectful; you need to be jolly. I am more than happy here". A relative told us "The staff are very very approachable; they are lovely. There have been familiar faces since the home opened. The staff are happy which means the residents are happy". We observed staff having warm, friendly relationships with people, providing time to listen and demonstrating patience and kindness when helping people. At lunch time we observed a hostess showing a new person to a dining table and introducing them to people; initiating conversation and helping them feel welcome.

The service met the requirements of the Accessible information Standard. The Accessible Information Standard is a law which aims to make sure people with a disability or sensory loss are given information they can understand, and the communication support they need. People's communication needs were clearly assessed and detailed in their care plans. This captured the persons preferred methods of communication and how best to communicate with them. A care worker explained how they supported a person with poor hearing "They have a board we complete for them every day; includes day, weather, anything that's happening they need to know. It works because they can see well". We saw a communication plan for a person with poor vision that provided details of how to support the person enabling them maximum opportunities for independence. An example was describing food on a plate as if it was a clock face.

Staff had a good understanding of people's interests, likes and dislikes. Life history books had been completed and included information about significant events in people's lives, wishes and aspirations, careers and the things that make them happy. This meant that staff could have conversations with people about things that were important and of interest to them. Families were able to visit at any time and described staff as welcoming. A care worker told us "We're always available to talk with families; will always find the time to speak about their loved one". The home had a positive approach to utilising people's skills. One person was used to public speaking and had been called upon to say the 'thank you's' after events.

Interactions between staff and people were respectful and involved the person in decisions. Throughout the inspection we observed staff explaining their actions to people, giving people time and listening to what they had to say. People who needed an independent representative to speak on their behalf had access to an advocacy service.

People told us that staff respected their privacy, dignity and independence. One person explained "When I have a shower they (staff) just supervise. I'm in charge. The reason for being here is to maintain my independence". The registered manager told us "Privacy and dignity is not just about knocking on a person's door, it's about waiting to be in invited in. It's all about choice. We encourage people to use all areas of the home; enjoy their time". They went on to say "We encourage people to lock doors. They have their own keys. There are locked drawers in people's rooms for whatever they want to use it for". Staff had master keys for use in an emergency. People's records were kept securely in cupboards or password protected on electronic devices.

Good

# Is the service responsive?

## Our findings

People had care plans which reflected their personal care needs and choices and were reviewed at least monthly. Care staff were able to tell us about their role in supporting people and were knowledgeable about how people liked to receive their care and their communication needs. Health leaflets were in files providing additional information to care staff about specialist care needs such as the care of prosthetics. Handovers took place at the start of each staff shift and shared information about changes in people's care needs. One person had been discharged from hospital without details of their post-operative exercises. We observed staff calling the hospital for clarification. Information about people's day were recorded by staff in daily records. These captured care and treatment and any changes. We read one that recorded a person had been dizzy and the actions taken in response. This demonstrated that people received the right care to meet their changing needs.

Staff had a good knowledge and were respectful of people's individual lifestyle choices. People had their religious and spiritual needs respected and examples included people attending local church services and having their choices respected at religious holidays.

People had opportunities to take part in activities both at the home and in the wider community. An activities planner was on display around the home and included painting, flower arranging, external entertainers; exercise sessions, a weekly film show in the cinema and trips into the local community. During our inspection we observed people participating in a retro shop experience based on shopping in the pre-1960's. One person was thrilled with the experience and told us "It brought back memories to see the old food packaging and the 1960 prices". We observed people wrapped up in coats in the garden potting hanging baskets and chatting about sharing gardening tips.

Some people had personalised activity diaries that had photographs of activities they had taken part in. They included photographs of walks along the beach, meals at local restaurants, visiting animals and Christmas baking. A care worker explained how they provided memories to share with families and something to look at and talk about together.

Some people chose to spend most of their time in their rooms and this was respected. One person told us "I can entertain myself; I love my TV and I like to go into the garden and go for a walk". We observed one person choosing a book from the library. Another person who had limited conversation due to sensory problems had travelled a lot in their life and travel books were being sourced to help provide a source of conversation with staff.

Some people had been involved in creating a wishing tree. People had written down things they would like to do which were written on a star and hung on branches of the wishing tree. One person had wanted to cuddle a cat again and we saw photos of them with a cat on their lap. Another wanted to sing in a choir and a local choir had visited the home. The person told us "Once you're hooked on it (choir) you can't drop it".

A complaints procedure was in place and people and their families were aware of it and felt able to use it if

needed. The procedure included details of how to appeal against the outcome of a complaint and provided details of external organisations such as the local government ombudsman. Two complaints had been received in the 12 months prior to our inspection both of which had been investigated in line with the organisations policy and to the satisfaction of the complainant. One person told us "I would definitely complain if I needed to. I didn't like something I feel able to let them know".

A 'resident of the day' programme was in place which provided people an opportunity to provide feedback about all aspects of the service. A staff member told us one person raised a concern that their tops were returning from the laundry with bobbles. They purchased a piece of equipment to remove the bobbles. Another person had feedback that they would like bacon sandwiches in the mornings and this had been organised.

People had an opportunity to develop care and support plans detailing their end of life wishes which included any cultural requirements and decisions on whether they would or would not want resuscitation to be attempted. The registered manager told us that McMillan nurses had supported with end of life in the past. "It was really supportive of our staff and their support made a massive difference".

Good

# Is the service well-led?

## Our findings

People, their families and staff spoke positively about the management of the service. A care worker told us "The manager (registered manager) is a good listener". Another told us "Communication is really good. I love working with the registered manager and other team members". Another explained "I am very happy here; the management and the team are all committed to success". A relative said "The management team are brilliant. Their visible and always happy". We observed a professional and friendly relationship between the management team and staff.

Staff told us they felt appreciated in their roles and spoke enthusiastically about both the people they cared for and their work colleagues. A reward scheme was in place to recognise staff that had gone the extra mile. The registered manager told us "This month we awarded it to staff who made it to work in the snow, some even stayed over to be here the next morning. The maintenance man came in on their day off to clear the drives".

The registered manager was committed to on-going learning and had attended a recent Dorset Mental Capacity Act conference and a Safeguarding for Managers workshop. Links had also been made with a local university and the home were supporting an 'End of Life' project being carried out by one of the students.

Staff described communication as effective. A daily ten minute meeting was held with a member of staff from each department such as cook, housekeeper, activity planner, nurses and administration. Information discussed was then shared with all the staff team and recorded for staff to refer to if needed. A nurse told us "As well as the ten at ten meetings we have a communication book, daily diary and recorded handovers".

Staff understood their roles and responsibilities. One care worker said "We know the line of making decisions". Another said "The management works. There's structure; in the morning ten at ten meeting. Charts have to be done every day. We do a room check twice a day. New staff know the structure from day one".

The registered manager had a good understanding of their responsibilities for sharing information with CQC and our records told us this was done in a timely manner. The service had made statutory notifications to us as required. A notification is the action that a provider is legally bound to take to tell us about any changes to their regulated services or incidents that have taken place in them.

Systems and processes had been introduced to ensure effective communication and engagement with people, their families and staff in developing the service. This had included scheduled minuted meetings. A relative forum in January 2018 had covered topics such as future plans for the service, upcoming events, activities and an opportunity for sharing ideas. Minutes of a colleagues meeting included sharing details of successes achieved at the service such as a 98% score in a health and safety audit and the head chef reaching the finals of the organisations 'Head Chef of the Year' award.

The organisation had published a group of Care UK booklets that had been designed as a guide for carers,

relatives and friends and available in the foyer. One booklet gave practical tips on communicating with people living with dementia. Another designed for family carers was a guide for dementia friendly days out.

The home had developed community links with a range of organisations. An example there had been a dementia friendly initiative with a local community group joint fund raising for a 'magic table'. The 'magic table' provides interactive light projections that are designed for people living with a dementia and create fun, stimulating activities. An inter-generational project had included a local school holding a competition to name suites at the service and then coming along to the opening of the home and sharing a sing along. The school had invited people from Ferndown Manor to their poetry day. The service had been involved in a project for older people living in the community who were experiencing isolation. An outcome had been an invitation to the home's monthly cinema club. The customer relations manager told us "It's proving quite popular we hold it on the first Sunday of the month and eight to 10 people living in the community come and join in". They went on to explain "I'm a dementia friends champion and have talked to families whose relatives live here but not living with a dementia. They have found the talks have helped them interact better with people who are living with a dementia who they come into contact with on their visits".

Quality assurance systems were in place and effective in capturing areas requiring improvement. An example had been a safeguarding audit had identified that information captured on a behaviour monitoring chart may not then also be captured on an incident form. This meant that there could be a risk of safeguarding information not being captured in a timely way. The registered manager explained this had led to a review of the information held on behaviour charts with the process now including an incident form when appropriate.

Records showed us that the service worked in partnership with other agencies in sharing and reporting information appropriately ensuring seamless care for people. One example was the home had worked with the local NHS and implemented the 'Red Bag Scheme'. The scheme involves using a red bag containing information about the person that stays with them and ensures an effective transition between services.