Ferringham House Limited

Ferringham House Limited Residential Care Home

Inspection report

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Worthing, West Sussex BN12 5LU
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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?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Inadequate**

Overall summary

The inspection took place on 10 December 2015 and was unannounced.

Ferringham House Limited Residential Care Home is registered to provide accommodation and care for up to 14 people with a range of health needs. At the time of our inspection there were 10 people living at the home. Ferringham House Limited Residential Care Home is situated in a residential estate on the edge of Ferring village. All rooms are single occupancy and some have en-suite facilities. There is a large, open-plan sitting/dining room and people have access to gardens at the home.

There was no registered manager in post. A manager was recruited in October 2015 and was in post at the time of this inspection. However, they resigned their position after our inspection in January 2016. The last manager to register with the Commission left the home in March 2015 and two managers had been recruited and subsequently left the service between March and October 2015. A

Summary of findings

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 provider was running the home for a few weeks in the summer of 2015.

Risks to people were not always identified and assessed appropriately or in a consistent way. Medicines were not managed safely and medication administration records (MAR) did not always record that people had received their medicine when required. Systems were not in place to ensure that staff were recruited safely. There had been a high turnover of staff recently.

There was a lack of evidence to confirm that staff had received training in essential areas; some staff training was out of date. Staff did not receive regular supervisions with management and annual appraisals were not undertaken. Two staff meetings were held in 2015. Consent to care was not always sought in line with legislation and guidance. Some staff had little or no understanding of the requirements of the Mental Capacity Act 2005 and associated legislation.

The service could not demonstrate good management or leadership. There had been eight managers in post since the current provider registered as the nominated individual in April 2012. There was a lack of stability and consistency in the way the home was run. Inadequate auditing processes and systems meant that areas of concern that we found at inspection had not been identified by the provider. People were not actively engaged in developing the service and their views not sought to drive improvement.

Staffing levels were adequate, but in addition to their caring responsibilities, staff also undertook housekeeping duties. This left them with little time to sit and chat with people, however, they were quick to respond to people's requests for help and support. People felt there was a lack of activities that were interesting to them and that they wished to participate in. Staff were caring of people and warm relationships had been developed between people and staff. People were treated with dignity and respect. They were asked for their views about the home, as were their relatives, and feedback generally was positive.

People were supported to have sufficient to eat and drink and to maintain a healthy diet. They had access to a range of healthcare services and professionals. People's rooms were comfortably furnished and the service had a 'homely' feel. People received care that was responsive to their needs and care plans contained detailed information on how they wished to be cared for and supported by staff.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the back of this report.

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.

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Summary of findings

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.

Systems were not in place to ensure the safe recruitment and vetting of staff.

Staffing levels were adequate.

The majority of staff had been trained in safeguarding adults at risk. However some staff had not received updated training in this area and not all staff were confident in responding appropriately to safeguarding concerns.

Is the service effective?

Requires improvement

Some aspects of the service were not effective.

Evidence could not substantiate that staff had completed all essential training to understand people's needs and they had not received regular supervisions or appraisals.

Capacity assessments had not been undertaken for people living at the home to determine people's capacity to make decisions about their care and treatment. Some staff had a limited understanding of the Mental Capacity Act 2005 and associated legislation. The provider could not confirm that staff had received training on this topic.

People had sufficient to eat and drink and were encouraged to maintain a healthy diet. They had access to a range of healthcare professionals.

People's rooms were comfortably furnished and there was a 'homely' feel to the environment.

Is the service caring?

Good

The service was caring.

People were looked after by staff who knew them well and caring, warm relationships had been developed.

People were treated with dignity and respect. If they wished, they were involved in planning their care.

Is the service responsive?

Requires improvement

Some aspects of the service were not responsive.

Summary of findings

People felt there was a lack of interesting and person-centred activities available to them that they could participate in.

Care was delivered to people that was responsive to their needs.

The provider and manager said no complaints had been received or recorded at the home.

Is the service well-led?

Inadequate

The service was not well led.

Eight managers had been in post since the change of legal entity in 2011. There was a lack of stability and consistency in the way the home was managed.

There were no 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 used 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.

The inspection took place on 10 December 2015 and was unannounced. Two inspectors undertook this inspection.

Before the inspection, we checked the information that we held about the service and the service provider. This included statutory notifications sent to us by the registered manager or 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 followed up on concerns that had been raised and sent anonymously to the Commission. We used all this information to decide which areas to focus on during our inspection.

We observed care and spoke with people and staff. We spent time looking at records including five care records, three staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with six people living at the service, one relative and one friend who was visiting a resident. We spoke with the provider, the manager, two care staff and the chef.

The service was last inspected in January 2015 and there were no concerns.

Inadequate

Is the service safe?

Our findings

Risks to people were not always managed to protect them from harm. We observed two occasions when two different members of staff were moving two people in their wheelchairs in the sitting room. On both occasions, the wheelchair footrests were not used and each person was at risk of foot injury as there were no supports in place to prevent their feet from dragging on the floor. In one instance, we observed that the member of staff was hesitant about using the brakes on the wheelchair before the person stood up. We brought this to the manager's attention and action was taken immediately, with the foot rests put in place. Following the inspection, the manager informed us that they had spoken with the members of staff involved and confirmed that both members of staff had received moving and handling training. Training records confirmed this. One member of staff said that the person did not wish to have their feet on the foot rests as this was painful to them. The other member of staff explained the person suffered discomfort when bending at the knee, so preferred not to use the foot plates. However, there was no evidence within people's care plans to show that this risk had been assessed or the person advised of the potential risk in not utilising the foot rests.

A risk assessment in one person's care plan described them as being at risk of falls; this had been completed by a previous manager. However, there were no further details of the risk and no guidance for staff on how to mitigate the risk. The same person had a risk assessment in place which measured their risk of developing pressure ulcers. It was recorded that this risk assessment needed to be reviewed in November 2015, however, no review had been undertaken at the time of our inspection. This person had been visited by the district nurse on 1 December 2015 as they had developed a red area on top of their foot. The manager had recorded that they checked the area several times on the day after the district nurse had visited, to monitor and contact the GP if needed. However, we checked the daily records for this person to see how care staff were monitoring the affected area to this person's foot in the days following 1 December. No further information had been recorded and no evidence was in place to show that the area had been monitored on a daily basis until 8 December, when the district nurse made another follow-up visit. The same person had a risk assessment in place relating to the use of their call bell. The risk assessment stated that staff were to remind this person to use their call bell if they needed assistance. However, the person had also been assessed as suffering from short term memory loss and may not have been able to retain this information. There was no assessment or information in place to show whether this person was capable of using their call bell to summon assistance if they required support from staff and alternative solutions if they were not able.

Another person had been assessed as having difficulties with swallowing. The assessment stated, 'I do have a swallowing problem and will sometimes cough up food when it is difficult to swallow. Please would you cut up my food for me and offer me soft options'. Advice had been sought from a speech and language therapist as the risk of choking had been established. However, when we spoke with the chef, they told us that no-one at the home required softened foods.

Risk assessments that had recently been reviewed and updated by the current manager showed that some people's risks had been identified and assessed appropriately. However, not all risk assessments were completed consistently, so that staff had incomplete information on how to manage people's risks safely. We looked at the record of accidents and incidents. One accident had been reported relating to one person who had sustained a fall. On 15 December, the manager forwarded us a 'falls analysis form' for November 2015. This showed that one person had sustained a fall resulting in a skin tear. It also stated that they had a urinary tract infection and were hospitalised, but no further information was supplied, for example, when the person returned to the home and whether their care plan and falls risk assessment had been reviewed as a result.

We observed that a physical restraint, in the form of a stair gate, was in place at the top of the stairs and that this was shut. We were told by care staff that the gate had always been there, but they had started to keep it shut for a new resident who was at risk of falling if they used the stairs without support. An alternative, effective and less restrictive way of keeping the person safe had not been considered, such as the use of a sensor mat or moving the person to another room. There was no risk assessment within the person's care record to show that the use of a stair gate was in their best interests to protect them from harm or that there was a less restrictive alternative. Whilst another resident demonstrated that they could open the

stair gate without assistance and came downstairs independently, the bottom of the stair gate was raised slightly above the carpeting and could have posed a trip hazard to anyone negotiating their way through the gate. The risks and benefits of the stair gate had not been considered in supporting people's independence. The stair gate had not been appropriately risk assessed to mitigate risk of tripping or falls.

People's medicines were not always managed so that they received them safely. We observed medicines being administered to people during the morning by a member of care staff. The staff member released tablets from blister packs for two people into two separate dosset pots. They then carried the dosset pots, together with a bottle of laxative, upstairs to people's bedrooms. This was not safe practice as there was a risk that, administering medicines to two people in this way, could have resulted in the medicines being inadvertently swapped over, with the result that people might have received the wrong medicine. We brought this practice to the attention of the manager who stated they would discuss the incident with the member of staff in question to avoid this happening again.

Eyedrops and some medicines that required refrigeration were kept in a domestic refrigerator in the kitchen and were stored on a separate shelf to the food. We brought this to the manager's attention who stated they would store medicines in a suitable receptacle within the refrigerator.

We checked the stock levels and Medication Administration Records (MAR) within the medicines trolley and found that medicines for two people had not been administered as prescribed the day before and the tablets for one person remained in the blister packs. We discussed this with the manager and were shown an entry that had been recorded in the staff handover book. The entry had been completed by the night care staff who recorded that the medicines had not been given to two people at breakfast the day before. Medicines that were missed were for stroke prevention, a thyroid condition and psychosis. The manager had been on leave that day and was unaware of this event. We discussed the issue with the provider who was insistent that the people concerned had not, "missed their medicines". The provider stated that one person received their medicine later in the day as they had been asleep during the early morning medicines round. However, the MAR had not been completed to this effect at the time of our inspection and there was a gap on the chart with no explanation or signature from staff to corroborate that the medicine had been administered later. However, the medicine was missing from the blister pack for this person. Similarly, for the other person, no explanation had been recorded on the MAR to show why the medicines had not been administered. The provider told us that the person often refused their medicines and that this had probably occurred that day. However, if this had been the case, it was not recorded on the MAR and no explanation provided or action taken. The majority of staff had received recent training in the administration of medicines, but one member of staff had received no updated training since 2011 to ensure their competence and skills.

On the day of our inspection, the sitting and dining areas of the home felt chilly and appeared to be below a comfortable temperature. This put people at risk, especially those with mobility issues that might remain seated in the sitting room for long periods. We checked the radiators in the immediate area, but they were cold. We raised this with the manager who checked the thermostat and found that the temperature setting had been turned down. The manager immediately adjusted the temperature controls and the room gradually warmed up. Blankets and hot drinks were offered to people in the sitting room during this time.

The above evidence shows that care 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.

Medicines were ordered in a timely way and people had sufficient stocks of their medicines to ensure they received them as needed. Where people administered their own medicines, their risk had been assessed and recorded appropriately within their care records. .

Safe recruitment practices were not in place. One staff record contained no references for one person and they had been working at the home for nearly a year as their recruitment had commenced in December 2014. We brought this to the attention of the provider. The provider insisted that references had been requested and obtained and asked a previous manager to email us to confirm that this was the case, which they did but the provider had no documentation of this to confirm the checks had been undertaken. The provider later requested and received two satisfactory references and forwarded us copies of these in

Is the service safe?

an email dated 15 December 2015. The new member of staff had been employed at the home for nearly a year before suitable character references were received and therefore the provider had not assured themselves that the individual was fit and proper to work with people living at the home. Although the provider had taken immediate action to respond to this, it was noted as an area for improvement.

A potential safeguarding concern was raised by one person during our inspection. The person described a situation with one staff member that had seemed to make them anxious and scared. The person went on to say, "But they have dealt with it and it's all okay now; most of the carers are very good". We discussed the issue with the manager who stated that they would speak to the staff member concerned. However, we emphasised the need for them to inform and seek advice from the local safeguarding team. Following our inspection, the manager confirmed that they had sought advice from the appropriate authority and had raised a safeguarding alert.

The majority of staff had received training recently on safeguarding adults at risk and two members of care staff confirmed this. However, according to the staff training plan, one member of staff had not had an update to their training since May 2009 and two others had not had updated training since August 2013. Following the inspection, the provider sent us a copy of a questionnaire that was used internally for staff training on this topic. However, the questionnaire received was a blank template and provided no evidence that all staff had actually received training in safeguarding . There were no certificates available to show that staff had completed training in this area. We asked one member of staff what they would do if they suspected abuse was taking place. They said, "I would report a concern to the boss". When asked what action they would take if they saw an unexplained bruise sustained by a resident, the staff member responded, "I would complete a body map and tell [named manager]". No reference was made by staff as to what further action they might take beyond reporting any concerns to the manager. For example, that they were aware of the local authority's safeguarding team or the multi-agency safeguarding policy and that they could report any concerns directly to the local safeguarding authority.

Staffing levels were adequate, with two care staff on duty on each shift for ten residents. At night, there were two members of care staff on duty, one waking and one sleeping. However, where people required the assistance of two care staff to assist with hoisting for example, then there was no additional staff available to provide support to other people if needed, except by the manager, if they were on the premises. At least three people at the home required the assistance of two care staff to assist with moving and handling. Care staff were also required to undertake housekeeping duties during the day, to clean communal areas, people's bedrooms and bathrooms. We observed that the staffing levels allowed staff to respond to people in a timely way and support them when they needed it.

There had been a high turnover of care staff in recent months; at least two staff had left in the previous month and the manager confirmed this. One person told us, "Some carers have just left and we have to get used to new ones". A relative referred to staffing and said, "The turnover of staff can be unsettling for residents – something needs to be worked on. The quality of the carers is the main ingredient and we have a good rapport. They all work very hard, we have nothing but praise". A staff member said that it was, "Upsetting, the amount of staff that have left". When asked if they thought there were sufficient staff on duty, they said, "We give all that we can. With more residents moving in, they all need top to toe washing, but there is only two of us, so we don't have the time to chat with the residents. We need more staff in the morning, somebody for a few hours like we used to have". The manager said that the provider had agreed that an additional person would be employed in 2016 to undertake housekeeping and caring duties.

Staffing rotas were checked between 30 November 2015 and 14 December 2015. These showed that one member of staff had worked a minimum of 66 hours one week and was scheduled to work 78 hours in the week commencing 14 December 2015. Another member of staff had worked 66 hours in a week. We asked one staff member about the number of hours they worked and they said, "I work about 45 hours per week", however, staff rotas contradicted this and showed they had worked more hours. We had a discussion with the manager about the long hours that one member of staff had worked and until we brought this to their attention, they had been unaware of the issue and had not discussed this with the staff member in question.

Inadequate

Is the service safe?

Whilst staff can choose how many hours they work in a week, the manager should be aware of how many hours staff work so that their wellbeing can be monitored and people protected from the risk of staff being fatigued.

Requires improvement

Is the service effective?

Our findings

People did not always receive effective care, based on best practice, from staff who had the knowledge and skills they needed to carry out their roles and responsibilities. There was a lack of evidence to confirm that staff had actually completed the training they needed to look after people effectively. We asked a member of staff about their training. They said they had completed safeguarding and administration of medicines training, as well as moving and handling. They also told us that they had completed training in mental capacity and dementia. Another member of staff had received training in a wide range of areas, however, this was training outside of Ferringham House. Training for staff was not easily evidenced as there were no training certificates available to confirm that staff had received appropriate training in all areas. We were told that some staff were completing diplomas in health and social care and that another staff member was pursuing higher education. The provider supplied us with a copy of the training plan which provided information on qualifications and/or training that staff had completed. The training plan showed that the majority of staff had completed a level 2 qualification in health and social care. These are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. The majority of staff had received training in moving and handling, health and safety, control of substances hazardous to health, fire and infection control. Some staff had received training in food hygiene and end of life care. However, there was a lack of training in areas such as first aid, end of life care, equality and diversity, dementia awareness, nutrition, continence and mental health, even though the training plan showed these areas. The manager told us that they had hoped to deliver some training internally, however, they have since resigned from their position at the home. Therefore staff may not have had training in areas specific to the needs of the people living at the service in order to meet their needs effectively.

Staff did not have regular supervision meetings with their manager, although the new manager had started to organise these. One member of staff had not had a recent supervision meeting and the supervision plan showed that their last supervision was in May 2014. No appraisals had been undertaken or could be corroborated as having taken place in the three staff records we checked. (One of these staff members was comparatively new, so we would not expect that an appraisal would have taken place.) The manager sent us an email on 15 December 2015 stating, 'Traditionally, we have treated supervision and appraisal as the same thing. Therefore, we don't have separate appraisals. This has worked for us. We will set up appraisals. We enclose supervision matrix'; notes from two staff supervision meetings were attached. A staff supervision plan handed to us at the time of our inspection showed that one member of staff had not had a supervision meeting since April 2013. However, the staff supervision document sent to us later showed they had received supervision on 14 December 2015, after our inspection. Another member of staff had not had a supervision meeting since January 2015. The later staff supervision document sent to us differed significantly from the document handed over to us at the time of our inspection. The later document showed that three additional supervision meetings had taken place following our inspection. There was no additional evidence to confirm that staff received regular supervision meetings with the manager or provider. The provider had no effective formal system in place to monitor staff performance, opportunities for staff to discuss any issues they might have in a confidential setting or evidence that staff were supported in their roles by management.

The above evidence shows that staff did not always receive appropriate support, training, supervision and appraisal to enable them to carry out the duties they were employed to perform. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, there was evidence to show that one member of care staff who had worked nearly a year at the home and another staff member, who had been working there since August 2015, had received supervision from the manager.

Staff meetings were held and minutes of meetings held in April 2015 and November 2015 were emailed to us. The email, sent by the manager and dated 15 December 2015 stated, 'Please note that not all staff attend meetings and the owner keeps regular contact with staff'. A staff communication book was used for messages between staff. Handover meetings between staff were held at the end of a shift. We observed the manager handover over to a member of care staff that came on duty. The handover

meeting took place in the dining area of an open plan lounge. One person was sat within earshot in the sitting area. The area used for the handover meeting was not conducive to keeping information discussed about people's care needs in a confidential way. Various items were discussed at the handover meeting including menu choices, as well as people's care needs. We brought this to the attention of the manager who stated that future handover meetings would be held in the office.

We asked one member of staff about their induction. They told us, "For two weeks I had shadow shifts and [named staff member] gave me my induction as she has worked here for fourteen years" and added that they enjoyed working at the home.

Consent to care was not always sought in line with legislation and guidance. The training plan did not show whether staff had completed training recently in mental capacity. Some staff did not have a thorough understanding of the requirements of the Mental Capacity Act (MCA) 2005. The 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. One member of staff confirmed they had completed mental capacity training, but this had not been recently and they did not have a good understanding of mental capacity. However, another member of staff had a better awareness and understanding of capacity and deprivation of liberty. We checked whether the service was working within the principles of the MCA. None of the people living at the home had an assessment of their capacity in place to determine whether they were able to make specific decisions about their care and treatment. The manager confirmed that no capacity assessments had been undertaken and an assumption was made that everyone living at the home had capacity. An email later sent to us by the manager stated, 'You advised that some of our residents may require assessing under MCA. I have identified one resident so far and will be assessing others. I have attached the MCA assessment form'.

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 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We asked the manager whether they had applied for Deprivation of Liberty Safeguards to be authorised by the local authority. The manager told us, "Nobody is deprived of their liberty, they are free to come and go".

We recommend that the provider refers to the Mental Capacity Act 2005 and associated legislation under the Deprivation of Liberty Safeguards for guidance.

In the email sent to us by the manager on 15 December 2015, they stated, 'Most of our staff are aware of DoLS requirement through past training of mental health. There will be further training by myself in January 2016. Staff will become more aware of MCAs as we carry out more assessments'.

People were supported to have sufficient to eat, drink and maintain a balanced diet. We observed people were offered a pre-lunch drink and some people chose to have a sherry which they bought themselves. The manager sat with people at lunchtime and ate with them. This afforded them the opportunity to chat and socialise with people and for people to talk about any issues affecting them. The lunchtime experience was a sociable occasion and people enjoyed their meals and were engaged in conversations with each other. We spoke with the chef who had only been in post for a couple of weeks. They told us that it was their plan to put together menus offering choices on a two-weekly cycle. On the day of our inspection, the lunchtime choice was fish or sausages, with chips or mashed potato and a selection of vegetables. Dessert was either apple crumble or a choice of cold options. People chose what they wanted to eat from the menu the day before and care staff recorded their choices and passed these on to the chef. People were offered drinks throughout the day we inspected by care staff and by the chef, together with additional snacks of biscuits or cake if they wished. People were positive about the food and one person said, "You get a choice, which is nice", although they added that, "It's not always hot". A relative said, "There seems to be enough choices most days and [named family member] doesn't need a special diet". A staff member confirmed that people were offered a choice of food and also offered additional helpings of food and enough drinks throughout the day.

Requires improvement

Is the service effective?

People were supported to maintain good health and had access to healthcare services and professionals. Care plans showed that people had received visits from healthcare professionals such as a district nurse, GP or chiropodist. On the day of our inspection, one person became ill and advice was sought from the GP. A member of staff supported one person to a foot clinic appointment.

People's rooms were comfortably furnished and the majority had en-suite facilities. People could bring their own furniture with them when they moved into the home and were encouraged to display photos and personal memorabilia. One person said, "I didn't bring anything, but everything was there that I wanted". The home was nicely decorated with pictures and other ornaments placed around the communal areas; it had a homely feel.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. During our tour of the home we were told that care staff completed supporting people with their personal care at around 11.15am each day and then they attended to any housekeeping duties. We observed this to be the case on the day of our inspection and two care staff on duty were very busy with delivering care and housekeeping. There appeared to be very little time for staff to stop and chat with people, although staff were quick to respond to people's requests. We heard staff frequently offering help to people and comments such as, "Would you like a drink?", "Would you like a biscuit?" and "How are you feeling today?" Staff engaged with people and were laughing and smiling; it was evident they knew people well and their preferences. We asked people their views about the care staff and one person said, "Very pleasant. Everybody's very kind. We all get on well". The manager was observed to be very caring and engaged positively with people throughout the day. Another member of staff was heard to encourage one person to be as independent as possible as they supported them to walk with their frame. They said, "Come on [named person] you can do it, just a little more".

We talked with one person who had lived at the home for a couple of years. They said, "I consider myself an oddity … I was out in the garden yesterday, all wrapped up". The person said, "I love it. I like the garden and I love the house". When asked what they needed help with they explained how staff supported them and added, "One or two of the carers are not terribly good in getting me ready in time, others are better". They added, "I am very happy here. I have one or two friends who visit me and they take me to church every Sunday". Another person confirmed they were happy with the care and support they received from staff and their relative added, "I agree with him. If he's happy, I'm happy, we don't have anything to compare it to". The relative said they felt confident that they would be contacted by staff if needed and said, "Yes, if I need to be consulted I am, I try to be involved". A friend of one person was visiting the home on the day of our inspection and said, "They are very welcoming here, it's like being at home". They went on to say that the person they visited, "Always looks respectable. I can't fault this home. They have sherry before lunch if they want it. It's [referring to the home] very small and very homely and I have no concerns".

A letter of compliment from relatives was on file and read, 'All members of staff care for residents as if they were related to them personally. When visiting, we are offered tea and home-made cake which is lovely. Their attention to detail makes us feel welcome and at home'.

We asked staff how they would deal with any potential behaviour which may challenge them. One said that they did not have any concerns and explained, "Gain their trust, get to know them and get a rapport with residents. I have a good rapport, they love me".

People were supported to follow their spiritual beliefs. One person attended church with friends and people could attend Holy Communion at the home when a member of the clergy visited once a month.

We observed that people were treated with dignity and respect. We asked one member of staff how they would promote privacy and dignity and they said, "I always knock on the door. I make sure the curtains are closed", referring to when they supported people with their personal care. Another member of staff said, "We don't discuss information on other residents with other people. We just look after them and care for them, use ways that they like".

People were asked whether they wished to be involved in planning their care and signed agreements to this effect were in people's care records. One person had indicated that they did not wish to be involved in monthly reviews of their care, whilst another person recorded that they did.

Some care records contained, 'Do not attempt cardio-pulmonary resuscitation' forms (DNACPR or DNR) and these had been completed by the relevant healthcare professional who had assessed the person's health and long-term prognosis in the event that they suffered a cardiac arrest. Where these legal documents were in place, they had been completed appropriately. However, in one care file, we saw a document which stated, 'In keeping with advanced decision to refuse treatment, I do not wish to be resuscitated should the occasion arise (copy of DNR at front of care plan)'. However, there was no DNR or DNACPR form in place and no evidence to show that a healthcare professional or other relevant person had been consulted about this decision. The person's capacity to make an informed choice in relation to an advanced directive had not been assessed. The manager later removed this document from the file.

Requires improvement

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. There was a range of detailed information in people's care records relating to how they wished to receive support with their care. Before people were admitted to the home, a pre-assessment was undertaken which outlined people's needs including, in some cases, their past history and hobbies. Care plans provided information and guidance to staff about people's communication, continence, mobility, personal care and health. There was also a detailed 'care summary' which provided an overview of all aspects of the person's life so staff could see this at a glance. This was an effective working tool as the information recorded was clear, current and meaningful. The new manager had implemented this section. Risks assessments were in place, but were not consistently completed to ensure safe care and treatment was delivered. We have explored this in more detail as a breach of Regulation in the 'Safe' domain. People told us that they were given a choice about who delivered their care, for example, whether they should be attended to by male or female staff. However, in practice, this could not always have been implemented, since sometimes only female care staff were on duty.

There was a range of weekly activities for people at the home and a programme of these was printed and handed to people. The programme for November stated, 'This is your weekly activity programme. You are not obliged to participate in any activity. This is for your information only. However, if you would like to participate, then please let the care staff know in advance. If you would like a one-to-one activity, please ask one of the care staff. Christmas will soon be upon us. I am busy planning your Christmas activities. I will let you know what's happening in a couple of weeks' and was signed by the manager.

Morning activities consisted of mid-morning drinks and a chat, reminiscence session, a look at newspapers, board games and music. Afternoon activities included an afternoon drink then cards, music, Bingo, armchair exercises, knitting club, dominoes, pamper sessions, watching a film or reminiscence. Occasionally, external entertainers visited the home, for example, a Pets as Therapy (PAT) dog was popular as was a musical entertainer.

People told us the activities on offer did not always meet their needs or preferences. One person thought there was, "Not enough to do. They don't organise anything I can do". Another person said, "We play cards, draughts and Pontoon for a measly bar of chocolate!" A third person said, "Nobody's involved in activities. Sometimes we have a game of cards, but there are only two others that are really interested". On the day of our inspection, people were asked by a staff member if they wanted to play a game of cards, however, the offer was declined. It was unclear whether the activities that had been organised for people were in line with their wishes or capabilities. A residents' meeting held in March 2015 showed that activities and entertainment had been discussed, but no meeting had been held since that time to revisit people's views on this area. If people wanted to go out, then they were reliant on their friends or relatives to support them if they were unable to go out independently. Staff did support people at their healthcare appointments, but not for social outings into the community.

We recommend the provider consider how the programme of activities on offer for people is planned and delivered in a person-centred way.

We asked the provider and the manager how they dealt with complaints. The provider said that no complaints had been received in the year and the manager told us that none had been recorded since they had been in post. The provider sent us a copy of their complaints policy by email. This stated that, 'Complaints received in writing will be logged in a manual held in the office. An acknowledgement of the complaint provided within two working days and a full investigation will be carried out'. The policy went on to state that, 'Ferringham House will endeavour to resolve all complaints within 28 days'. It also stated that a complainant could contact the Care Quality Commission if a complaint was not resolved satisfactorily.

Inadequate

Is the service well-led?

Our findings

The service did not demonstrate good management or leadership. Since the provider had taken over ownership of the home and registered with the Commission in 2011, and at the time this report was written, a total of eight managers had been involved in the running of the home, including the provider for a few weeks in the summer of 2015 when no manager was in post. Some managers had registered with the Care Quality Commission, but others were only in post for a short time and did not register. It is a requirement of the provider's registration that a manager is appointed and registered with the Commission. The last manager who was registered with the Commission left in March 2015. Since that time, three people have been appointed to manage the home, but all have now left the service, the last in January 2016. In the last year, there has been a lack of consistency in the management and leadership of the service. This inspection has identified a number of breaches of regulations where improvements are required, some of which may be due to the lack of consistent leadership.

The provider did not respond to our requests for information. Before the inspection, intelligence was received by the Commission, which was sent anonymously, alleging that Disclosure and Barring Service (DBS) checks had not been completed for all new staff. DBS checks are required for all new staff before they commence employment, to ensure they are safe to work in the care profession. On 30 September 2015, we emailed the provider asking for their assurance that DBS checks had been completed for new staff before they commenced employment. No reply was received and so we sent a follow-up email to the provider on 20 October 2015, but again no response was forthcoming. At this inspection, we confirmed that the correct email address had been used for our request.

We spoke with the provider about our concerns and referred to the lack of stability that affected the consistency of the service provided and the change of managers. The provider felt that systems had not changed as a result of the high turnover of managers. We discussed the regulations and how we inspect against these under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We talked about Regulation 17 (Good Governance) and encouraged the provider to look at this Regulation which references the need for systems and processes to be established to ensure the service is operated effectively and is compliant with this Regulation. The provider responded to this, "I am a small provider, I don't need to do extra work".

We talked about the surveys that had been completed by people and their relatives, however, no actions had been recorded as a result of the points raised in the completed questionnaires to improve the service. For example, one person stated they were, 'Fed up with chicken' and a relative had asked that their family member, 'Be taken for a walk a little way down the road occasionally, to help her regain confidence in her mobility'. There was no evidence that this feedback was used to improve people's experiences. We talked about the lack of analysis of accidents and incidents and the provider arranged for a record of incidents that had occurred in November 2015 to be sent to us separately. However, there was no system in place to analyse incidents or accidents that had occurred during the year and any resultant patterns or trends had not been identified to reduce the risk of future events. The provider stated that they did not understand how other systems would help as they were so "on top".

As well as the issues recorded above, we also discussed with the provider our concerns relating to gaps in the training programme and a lack of evidence to corroborate that staff had received all essential training. The provider responded, "All I ask is that me sitting here talking to you is my governance. I am on top of things." There were no effective systems in place to measure the quality of the service or care delivered to continually evaluate the service and to drive improvement. The last quality audit undertaken was out of date and related to outcomes under previous legislation which was no longer valid. We talked about the current regulations with the manager and showed them a copy of, 'Guidance for providers on meeting the regulations' which was published in March 2015. The manager seemed unfamiliar with the new regulations and the legislation under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. They downloaded a copy from the CQC website on the day of our inspection.

We discussed our concerns relating to a lack of capacity assessments and understanding by staff about capacity. We fed back our concerns about the lack of guidance for staff within risk assessments and our concerns that staff had not received regular supervisions or appraisals and

Is the service well-led?

gaps in training. We referenced the missed medicines and the fact that there were no references in place for one member of staff. We noted that no residents' meetings had taken place since March, that there were limited activities for people and a lack of effective monitoring or systems in place for quality audits. It was clear that these areas for improvement had not been identified as part of an on-going quality monitoring process.

Staff were not supported to question practice and whistleblowers who raised concerns were not protected. The provider referred to anonymous concerns raised and received by the Commission. They dismissed the concerns as being from disgruntled staff. Although the provider stated they were "happy to discuss any complaints," they had not used this feedback to improve the quality of the service.

People were not actively involved in developing the service. The last residents' meeting was held in March 2015 during which items under discussion were activities/ entertainment, staff wearing name tags, signage on people's doors and discussions about the laundry and food. A suggestion had been made that people could have their names up on the outside of their bedroom doors and this was agreed by everyone. However, no meeting had since been held and there was no evidence to show what action points had been agreed or acted upon. People and the manager confirmed to us that no residents' meetings had been held recently.

Risks to people were not consistently assessed, recorded in care plans and managed safely. There was no recruitment monitoring system in place to ensure that all relevant checks had been undertaken for new staff before they commenced employment. (Refer to 'Safe' within this report.)

Staff were not adequately trained or supervised and staff turnover had been high. (Refer to 'Effective' within this report.) The provider's quality monitoring systems had failed to identify these areas for improvement and had not been effective in taking action to address these shortfalls.

The above evidence shows that there were inadequate systems or processes in place that operated effectively to ensure compliance with requirements. This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some audits were in place in the form of check sheets which showed that daily checks were undertaken by staff in some areas, for example, medicines, residents' bathing, cleanliness, fire check, safety check, and food checks. This ensured that these areas were reviewed and any issues could be responded to.

People were asked for their views about the home and questionnaires were circulated during the summer of 2015 when a previous manager was in post. Generally, out of ten responses received, comments were positive, although one person did not always feel their call bell was responded to quickly by staff and another person stated that they were, 'Often forgotten on drinks … and missing laundry'. In addition, they did not feel that they were encouraged to pursue hobbies or were socially stimulated.

The manager stated that they had an 'open door' policy and they were always available to talk with relatives or visitors. One person liked the manager and said, "She's beautiful, the manager, if she can stand it". The manager had been in post for only a short time and resigned their post following the inspection, in January 2016. The manager told us, "I love the residents, they're such wonderful characters. The older staff (referring to staff who had been at the home for a while) I think are fabulous. They turn up for their shifts and they're so reliable". We asked the manager about the culture of the home and they said, "There's a lovely atmosphere here. This home works well". The manager said they did not always feel supported by the provider in carrying out their role.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met: Persons employed did not receive appropriate support, training, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform. Regulation 18 (2) (a)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Risks to people were not always assessed accurately and the provider did not do all that was reasonably practicable to mitigate risks. Medicines were not always managed safely. Regulation 12 (1) (a)(b)(g)

The enforcement action we took:
Warning Notice has been issued

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The provider did not have systems or processes in place that operated effectively to ensure compliance or assess, monitor and improve the quality and safety of the services provided. Regulation 17 (1) (2)(a)(b)(e)

The enforcement action we took:
Warning Notice has been issued