Monarch Healthcare (Ferndene) Ltd

Ferndene Care Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Ferndene Care Home is a residential care home providing personal and nursing care to 45 people aged 65 and over at the time of the inspection. The care home can accommodate 45 people in one purpose-built building.

People's experience of using this service and what we found
Quality Monitoring systems were in place, they were not always effective and failed to identify some of the shortfalls found at inspection.

Infection control measures had failed to identify environmental issues placing people at risk. Following the inspection action was taken to improve systems and processes.

Medicines were administered in people's preferred way. Medicines management was not always effective, meaning stock was not always accounted for.

Safe recruitment processes were in place. Staff received training relevant to their role with their competency checked regularly. However, additional training needs were identified following the inspection.

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

Rating at last inspection
The last rating for this service was requires improvement (published 24 October 2019). The service remains rated requires improvement. This service has been rated requires improvement for the last three consecutive inspections, however, they had not been in breach of the regulations.

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

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

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

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

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to the assessment and management of potential risks to people's safety, infection control management and organisational governance at this inspection.
Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-Led findings below.

Ferndene Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Ferndene Care Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Ferndene Care Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This service is required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback

from the local authority and professionals who work with the service. The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with nine people and their relatives who lived at Ferndene Care Home about their experience of the care provided. We also observed the care and support people received as some people were not able to share their experiences with us. We spoke with six members of care staff, housekeeper, a senior carer, nurse, the registered manager and regional director. We looked at a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

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

Assessing risk, safety monitoring and management; Learning lessons when things go wrong; Systems and processes to safeguard people from the risk of abuse

- Risk management was not always effective
- An incident had occurred leading to a significant change to a person's nutritional needs. We found no action had been taken to update the persons care plans or risk assessments. A period of 17 days had elapsed since the incident occurred. This meant they remained at significant risk of choking due to a failure to ensure follow up actions stated were taken.
- During the inspection we found a person who could not ensure their own safety, had obtained toiletries and used them in a way other than intended. Medical advice was sought due to an injury from the use of the product. This meant people were at risk of harm due to the provider's failure to assess, manage and mitigate risks. We also found staff personal belongings in communal areas accessible to people, this posed a risk to people obtaining unsafe items and using them inappropriately.
- A person experienced seizures, following these monitoring had not been initiated and the person's care profile had not been updated and still stated they did not have seizures. This meant the person was at risk of health deterioration, due to ineffective monitoring and inaccurate information in their care file.
- The registered manager demonstrated an ability to identify incidents of a safeguarding nature. However, these were not always reported in a timely way. This meant any formal investigations by external professionals were delayed, which placed people at risk of further harm.

Using medicines safely

- The management of medicines was not consistently safe. We found topical creams were left out on bedside cabinets and on top of wardrobes. Some people within the home lacked capacity which meant they were at risk of using the creams in a way other than intended, placing them at risk of harm. The provider failed to establish an effective system to monitor and mitigate risks relating to the administration and storage of medicines for people.
- We found multiple discrepancies with people's stock of medicines. This meant it could not be clear if people were receiving too much or too little of their prescribed medicines.
- During the inspection a large amount of loose medicines were found in a drawer in the medicines room. It was unclear who they belonged to, and they were not accounted for in stock checks. We addressed this with the clinical lead who took action.

Preventing and controlling infection

- Several areas of the environment were unclean which posed a risk of infection and compromised the effectiveness of cleaning. Equipment in the kitchenettes was unfit for purpose, temperatures to ensure safe

storage of food had not been completed, we also found thermometers not working in fridges.
● We found bodily fluids in lounges and corridors. These communal areas were frequently used by most people living in the home. In particular an area which mainly accommodated people living with dementia who were unable to ensure their own safety. This posed a significant risk of harm due to poor environmental safety and impacted on effectiveness of cleaning.
● Staff were not always wearing Personal Protective Equipment (PPE) correctly, we witnessed masks were often worn below the nose. At the time of the inspection the home was being supported by health professionals due to a respiratory outbreak. The incorrect use of PPE increased the risk to people, and the provider's ability to effectively manage the outbreak. This was addressed with the registered manager and action was taken.
● Some staff were found not to be wearing a mask at all due to an medical exemption. Current government guidelines for wearing PPE in a care home had no provision for an exemption for not wearing a mask. The provider had in place a risk assessment but had failed to follow their own mitigation of risk. This placed people at risk of harm from the spread of infection.

The provider failed to ensure risks to people were identified, assessed and managed appropriately. This was a breach of Regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the senior management team put an improvement plan in place to address the above identified concerns.

● We were assured that the provider was meeting shielding and social distancing rules.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● We were assured that the provider's infection prevention and control policy was up to date.

We have also signposted the provider to resources to develop their approach.

● We found measures in place to facilitate visiting. This included temperature taken on entry to the care home, alongside Lateral Flow Testing and donning of PPE prior to seeing their relative.

Staffing and recruitment
● Records showed there were safe recruitment processes in place that ensured people were supported by suitable staff. A number of background checks had been completed. These included checks with the Disclosure and Barring Service to show that the staff concerned did not have criminal convictions.
● We found there were enough staff to meet people's needs. However, relatives told us they felt at times the home did not appear to have enough staff. One relative said, "The staff are friendly and helpful, nothing is too much trouble, but you can see they are short staffed my [relative] can be late getting his medication."
● We observed staff answering call bells and attending to peoples needs when requested, during the lunch period we saw people were appropriately supported.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

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

Requires Improvement

Is the service well-led?

Our findings

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

At our last inspection we rated this key question requires improvement. The rating for this key question has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The registered manager and provider had multiple systems and processes in place to monitor the safety and quality of the service. Whilst some of these were effective, we found infection control, medicines management and risk management audits were not always effective in identifying risks to people.
- The registered manager undertook a daily walk around the service, with a purpose to identify immediate and apparent risk to people. Evidence showed these were taking place but had failed to identify the environmental issues at the service as described in the safe section of this report.
- The structure of responsibility was unclear. For example, environmental issues including the lack of temperature recording and broken equipment had not been identified. We were informed three different people were responsible for this, however, none had identified this or took responsibility for this task. The registered manager had failed to identify and address this issue.
- Audit systems in place for medicines had identified medicines stocks had discrepancies and the allocation of stock checks were not completed in line with their own policy. However, no actions were detailed to resolve this and prevent this from occurring again. This meant people were at risk of unsafe administration of medicines.
- The registered manager failed to notify the commission and external professionals of incidents in a timely way, they also stated action was taken to safeguard people. We found evidence these actions had not taken place, this meant people remained at risk.

The provider had failed to ensure there were effective quality monitoring systems and processes in place to monitor quality and safety of the service and maintain oversight. This was a breach of Regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

- The registered manager and provider had multiple communication systems in place for staff; however, these were not always effective. For example, the concerns found during inspection, as detailed in the safe section of this report, were a result of poor communication and a lack of understanding of responsibility for staff.

● When we spoke with relatives, we received generally positive feedback. One relative told us, "I know the manager and I feel that she is approachable and will action any complaint." Another said, "The home is well managed, absolutely-very friendly and welcoming, nothing is too much trouble."
● Relatives informed us communication was an issue and felt it could be improved. One relative said, "General communication wise, they are bad." Another told us, "I would recommend the home, but I never been asked my opinion of the service and not kept up to date with any changes or news."

Continuous learning and improving care; Working in partnership with others
● Following the inspection, the senior management team put in place an improvement plan based on the findings during the inspection.
● We were also informed of a new management structure they planned to put in place as they identified the current system had not been effective, this required time to be implemented and embedded into the service.
● The service worked with external professionals to ensure people had access to support services when required. We spoke to an external professional who told us, "They work effectively with us and happy to place people here. Staff are always around and interacting with people."

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure risk to people were identified, assessed and managed. Infection control and environmental safety measures were not always effective.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had failed to ensure there were effective quality monitoring systems and processes in place to monitor quality and safety of the service and maintain oversight.

The enforcement action we took:

Warning Notice