Central Bedfordshire Council

Ferndale Residential Home

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
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

This inspection was carried out 16 February 2016 and was unannounced.

Ferndale Residential Home provides care and accommodation up to 30 people, some of whom are living with dementia. At the time of our inspection there were 30 people living at the home.

The home had a registered manager in post at the time of our inspection, however they were absent from the service on the day of this inspection. A registered manager is a person who has registered with the Care Quality Commission (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.

There were effective processes in place to manage people's medicines. However, medicines were not always administered in a safe way.

Staff were aware of the safeguarding process. Personalised risk assessments were in place to reduce the risk of harm to people, as were risk assessments connected to the running of the home, and these were reviewed regularly. Accidents and incidents were recorded and the causes of these analysed so that preventative action could be taken to reduce the number of occurrences.

There were enough skilled, qualified staff to provide for people's needs. The necessary recruitment and selection processes were in place and the provider had taken steps to ensure that staff were suitable to work with people who lived at the home. They received training to ensure that they had the necessary skills to care for and support the people who lived at the home and were supported by way of supervisions and appraisals.

People had been involved in determining their care needs and the way in which their care was to be delivered. Their consent was gained before any care was provided and the requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

People had enough variety of nutritious food and drink available to them. However, there were not always choices available that reflected people's individual dietary requirements and people were not always supported to eat their meal in a way that enhanced the mealtime experience for them

Staff were kind and caring and protected people's dignity. Staff treated people with respect and supported people in a way that allowed them to be as independent as possible.

There was an effective complaints system in place. Information was available to people about how they could make a complaint should they need to and the services provided at the home. People were assisted to access other healthcare professionals to maintain their health and well-being.

People and staff were encouraged to attend meetings with the manager at which they could discuss aspects of the service and care delivery. People were asked for feedback about the service to enable improvements to be made. There was an effective quality assurance system in place.

During this inspection we identified that there had been a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as people's medicines were not always administered in a safe way. You can see what action we told the provider to take at the back of the full version of the 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?

Requires Improvement

The service was not always safe.

People's medicines were not always administered in a safe way.

Staff were aware of the safeguarding process and appropriate referrals had been made to the local authority.

Personalised risk assessments were in place to reduce the risk of harm to people.

There were enough skilled, qualified staff to provide for people's needs

Is the service effective?

Good

The service was effective.

People had a good choice of nutritious food and drink

Staff and managers were trained and supported by way of supervisions and appraisals.

The requirements of the Mental Capacity Act 2005 and associated Deprivation of Liberty Safeguards were met.

Is the service caring?

Good

The service was caring.

Staff were kind and caring.

Staff promoted people's dignity and treated them with respect.

Is the service responsive?

Good

The service was responsive.

people were involved in developing their care plans.

People were supported to follow their interests and hobbies.

There was an effective complaints policy in place.

Is the service well-led?

Good

The service was well-led.

There was a registered manager in place.

The manager and deputy manager were visible and approachable.

There was an effective quality assurance system in place.

Ferndale Residential 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 was planned to check 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.

This inspection took place on 16 February 2016 and was unannounced. The inspection was carried out by one inspector 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.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed the information available to us, such as notifications and information provided by the public or staff. A notification is information about important events which the provider is required to send us by law.

During our inspection we spoke with five people and four relatives of people who lived at the home. We also spoke with a healthcare professional who was visiting the home during our inspection, three care staff, an assistant cook, the supporting Deputy Manager and the provider's Operations Manager.

We observed the interactions between members of staff and the people who lived at the home and looked at care records and risk assessments for three people. We also looked at how people's medicines were managed and the ways in which complaints were handled.

We looked at two staff recruitment records and reviewed information on how the quality of the service, including the handling of complaints, was monitored and managed.

Requires Improvement

Is the service safe?

Our findings

During this inspection we found that people were not given their medicines in a safe way. We observed a team leader giving people their medicines at lunchtime. They transferred medicines into small pots before offering them to people. They then returned to the trolley and signed the medicines administration record (MAR) to confirm that the person had taken their medicines. However, people had not always done so and we saw that some people had removed the medicines from the pot and placed them on the table by their plate. Other people had left the medicines in the pot and took them whilst the team leader was occupied with providing other people with their medicine. The team leader could not have known whether people had taken their medicines as they had not seen them do so.

The team leader asked one person who had been prescribed medicine on an 'as and when needed' (PRN) basis whether they needed any and if so whether they wanted one or two tablets. The person had indicated that two tablets were required. The team leader took these from the foil wrapper in the box of medicine and placed them in a pot to give to the person. However, when they were offered the person refused them. The team leader then returned these to the box of medicines. When asked whether this was the correct action to take they appeared confused as to the action they should take in such situations. The Deputy Manager confirmed that the medicine should have been recorded on the MAR as having been refused.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014.

We saw that medicines were stored securely in a locked trolley within a dedicated locked room. Controlled drugs were stored in a safe within a locked cabinet in the medicines storage room. We reviewed the controlled drugs record and checked the stock of the controlled drugs, which we found to be correct. The Deputy Manager told us that the stock of controlled drugs was checked and signed for three times daily at shift handover. We held a reconciliation of the medicines held for one person and found these to be correct. We looked at the MAR for five people and found that these had been completed with no unexplained gaps. However, in view of our earlier observation we could not be sure that the member of staff who had signed the MAR had actually seen the person take the medicine.

People we spoke to told us they felt safe living at the home. One person told us, "We're all together and kind of locked in. I feel safe because of that. People can't just walk in and out." A relative told us, "[Relative] has got the panic button overnight, so if she needs anybody they are there. The home was secure and visitors were required to sign in and out of the building. This protected people who lived at the home from harm but would also be used to ensure that the building was properly evacuated in the event of an emergency. People were given the access code to unlock the door to enable them to enter and exit freely if this was appropriate to their needs.

The provider had up to date policies on safeguarding and whistleblowing. Whistleblowing is a way in which staff can report misconduct or concerns within their workplace without fear of the consequences of doing so. Information about safeguarding people was displayed within the home. Staff told us that they had been

trained in safeguarding and were able to explain the procedures on keeping people safe. One member of staff said, "I would report it to the manager. If they were not available I would send the details of the allegation to the safeguarding team and CQC." They also told us what actions they would take if they had concerns about people's safety and wellbeing. Staff also said that they were aware of and understood the provider's whistleblowing policy and would not hesitate to use it. One member of staff told us that they had used it in the past and had been told of the outcome of the investigation.

There were personalised risk assessments for each person who lived at the home. Each assessment identified the people at risk, the steps in place to minimise the risk and the action staff should take should an incident occur. Examples of risk assessments carried out included the risks associated with the use of an electrically operated profiling bed and the use of wheelchairs. We saw that where people had been assessed as at risk of falling, a falls diary was kept and the cause of any fall was recorded. The falls were also recorded in the incident and accident log. Analysis of both of these records enabled the staff to take steps to reduce the risk of a person suffering a fall. Risk assessments were reviewed regularly to ensure that the level of risk to people was still appropriate for them. Staff told us that they were made aware of the identified risks for each person and how these should be managed by a variety of means. These included looking at people's risk assessments, their daily records and by talking about people's experiences, moods and behaviour at shift handovers. This gave staff up to date information and enabled them to reduce the risk of harm occurring.

The manager had carried out assessments to identify and address any risks posed to people by the environment. These had included fire risk assessments and the checking of portable electrical equipment. Each person had a personal emergency evacuation plan that was reviewed regularly to ensure that the information contained with it remained current. These enabled staff to know how to keep people safe should an emergency occur.

Accidents and incidents were reported to the manager. We saw that they kept a record of all incidents, and where required, people's care plans and risk assessments had been updated. The records were reviewed by the manager to identify any possible trends to enable appropriate action to reduce the risk of an accident or incident re-occurring to be taken. The records showed that, following an incident in January 2016, modifications had been made to the emergency door release and an additional member of staff was employed at night. This demonstrated that the provider acted promptly to reduce the risk of a similar incident occurring.

People had mixed opinions as whether there were enough staff to support people effectively at all times. One person told us that there were enough staff, both day and night and went on to say, "I don't want much help. I'm fairly confident with myself. Unless you want them and then they're there." Another person said, "Usually [there are enough staff]. Sometimes they are a bit short." However, a third person said, "Sometimes there's not many here and you have to wait." People told us that when they used their call bell to request assistance staff responded quickly which would indicate that there were enough staff to support people appropriately.

The Deputy Manager told us that there were four care staff and the team leader on duty during the day and explained that staffing levels had been determined based on the level of dependency of the people who lived at the home. Staff from an agency were used on a regular basis to cover absences and the Deputy Manager and the Registered Manager also provided care if needed. They told us that a member of staff booked through an agency had failed to arrive the previous day and they had covered the shift themselves.

One member of staff also told us that they did not think there were always enough staff available. They said,

"I have said there are not enough staff. Yesterday we were short as one agency staff did not turn up. That meant we were busy and rushed, although the night staff supported us by helping to get people up." However, they went on to say, "It's safe in terms of being able to meet people's needs but there may be a delay."

There was a printed staff rota that shows staffing was planned 12 weeks in advance. Gaps in the 12 weeks of planned rotas were filled by regular or bank staff and gaps were only filled by agency staff as a last resort. Staff rotas showed the full name and rank of staff and included clear information about 'on call' duties and who to contact 'out of hours'. At least one person trained in first aid was present on every shift, and were highlighted on duty rotas.

We looked at the recruitment documentation for two members of staff who had yet to start work at the home. The provider had robust recruitment and selection processes and we saw that appropriate checks had been carried out. These checks included Disclosure and Barring Service Checks (DBS), written references, and evidence of their identity. This enabled the provider to confirm that staff were suitable for the role to which they were being appointed.

Good

Is the service effective?

Our findings

People and their relatives told us that staff had the skills that were required to care for them. One person said, "They do look after me well." When asked if they thought that the staff were well trained and knew what they were doing one relative commented, "Yes, I would say so from the limited amount I see."

Staff told us that they received a full induction when they started working at the home and there was a programme in place which included the training they required for their roles. One member of staff told us, "I came in for a day when I was shown around the home, had a basic tour, and I asked lots of questions. I looked at risk assessments and met the residents and the staff. When I started I shadowed experienced staff for two weeks. They went on to explain that the training they had received had enabled them to assist people to move around the home more safely.

Staff also told us that they received regular supervision and felt supported in their roles. Staff were able to discuss the training they had received and any that they wanted to maintain or improve their skills during their supervision meetings. This meant that they were supported to enable them to provide care to a good standard. The provider's Operations Manager told us that they completed supervision with the manager on a six weekly basis.

People's capacity to make and understand the implication of decisions about their care were assessed and documented within their care records. 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 looked at the home's records around the requirements of the Mental Capacity Act 2005, and the associated Deprivation of Liberty Safeguards and saw that these had been followed in the delivery of care. Records showed that, where applicable, assessments of people's mental capacity had been carried out and decisions had been made on their behalf in their best interest. We saw that one care record we looked at contained an authorisation from the relevant supervisory body to deprive a person of their liberty in order to keep them safe. People told us that staff asked for permission before they supported them. Staff told us that they always asked for people's consent before providing any care or support. We heard one member of staff ask someone, "Is it okay if I assist you to the bathroom?"

People were able to make choices, although staff encouraged them to make the more appropriate choice where possible. One person said, "This morning we had an 'argument' about what I should wear." Another person told us, "I have to have my legs up. They come and they ask, 'Do you want your legs up?' I say, 'Don't bother', so they say, 'Come on let's get your legs up."

Staff explained how they communicated with people. One member of staff said, "Some people can tell you how they want to be supported or what they want. With others I use objects of reference. Some people can lip read and one person writes down everything." This meant that people were able to express their views and make their own choices.

People told us that they had a good variety of nutritious food and drink. One person told us, "The food here is very good." Another person said, "I'm quite satisfied with it. I've got no complaints really. There's a variety." A third person told us, "The food is excellent here. There is more than enough. If you want more, you can have more. They come round and offer you something in between."

We observed the lunch time experience for people who lived at the home. The tables were nicely presented and people were asked what meal they would prefer. Staff understood that people's needs for assistance to eat their meal fluctuated from day to day. They checked with people as to whether they required assistance or wanted to eat independently. People's care plans indicated whether they were likely to require assistance. Staff that supported people in eating made some attempt to talk to them by asking questions such as, "Have you finished?" or "Did you enjoy that?" However there was little in the way of social conversation between staff and the people they were supporting to eat and we observed one member of staff standing over one person whilst they were supporting them to eat their meal. This looked uncomfortable for both the member of staff and the person they were assisting and did not enhance the person's meal time experience.

We spoke with the Assistant Cook who was on duty that day. They told us that they were advised of any special dietary needs via a communications book which the care staff completed for this purpose. Any special dietary requirements were then entered on a noticeboard in the kitchen. We saw that this displayed the names of people who required special diets as well as any allergies they had. The Assistant Cook told us that one person had a violent allergy to seafood. The service did not have any seafood on the menu because of this. They told us that if relatives brought seafood in for people this was stored in a refrigerator outside of the kitchen to avoid contamination.

People's weight was monitored and food and fluid charts were completed for people where there was an identified risk in relation to their food and fluid intake that provided detailed information on what they had consumed. Where needed, referrals had been made to the local dietetic service and the speech and language therapists.

People were supported to attend medical appointments in different ways. One person said that staff went with them and stayed throughout the appointment. Another person said, "Staff probably would take me but my family do." People told us that they had seen a number of different healthcare professionals whilst at the home. These had included Speech and Language therapists, Occupational Therapists, a Tissue Viability Nurse as well as GP's and District Nurses. A relative told us, "They've had the Occupational Therapist out to try and get [relative] to stand so [they] can transfer to a proper dining chair." Another relative said, "The doctor's been here. The nurse has been here. The doctor was called again. I can't fault that."

One healthcare professional we spoke with during the inspection was very positive about the responsiveness of the service in contacting them if there were any concerns about a person's health or well-being.

Good

Is the service caring?

Our findings

People and the relatives we spoke with told us that the staff were kind and considerate. One person told us, "I'm super, super happy here. I would rate staff as 10 out of 10. In fact they are 12 out of 10." One relative said the care was, "Overall very good. Yes, very happy with it." Another relative told us, "'[Relative] loves it here and I've got no complaints."

Staff we spoke with were aware of the life histories of people who lived at the home and were knowledgeable about their likes, dislikes, hobbies and interests. They had been able to gain information on these through talking with people and their relatives, and from the lifestyle profiles within people's care records, which included a 'Map of Life' and 'Who am I' section. The lifestyle profiles had been developed in discussion with the people and their relatives to give as full a picture of the person as possible. One person told us, "Staff find out what I like and help me to do it." This information enabled staff to provide care in a way appropriate to the person. One member of staff told us that they were just beginning to understand the preferences of one person who had moved into the home for a period of respite care. This was done by a mixture of talking with them, observing them and talking with their family members.

We observed the interaction between staff and people who lived at the home and found this to be friendly and caring. One relative told us, "They're all very pleasant and calm and polite to the residents." We saw that staff communicated appropriately with people. They engaged in joking and banter as well as talking in a gentle and caring way. We saw one member of staff gently wake someone who had fallen asleep at the breakfast table with their head resting on the table which could have caused discomfort. This was done in a very caring, friendly way and the person was very happy to have been woken.

People told us that the staff protected their dignity and treated them with respect. One person told us, "Staff knock on my door staff ask to come in. They put my clothes away. They put everything back in the wardrobe beautifully on hangers." A relative told us that their relative was well groomed, well presented and that their bedroom is kept tidy. Staff members were able to describe ways in which people's dignity was preserved. For example asking quietly if they require personal care in communal areas, , ensuring that doors and curtains were closed when providing personal care and covering people when helping them to wash. Staff explained that all information held about people was confidential and would not be discussed outside of the home to protect people's privacy.

People told us that they were encouraged to be as independent as possible. One person told us, "I'm pretty able to do things for myself." Another person told us, "Last week I started to walk down to the Spar shop three days and the last two days I've been to Tesco's." They went on to tell us that they went on their own to medical appointments and were waiting for community transport to take them to an appointment on the day of our inspection. We noted that walking frames were within reach of those that used them and that a number of people were using their frames to move around the home independently.

People told us that their relatives were free to visit them at any time and the relatives we spoke with confirmed that they could visit any time during the day and evening.

One person told us that they had been given information about the service that was clear and they had understood it. A relative said, "There's a folder in the bedroom in one of the drawers." There were a number of information leaflets available in the reception area of the home which included information about services available from the provider and their 'Philosophy of Care'. Information was also provided on safeguarding, complaints, transport for appointments, fire evacuation instructions and details about local advocacy services and charitable organisations that offered support to older people and those living with dementia. Aids to communicating effectively with people who are hearing impaired were also available in the reception area. The provider's Operations Manager told us that a monthly newsletter had been introduced to improve communication with people and their families. People were able to look at the newsletter to remind themselves of its content as frequently as they wished.

Good

Is the service responsive?

Our findings

People and their relatives told us that they had been involved in deciding what care they were to receive and how this was to be given. One relative told us, "There were two people from the home and obviously my [relative]. I requested to be present and they were more than willing."

People and their relatives told us that the care they received reflected their individual needs. One person said, "They treat individual people with their individual problems." The care plans followed a standard template which included information on people's personal history, their individual preferences and their interests. Each was individualised to reflect people's needs and included clear instructions for staff on how best to support people with specific needs. One care record showed that the person required encouragement to participate in social activities to prevent them from becoming isolated. A health and safety checklist had been completed by the maintenance person when people were admitted to ensure that furniture and equipment was available and in working order in people's rooms.

People told us that they or their relative were involved in the regular review of their care needs. One relative told us, "My husband and I are having a meeting with the social worker and somebody else to talk about [relative's] care plan." We saw evidence that relatives were kept informed of any changes to a person's health or well-being. An entry in one care record showed that a relative had been informed following a person having had a fall.

Staff told us that there was a 'resident of the day' initiative in place on a rolling 30 day cycle in which the particular person had their care plans reviewed. They also spoke with a member of staff from the kitchen about the food they received and a member of staff from housekeeping about the cleanliness of their room. Maintenance also checked that the furniture and equipment in their room was in working order. This meant that every person had a full check of their care plans and their satisfaction with the service once a month.

People told us that that took part in various activities. One person said, "Every so often we have a very good entertainer and we have a really good time with him. We have a little sing song." Another person commented, "Every so often we have a very good entertainer and we have a really good time with him. We have a little sing song." Other people told us that they made their own entertainment. One person said, "I provide my own. I do crosswords. I do puzzles and I read." Another person told us of their regular trips to local shops and supermarkets.

There was a schedule of planned activities available in the entrance hall so people and their relatives could plan their time. There were photographs of people taking part in activities on a noticeboard by the activity timetable. One member of staff told us, "We all try to do activities. We all try to engage them in some way." Another member of staff said, "I played cards with people when I had time yesterday. In summer we have a group who like to do the bedding plants and gardening." The care records included information about people's hobbies and interests that enabled staff to encourage them in suitable activities.

Visitors from the local church visited people who lived at the home. One person told us, "The vicar comes

in." Another person said, "I had Communion a week ago. She comes in once a month." A staff member said visitors from the church used to visit once a week but that it was now
as and when they had been able to get someone to host the Communion for them.

The provider's Operations Manager told us that they planned to use volunteers to increase the amount of activities offered on a daily basis. They planned to contact people's relatives and local groups to source the volunteers.

There was an effective complaints policy in place. The provider issued a leaflet inviting people and their relatives to provide comments, compliments and complaints, and we saw these were on display in the reception area. Although the people we spoke with were aware of the complaints system they said that they had no cause to use it. One person told us, "I have nothing to complain about at all." A relative told us, If I was aware of an issue, I could approach any number of staff in the office." The deputy manager told us that there had been no complaints received but if any were they would be dealt with in accordance with the provider's policy and procedures and monitored by the provider's central complaints department.

Good

Is the service well-led?

Our findings

The registered manager was not available on the day of our inspection as they were overseeing another of the provider's homes for a short period. An experienced deputy manager from another of the provider's homes had been asked to support the deputy manager of the home during this period. The deputy manager of the home was not working on the day of the inspection.

People had confidence in the manager and deputy manager and found them to be approachable. One person said of the manager, "She's made time when I've asked her questions." Another person told us, "She comes in and asks you are you happy with the food and everything." A relative told us that they knew who the manager was and said, "She's about and does talk and chat with us." During our inspection we saw that the supporting deputy manager walked around the home frequently and had a good rapport with people and the staff.

People were asked their opinion of the service that was provided and for ways in which this could be improved by way of questionnaires . When asked if they completed these one person told us, "We do sometimes. Questions like 'What's the food like?" A relative told us, "We did. Before Christmas. There was one that was sent to my address." Another relative said, "I've seen the carers come round and go through it with people." We saw that there was a large poster in the reception area headed, 'You said, We Did' that showed people how the home had acted on their suggestions for improvements.

In addition to the questionnaires the provider held meetings with people and their relatives at which they were able to discuss the operation of the home and ways in which the service provided could be improved. One relative told us, "There was a meeting here some time ago. I think that was a relatives', residents' or family meeting." Minutes of the meeting held in November 2015 showed that topics people had discussed included activities, food, the Christmas party and the purchase of a larger television for one of the lounges and the siting of a television in another lounge. The supporting deputy manager told us that an additional trolley service had been introduced at six pm to give people a regular serving of hot drinks after the tea time meal following feedback from people. This demonstrated that the provider listened to and acted on people's suggestions as to how the service could be improved.

Staff were also able to contribute to the development of the service during staff meetings. One member of staff told us, "There is a formal agenda. Staff are asked if anyone wants to discuss anything. It is personally up to people to say if they have anything. Some do, some don't." Minutes of a staff meeting held in January 2016 showed that topics discussed had included the communication book, care plan writing and body mapping. Staff told us that they were supported by their management team and by regular reviews of their competency. They were knowledgeable about their roles and what was expected of them.

There was an effective quality assurance system in place. Quality audits completed by the manager covered a range of areas, including a monthly audit of care plans, infection control and medicines management. Action plans had been developed where shortfalls had been identified and the actions were signed off when they had been completed. The provider's Operations Manager told us that they also completed regular

audits of the service which included doing a 'walk round' of the service and talking with people, relatives and staff. We saw the report of an audit completed by the provider's Operations Manager in October 2015 against the Care Quality Commission's key lines of enquiry. This report identified areas in which improvements were required and the actions to be taken to address these.

We saw that there were robust arrangements for the management and storage of data and documents. People's written records were stored securely and data was password protected and could be accessed only by authorised staff.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were not protected against the risk associated with medicines because medicines were not always administered in a safe way.