Ferringham House Limited

Ferringham House Limited Residential Care Home

Inspection report

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

The inspection took place on 25 and 28 April 2017 and was unannounced.

Ferringham House Limited Residential Care Home is registered to provide accommodation and care for up to 14 older people with a range of health needs. At the time of our inspection, eight people were accommodated at the home, some of whom were living with dementia. Ferringham House Limited Residential Care Home is situated in a residential estate on the edge of Ferring village. All rooms are used as single occupancy and all have en-suite facilities. There is an open-plan sitting/dining room and people have access to gardens at the home.

There was a registered manager in post who registered in February 2017. They had been working as manager at the home since October 2016. 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. The registered manager was on annual leave at the time of our inspection. We were joined by the provider for both days.

We found a significant lack of risk assessments in place and when information was provided it did not detail the exact support each person needed. Some risks had not been identified in the recent review of care plans. This included a lack of detailed guidance surrounding skin integrity, diabetes and mental health issues. Guidance was limited when advising staff how to support peoples specific needs. The lack of assessment and guidance available to staff meant risks were not managed safely putting people at risk of unsafe care and treatment.

Medicines were not managed safely. We found numerous concerns regarding how the home administered, stored and recorded medicines which were prescribed to people. This included gaps and errors in Medication Administration Records (MARs). One person did not receive their medicines for nearly two days. There was a lack of information in place to guide staff of what to do when people missed their medicines which meant the person was at risk from harm. The inspectors shared the incident of missed medicines with the local authority safeguarding team for their review.

During our inspection, a district nurse shared their concerns about one person's care and the potential delay in receiving the correct medical attention. They gave us permission to use their professional view in this inspection report.

Supervisions and training were provided to the staff team. The recently registered manager had commenced a supervision programme with the staff team. However, there were inconsistencies regarding the competencies of some staff in their knowledge and abilities to carry out their role and responsibilities safely and effectively. This included a lack of knowledge about managing medicines safely and risks associated with supporting people.

Care was not personalised. Care plans failed to offer the level of guidance required for staff to meet people's physical and emotional needs. Information was limited regarding people's preferences, likes and dislikes. Care plans were very similar to each other within the detail written about how people wished to be supported by staff. People living at the home had limited access to activities and other daily stimulation as their individual choices had not always been considered. There was very little detail available within each care plan about how people wanted to spend their day. This meant staff members supporting people may not of had information about people to enable them to be supported in a person-centred way.

Confidential sensitive information relating to people including their care plans and MARs were kept unlocked throughout our inspection. This meant private and personal information relating to individual people and their care was at risk of not remaining confidential.

We observed staff involving people in day to day decisions about the care they received. However, there were no records to suggest people had been involved with their own care. This meant people may not have had care delivered the way they preferred. We observed one occasion where a person's dignity was not respected.

Audits to monitor the quality of the health and safety of care provided were not accessible to the provider or inspectors at the time of our inspection. Audits received since the inspection had failed to highlight the potential risks to people within how medicines were managed. They had also failed to effectively assess gaps within care plans, risk assessments and the activities provided to people. Therefore, there was a failure to assess and monitor and to improve the quality and safety of the services provided to people.

There was a lack of governance and accountability in reviewing and checking the care being provided to people. This included decisions regarding which care staff were leading the shift in the registered manager's absence. There was a lack of knowledge from the provider about seeking guidance from health and social care professionals in accordance with safeguarding adults procedures and regulations. This meant the correct action to protect and support people was not always taken in a timely manner. The provider was advised to contact the local safeguarding team regarding one incident for their review.

Since 2014, Ferringham House has failed to deliver high quality consistent care and support to people. The provider had been unable to sustain improvements to the quality of care provided to people.

Records relating to health appointments people had attended were inconsistent and required improvement. Information was not always shared with staff regarding specific health conditions.

Staff gained consent from people prior to supporting a person and staff had some understanding of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards.

People had developed positive relationships with the staff supporting them and mostly enjoyed living at the home. The food cooked for people looked appetising. People spoke positively about their mealtime experience. No complaints had been received at the time of our inspection. Mostly, the home operated safe recruitment processes. Bedrooms were personalised with people's own belongings. The home smelt fresh and clean throughout our inspection.

Full information about CQC's regulatory response to these concerns will be added to reports after any representations and appeals have been concluded.

The overall rating for this provider is 'Inadequate'. This means that it has been placed into 'Special

measures' by CQC. The purpose of special measures is to:

• Ensure that providers found to be providing inadequate care significantly improve.

• Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made. Services placed in special measures will be inspected again within six months. The service will be kept under review and, if needed, could be escalated to urgent enforcement action.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Risks to people had not always been assessed and managed adequately to prevent them from harm.

People's medicines were not always managed so that people received them safely.

The provider had not always sought advice when people were at risk from harm.

Systems were in place to support the safe recruitment of staff.

There was enough staff on duty to meet people's needs.

Staff had been trained in safeguarding adults at risk.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

Records relating to access people had to health and medical appointments lacked consistency.

Supervision and training was provided to the staff team, however staff did not always implement their training into care practice whilst supporting people.

People enjoyed the meals served to them. Staff lacked guidance regarding one person's specific diet.

Consent to care was considered on behalf of people.

Is the service caring?

Requires Improvement

Some aspects of the service were not always caring.

People's dignity and right to privacy were not always respected.

Involvement from people in their own care was not always sought and/or recorded.

People were encouraged to be independent when being supported with personal care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care was not personalised and responsive to people's needs. There were gaps and inconsistencies to information within care plans.

There was a lack of interesting and person-centred activities available for people to participate in.

There were no formal complaints at the time of our inspection.

Is the service well-led?

Inadequate

The service was not well led.

There was a lack of stability and consistency in the way the home has been managed.

There was a lack of governance and accountability regarding the supervision of the home in the registered manager's absence. Communication was poor.

There was a lack of effective auditing systems in place to measure the quality of the service delivered or to drive continuous improvement.

People were not actively involved in developing the service and their feedback was not obtained to improve the quality of the service.

Ferringham House Limited Residential Care 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 25 and 28 April 2017 and was unannounced.

The inspection was carried out by two inspectors and a pharmacist. Prior to this inspection we reviewed information we held about the service including previous inspection reports. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. We used all this information to decide which areas to focus on during our inspection.

During the inspection we observed care provided by staff to people, including how medicines were administered to people and the lunchtime experience. We met with eight people living at the service. A district nurse who visited the home at the time of our inspection also shared their views on support provided to one person living at the home. They gave us permission to use information within our inspection report.

We spoke separately with a senior care worker, two care workers and the cook. The registered manager was on holiday at the time of our inspection. The provider was available throughout the inspection.

We spent time looking at records including eight care records, nine staff files and staff training records. We also looked at staff rotas, medication administration records (MARs), health and safety maintenance checks, compliments and complaints, accidents and incidents and other records relating to the management of the service. We shared our findings with the local authority.

Inadequate

Is the service safe?

Our findings

People told us they felt safe living at Ferringham House. However, we found many shortfalls within the home which held potential risks for people living there.

A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details of what reasonable measures and steps should be taken to minimise the risk to the person they support. At the last inspection in August 2016, improvements had been made since inspecting in December 2015 regarding how risks to people were being managed. However, we made a recommendation to the provider to review all risks associated with people and their care. At that time, we had identified further work was required as not all risks relating to people and their care had been assessed. At this inspection, we found the registered manager had reviewed and amended care plans including risk assessments. We checked all eight care plans and there were noticeable gaps where risks to people were not always identified or assessed. Therefore, the necessary guidance was not in place for staff on how to meet people's needs safely. The lack of risk assessments and written guidance available for staff placed people at risk of receiving unsafe care.

For example, one person had a history of skin integrity issues. The risk had been identified within the persons care plan. However, the care plan lacked the level of detail required for staff on how to support the person in relation to pressure sores. At the time of our inspection the person had a pressure sore on their heel. Staff supporting the person were unable to tell us how often a medicine in the form of a topical cream was being offered and applied to the person. Topical preventative barrier creams are prescribed to people when they are at risk of pressure sores. The person had a pot of cream in their bedroom. The staff told us the cream had come with the person when they moved into the home. The person told us some staff had applied the cream however, there were no Medicine Administration Records (MARs) in place to state whether staff had been administering the cream or not and when applied how often.

There was conflicting information regarding when the staff became aware of the pressure sore. The provider and registered manager told us and the district nurse they were made aware of the pressure sore on 19 April 2017. The provider and registered manager told us and records confirmed, they contacted 111 for health advice on 20 April 2017. However, there was no information or advice outcome provided to the staff team regarding what action they should take to support the person. There was no direct contact from the staff team at the home with the district nurse team. The district nurse confirmed the staff team are able to contact them direct with any concerns, queries or advice however, on this occasion they did not. A district nurse had visited the person after a referral from the paramedics. The paramedics had been contacted by the staff team on 22 April 2017 as they had been concerned about the persons health. The inspectors read information left by the district nurse for the staff team on 22 April 2017 in the home's communication book. This included guidance for staff about applying the cream to the person's body. However, by the time of our inspection on the 25 April 2017 staff did not know how often this should be done and there were no entry records in the person's MAR to state whether this had been offered and administered or offered and refused by the person.

Medicines were not managed safely. We checked records and observed a staff member administer

medicines to people. Medicines were kept in a locked medicines trolley which was attached to the wall in the dining room. On the first day of our inspection, the keys to the locked medicines trolley were left on the top of the trolley therefore medicines were not kept securely. We were told by one staff member this happened at least once a week, "Depending which staff were on duty". We found concerns regarding how medicines were stored, administered and recorded by the staff team.

For example, one person had not received their medicines on 24 and 25 April 2017. On the first day of our inspection, the staff on duty were, "Chasing up", on the medicines on behalf of the person. They were awaiting blister packs to be delivered from the pharmacy. We were told by the staff and provider the delay was due to the person recently moving to the home and a change to the pharmacy the home used. We established the person moved in to the home on 14 February 2017. We were told the registered manager had followed up the missing medicines prior to going on holiday. We asked staff on duty and the provider whether any medical guidance from a health professional, such as a GP had been sought in the interim. The staff on duty and provider told us this had not happened. A GP would inform a staff team whether there was any impact on the person's health or well-being due to their missed prescribed medicines. They would also inform staff how to monitor the person including any signs or symptoms they should look out for indicating they might be unwell. Staff told us they were, "Observing" the person. However, we asked the staff member leading the shift if they knew what the medicines were for that had yet to arrive, they told us, "If I am being honest, no". Daily notes on one day where medicines had not been given had been completed by a staff member and stated, 'Medication given' however the person had not received any of their blister packed medicines. We asked the staff member who had recorded this in the daily notes about this and they said, "I meant Movicol only" which meant the daily notes were not accurate and could have been misleading to other team members. Safe medicine procedures had not been followed which had the potential to affect the person's health and well-being. The inspectors made a safeguarding referral to the local authority about the above issue.

In the Discharge Summary, for one person, from a local hospital, it recorded they had an allergy to antibiotics. However, it was not mentioned anywhere in the persons care plan that this was a risk. The care plan stated, 'No known allergies', which was inaccurate. In a copy of a MAR from the person's previous care home it stated the person was allergic to Penicillin, but this was not noted on their current care plan. This gap in information could mean the person was at potential risk of being given a medicine they were allergic to and becoming unwell.

We observed staff give medicines to people. We observed the staff member signed MARs a significant time after administering medicines to people. We overheard them saying, "'These are ones that I forgot to sign this morning as it has been busy." This meant records relating to medicines people had received had not been kept up to date which could be misleading for other staff members administering medicines and place people at risk from harm.

A senior care worker told us that the change in the pharmacy used by the home had influenced the amount of errors on MARs. They said, "I like the blister packs but I don't like the MAR chart, it's confusing". They added there was, "Confusion about whether to sign for topical creams."

The above evidence shows that not all was done that was reasonably practicable to mitigate risks on behalf of people and treatment was not always provided in a safe way. This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We chatted with people about their views of the care they received. One person told us, "I feel safe living here." Other people looked comfortable and at ease in the company of the staff supporting them. Staff had

all attended training in how to recognise the signs of potential abuse and in safeguarding adults at risk. Staff could name different types of abuse and what action they would take if they saw anything that concerned them. All staff told us that they would go to the registered manager in the first instance. One member of staff told us, "I would come straight to the manager and whistle blow." They added, "If I didn't get the right answer I would come to you CQC".

We checked staff recruitment practices which were safe. Staff commenced employment once all appropriate checks had been carried out including obtaining two satisfactory references, checks with previous employers and that clearance was obtained through the Disclosure and Barring Service (DBS). Recruitment checks helped to ensure that suitable staff were supporting people safely within the home.

At the time of our inspection there were enough staff supporting eight people living at the home. We observed call bells were readily available for people to summon staff, especially those who remained in their rooms or were cared for in bed. One person said, "They come quickly when I call and I don't need help at night." Another person told us, "I'm very well cared for. I have just got to ring the bell and somebody comes no problem." A third person said, "I press the button and they come." We were told, and rotas confirmed there were two staff on duty throughout the day and evening and then two waking staff at night time to meet people's needs. In addition, a cook worked five days per week to prepare and serve meals to people. Staff told us the waking night staff completed most of the cleaning during their shift and the day staff continued, in addition to providing care to people. The home was clean and smelt fresh at the time of our inspection.

We were told two staff members lived in staff accommodation above the home and they could be called upon if there was a need. We saw staff call upon one of the staff members so they could spend time with the inspectors. A senior support worker told us, "We have the best team at the moment." One of the reasons they gave was due to being able to call on additional support when they needed to from the staff members living at the property. Another staff member told us, "We do try and make sure they (people) are safe and well."

Requires Improvement

Is the service effective?

Our findings

Aspects of people's care were not managed effectively. Staff told us, and records confirmed staff had received an induction when they commenced their role and attended training which was updated when required. Training attended covered topics such as safeguarding, health and safety, medicines and infection control. The provider used an online training system which provided a certificate at the time of completion and a percentage score of achievement. However, we did not always observe staff put their training into practice. For example, despite staff receiving training in the administration of medicines to people, we found concerns within how medicines were managed. This included how medicines were administered, stored, recorded and knowledge gaps regarding medicines prescribed to people. Staff had also received training in dementia. However, some staff seemed unclear whether a person had a diagnosis of dementia or which type. One staff member described a person as a, "Bit confused", but was unaware of their diagnosis of dementia. This meant staff were not always able to implement in practice the training they had attended effectively.

Staff and people told us they had access to health professionals. Staff either supported people to attend appointments or health professionals visited the home. We asked one person whether they saw their GP on a regular basis and they told us, "Now and again". Daily record notes made reference to some health care appointments people had attended such as with their GP or a chiropodist. However, there was a lack of monitoring within people's care plans regarding the timeliness of such appointments. There was also a lack of information provided on the action staff may need to or had taken after each appointment. For example, daily notes made reference to a person's back pain. They stated the person had requested to see their GP on the night of 19 April 2017 for what the daily record described as, 'In a lot of back pain'. Staff made reference to back pain the person was experiencing on 20 April 2017 and the registered manager telephoning 111 for medical advice. However, there was no record of the outcome of the advice given when the registered manager telephoned 111, including any guidance for the staff supporting the person. On 21 April 2017, staff recorded the person needed to see a GP for their back pain and that an appointment had been booked for the following week. We were told, and records confirmed, the paramedics attended to the person on 22 April 2017 at the request of staff. The person saw their GP on 24 April 2017. Records were unclear as to why when the person requested to see a GP on 19 April they were not taken to the surgery by the registered manager and provider until 24 April 2017. This lack of written communication meant staff may not always have been aware of how to support people's physical and emotional well-being and needs effectively. Since the inspection, the registered manager provided the inspectors with a record of the advice given by the person's GP. They told us they had shared this information with the staff team verbally prior to their leave.

The cook had not been made aware of everybody's dietary needs. One person lived with diabetes. There was no associated risk assessment in place providing guidance for staff on how to minimise risks to the individual. Their care plan stated, ' Please note that [named person] has a diagnosis of diabetes and not to give [named person] too much sweet items'. We talked with staff and checked their MARs. We established the person received oral medicines in the form of tablets for their condition. We asked the cook if they knew if any people in the home had any special dietary needs, including diabetes, they did not. The care plan was

limited in guidance and the person in charge of cooking most of the main meals was not aware of the person's health condition. Therefore, on this occasion, the lack of guidance provided to staff put the person at risk of receiving the wrong diet which may have impacted on their health.

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 that the home was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met. At the time of our inspection, we were told people living at the home all had capacity to make decisions. Staff had attended training on MCA and DoLS and could share some knowledge on these topics. One staff member told us, "Everybody here has capacity". Another staff member told us, "They (people) have their mental capacity". Since our inspection, the registered manager has sent the inspectors copies of mental capacity assessments they had completed on behalf of two people living at the home since the inspection.

We talked with the staff team about the training and support they were provided. The provider told us the registered manager was going to be trained as an instructor in how to move people safely, so would be able to train staff face to face. Staff told us, and records confirmed, they had attended a supervision session with the new registered manager and they had held two staff meetings since joining the team. One staff member told us, "The [registered manager] is a good manager he listens to us. If we have got a problem, he will rectify it the best he can." People told us they appreciated the support they received from the staff team. One person told us, "I can be a bit awkward, we (with the staff team) get on well."

Food offered to people smelt and looked appetising. Some people ate in the dining room which was part of an open plan lounge, however, some people chose to eat in their bedrooms. People we spoke with complimented the food cooked for them. One person, who preferred to stay in their room, told us, "It's very nice here and good food. Staff bring my food to me. I always get plenty to drink." On the first day of our inspection people enjoyed a roast dinner, on the second day it was fish and chips. Support was provided by staff if people required anything additional. We observed staff were patient when supporting people and sat with them whilst eating their own lunches. We overheard staff saying, "You ok there, have you finished?" The cook told us they spoke with people living at the home about what their favourite foods were. The cook used a four week rolling menu which provided two choices for people at mealtimes and we observed snacks being offered throughout both days. The cook told us how they accommodated one person who was vegetarian and how they were trying to introduce a more balanced menu to people and add variety by adding new dishes.

Requires Improvement

Is the service caring?

Our findings

During both days of our inspection, we found written confidential information relating to people was not maintained securely. This included MARs, daily notes, people's care plans and activity records. The MARs file was kept on top of the medicine trolley next to the dining room table. Staff told us this was common practice which meant sensitive confidential information relating to people's health needs, was not kept locked away. We found one loose MAR on the dining room table and another on the window sill near the medicines trolley. We spoke with staff about their understanding of why care records relating to people should be locked away. One staff member told us because the information was, "Private" to the person. However, we observed staff did not apply this in their everyday practice whilst supporting people. We had been looking at care plans in the dining room on the second day of our inspection. We handed back some care plans to a staff member who went to put these documents in an unlocked dining room sideboard. The staff member said, "I'll just put them there for the moment". We informed the staff member that since we had finished looking at the records, they needed to be locked away. We discussed this with the provider throughout our inspection as this practice did not respect people's right to privacy.

People living at the home told us the staff were caring. However, staff during our inspection did not always use a caring approach. We observed one occasion whereby people's dignity was not respected. One staff member was overheard speaking loudly by both inspectors, "Do you want to go to the toilet?" after a relative told them a person in the lounge area needed support. It was said in front of two other people living in the home and one relative. The staff member had not considered the need to be discreet and sensitive when supporting the person with their personal care need.

However, we observed other examples where we overheard staff chatting to people using a more dignified and caring approach. For example, staff knocked before they entered people's rooms and left people to be able to speak privately with the inspectors if they wanted. We observed a senior care worker engaged with one person about a skill they had developed in their past career. They encouraged the person to share their ability to use short hand with a passing inspector. The person was pleased to be able to share this and it meant the staff member had taken the time to learn something interesting about the person they were supporting. We also observed how staff paid interest in a visiting relative. We overheard comments such as, "How are you today?" and providing the person assurances about their family members care. We heard staff talk with people about the weather and other matters of local interest during meal times which created a pleasant and uplifting ambience. One person told us they were happy with how the staff cared for them and said, "I am very happy here." They added how much they liked their bedroom as it had, "Lovely sunshine all day."

Staff told us they encouraged people to be as independent as they were able regarding their personal care needs. We observed staff provide choices regarding what people wanted to wear that day and what they wanted to eat. Staff described how they knew what people were able to achieve regarding their own personal care and how they encouraged them to do things for themselves, like brush their own hair. One member of staff said, "I enjoy being with people and caring for them and making their life much more pleasant. I find them interesting to listen to."

We observed staff involving people in day to day decisions about the care they received. A residents and relatives meeting had also taken place. The provider and the registered manager had attended on 16 February 2017. Items discussed were in relation to what the recently registered manager was about to implement. Three people and their relatives were in attendance. However, it was difficult to ascertain how directly involved people and their relatives were with their own care plans as people were unable to discuss their contents with us during our inspection. Since the inspection, the registered manager has told the inspectors he sat with people living at the home individually and discussed their care. We have referred to care plans in more detail in the Responsive section of this report.

Requires Improvement

Is the service responsive?

Our findings

Care was not personalised and the staff team were not always responsive to the individual needs of people they were supporting.

Each person had a care record which included a care plan. Five care plans had been revised and updated in February 2017 by the registered manager. They did not reflect all people's preferences, likes and dislikes as they were very similar to each other within the detail written about what support people required. Care plans did not hold information about a person's past employment, hobbies or interests. One person's care plan failed to name family members or friends who may be important to them, yet we saw them with a visitor on the second day of our inspection. One care plan was identical to another only the name had been changed. Each person within the two care plans therefore had been listed as having the same diagnosis and medicines. This was completely inaccurate for one person. On the first day of the inspection, the provider could not locate one person's care plan and it had to be printed off. Staff did not have access to the computer care records on a day to day basis. After our inspection, the registered manager told us we had been given the wrong care plan and sent us the correct care plan. Two people's care plans showed their date of birth as the same date, but this was only accurate for one person since the other person had was born in a different month and year. Information had been copied and pasted inaccurately. The revised care plan format contained sub headings entitled, Personal care needs, nutrition, daily routines, hobbies and interests. However, several care plans contained significant gaps under particular headings which left the reader without knowledge of a person. This influenced the lack of knowledge some staff had over people's diagnosis and their identified risks associated with their care. This included the staff member leading the shift at the start of our inspection.

Three people's care plans had not been updated and care plans remained as written by the previous manager. Notes at the front of these stated to be updated by '13 April 2017' however this had not happened. A senior staff member told us they felt care plans had not yet been completed.

One person's care plan had failed to include important information about their mental health. A hospital assessment about the person written in January 2017 prior to the person moving to the home in February 2017 stated they had a history of mental health issues and self-injurious behaviour. No risk assessment or guidance had been completed for staff about how to manage this need or what signs to look for if the person's mental health was to deteriorate. Due to the lack of information and guidance for staff readily available meant the person may be at risk of those supporting him not knowing what signs to look for if they were to become unwell.

Since our inspection, the registered manager told us that the care plan relating to one person was not the most up to date accurate copy. He told us the latest revised version was on an online system which he sent to us. At the time of our inspection, during the registered manager's absence, the provider, the care staff and person being written about did not have access to the revised version. This meant there was a risk staff supporting this person were not providing assessed and agreed person centred care.

There were poor and limited activities offered and provided to people living at the home. The provider had failed to assess what activities people liked and enjoyed doing and care plans failed to reflect people's interests. Generalised comments such as 'enjoys socialising' were present in the care plan. The care plan did not reflect how people liked to spend their day however focused on task led subjects. There were very little planned activities, one indoor activity took place on our first inspection day. There was no written structure available to inform people what may be offered on a particular day. People were in the same position either in their own rooms or in an armchair in the lounge, or at the dining room table for the whole of both inspection days. A care worker leading on the first day of our inspection told us "We try and do one thing each day." The provider told us they had offered people in the lounge a game of skittles on the first day of our inspection. However, we observed there was a lack of stimulation and opportunities provided in the communal area. The television was on all day on the first day of inspection. We spoke with one person who was sat in the lounge for the duration of the first day of our inspection (5.5 hours). We asked what they did all in the day time and their response was, "I sit here and mope, there is nothing". I asked the person what they liked to do they said, "I'm a reader, but there is nothing here, it's just the TV all day." We asked if they liked the home and the staff and they replied "Yes, its okay you know".

On the second day a staff member did switch off the television and change over to the radio, but the actual stimulation offered in general was very limited. The atmosphere was uplifted by a more 'cheery' staff member on the second day of our inspection, who had been working at the home longer and they were skilled in interacting between people and each other. On the second day of our inspection, at 4.15pm, we heard a member of staff asking people in the sitting room if they wanted to play cards. Four people were asleep in front of the television and the others stated they were not interested in playing cards.

Records kept of activities people had attended included games such as Pontoon, skittles, Bingo, cards and talking about the past. However there was no evidence to suggest these were chosen by people living at the home. There were no trips out away from the premises in April 2017 organised by the home. A staff member told us two people had started to go out into the gardens. However, we observed very little encouragement of this during our inspection.

We were told some people chose to spend time in their bedrooms and preferred to be alone. However, we found one person described as preferring to spend time in their room enjoyed the company of staff and chatted away to the inspection team. Opportunities had been missed to capture this within care plans and activity records. One person had a history of mental health issues. This had not been taken into account when assessing their needs and how they wanted to spend their time whilst living at the home. We had little evidence to suggest staff were able or provided stimulation to people who wished to remain in their own bedrooms hence they were at risk of social isolation.

The above evidence showed the provider had not ensured that the care and treatment of service users was appropriate, met their needs and reflected their preferences. This is a breach of Regulation 9 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the time of our inspection, no complaints had been recorded. The home had an accessible complaints procedure. One person told us, "I have no complaints at all. They (staff) are very, very understanding and helpful". Staff told us people were listened to and any concerns they had were acted on. One staff member told us, "I think it is very happy and safe. Families have said they (people) are happy here. It is family orientated. They get treated the way my own family get treated".

Inadequate

Is the service well-led?

Our findings

Since 2014, Ferringham House has failed to deliver high quality consistent care and support to people. The provider had been unable to sustain improvements to the quality of care provided to people.

This lack of sustainability was influenced by the input of a high number of managers who started their role, often made improvements and changes to how the home was managed and very soon after left their employment. There had been five managers and five registered managers in post since 2011. At the time of this inspection the registered manager had put in a notice to cancel their registration. They had completed their notice to cancel their registration on the 21 April 2017. Since the inspection we have been told by the provider that the registered manager would be remaining in post. Significant changes in the management and leadership of the home meant the home lacked stable management and strong leadership. This had an impact on people, the staff team and records relating to people and record management.

Areas which had required improvement in the past were similar to the concerns we found at this inspection. As a result of our inspection in December 2015, an overall rating of Inadequate was given and the home moved into special measures. At the inspection in August 2016 we found some improvements had been made yet further work was required and an overall rating was given of Requires Improvement. We found at this inspection, amongst other areas, repeated concerns within risk management and medicines management. Therefore, the improvements were not sustained. We also found concerns regarding a lack of involvement of people in decisions relating to their care, a lack of activities and person centred care and a lack of robust auditing systems. We found the provider, who was the responsible person in the registered manager's absence, had a lack of knowledge associated with safeguarding and associated regulations. This impacted decisions made within the home including when advice needed to be sought from outside health and social care agencies on behalf of people. Examples of missed medicines and our referral to the local authority safeguarding team was a specific example of this.

At the time of this inspection the home was not well-led. There was a lack of effective monitoring audits to measure the care delivered to people. There were no accessible audits available during our inspection, as the provider was unable to locate any current audits. Following our inspection, the registered manager has sent audits they had carried out since coming into post. This included monthly medicine audits and infection control audits. However, they had failed to identify gaps and concerns we found within risk assessments and medicine management. They also failed to identify gaps we found within care plans, storage of confidential and private information relating to people, lack of involvement from people, lack of personalised activities and a lack of records relating to people's access to health appointments. We have referred to these concerns throughout this inspection report.

For example, The medical conditions in one person's care plan were listed as exactly the same medical conditions and medicines prescribed to this person were listed for a different person in their care plan. We checked and for one person the information was completely inaccurate. It put the second person at risk as they did not have these medical conditions and were not prescribed the same medicines. This influenced

staff's ability to carry out their role and responsibilities as they had a lack of specific knowledge about some people living at the home.

We found other examples whereby the records we checked put people living at the home at potential risk of their care needs not being met. We read a body map record which had been completed on 28 February 2017 on behalf of one person. It stated they had a 'cluster of small bruises'. The staff member had circled the arm area on the body map indicating where the area of concern was. As there was no incident form or information explaining the action taken by the staff team following the completion of the form, we talked with the staff member who had completed the document. They told us they were not bruises they were, "Little red marks", however, they added they did not know how to write that. The staff member told us they had been asked to record what they had found. They were not aware of any further action taken by the registered manager yet the person had a history of skin integrity issues. This meant an issue with the person's skin integrity may have not received the appropriate care and treatment.

Decisions made regarding how the home was supervised in the registered manager's absence were not robust and put people at risk of unsafe care and treatment. There were minimal systems in place of governance and accountability for the home to keep people safe and free from risk of harm. Ferringham House had a relatively small staff team of ten. Most staff were relatively new to working at the home from one month to one year. The management structure consists of the provider, the registered manager, one senior support worker, care staff and a cook. Some staff worked night shifts only. Whilst the registered manager was on leave, the senior care worker employed by the home was working waking night shifts. This meant the day shifts were covered by two care staff. We were told one of the care staff on each day shift was nominated to lead the shift. The senior care worker told us, "There has not been much communication between the new manager and me because of working nights." We observed, and rotas checked, meant there was enough staff on duty on each shift to support the eight people living at the home. However, there were inconsistencies regarding the experience, knowledge and competencies of care staff leading each shift. This included a lack of knowledge regarding people's diagnoses and their individual health needs. During our inspection, the provider changed the rota and brought the senior care worker off waking nights duties and told us this had been discussed prior to the inspection.

The above evidence shows that there were inadequate systems or processes in place that operated effectively to ensure compliance with requirements. There was a failure to assess and monitor and to improve the quality and safety of the services provided. There was a failure to assess, monitor and mitigate the risks relating to health, safety and welfare of service users. There was a failure to maintain securely an accurate and cotemporaneous record in respect of each service user. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Shortly after our inspection, we spoke with the registered manager to request further information, gain their insights into the home and provide feedback regarding our concerns. The registered manager told us they had been working on improving records which would be implemented after they had returned from leave. They told us they had revised all the policies and procedures as they had been in place since 2011 and required updating. They also felt the infection control audit had proved effective. We agreed with this as the home was clean and well maintained at the time of our inspection.

Mostly, staff spoke positively about the registered manager. One staff member told us, "It's quite well run." However, one staff member told us, "[Named registered manager] spends more time in the office". They added, "We need more direction." Apart from one resident's and relatives meeting there were very little records available on how the provider and registered manager had engaged with people and their families. We checked questionnaire records and found the last opportunity people and their relatives had been asked

for their feedback was in September 2016 however this was under the previous manager. The majority of people who had completed this questionnaire had since left the home, therefore, the feedback was not current.