HC-One Limited

Ferndale Court Nursing Home

Inspection report

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25 September 2017

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection of Ferndale Court Nursing Home on the 20 March 2017 when it was found to be meeting all the regulatory requirements which were inspected at that time.

Since our last inspection in March 2017, we received information of concern regarding the standard of care and treatment provided to people using the service and the overall management of Ferndale Court.

We therefore undertook a focussed inspection on the 25 September 2017 in response to the concerns raised.

This report only covers our findings in relation to the areas of concern. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for 'Ferndale Court Nursing Home' on our website at www.cqc.org.uk.

Ferndale Court Nursing Home is owned by HC-One Ltd (the provider) and is located in the Ditton area of Widnes, close to local shops, pubs and St. Michael's church. The home provides care for up to 58 people.

All the bedrooms are single with en-suite facilities. In addition to lounges and dining areas with drinks making facilities, there is a cinema room and a hairdressing salon. The home is divided into three units. The 'Blue bell' nursing unit is on the first floor and at the time of the inspection 27 of the 34 beds were occupied.

The ground floor 'Primrose' unit provides personal care for up to 10 people with needs related to a physical disability or frailty, and this was occupied by 10 people on the day of inspection. Also on the ground floor is 'Sunflower' unit which provides personal care for up to 13 people with needs related to dementia, and this was occupied by 13 people on the day of inspection. At the time of our inspection visit there were 50 people in total living in the home.

There was no registered manager at Ferndale Court Nursing Home. 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.

A peripatetic home manager had been assigned to oversee the management of Ferndale Court Nursing Home and was present during the day of the inspection, together with the area director.

During this inspection we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to staffing and governance.

We found that the registered provider had failed to ensure that effective systems were in place to assess,

monitor and improve the quality of the service. We also found that care plans did not always address the holistic needs of people using the service such as behavioural challenges or psychological needs or identify all relevant information such as the type of mattress to be used, the required setting or the positioning needs of people.

Furthermore, care plans and associated records were not always reviewed appropriately and some staff were therefore not clear about people's support needs. Monitoring charts viewed were also completed to a poor standard and we noted that a few charts had been recorded in advance.
Additionally, the registered person had failed to ensure that sufficient numbers of suitably qualified, competent skilled and experienced persons were being deployed effectively.

You can see what action we told the provider to take at the back of the full version of the report.

We have also made a recommendation that records relating to the application of topical creams are reviewed to ensure they provide more detailed information to staff on where and how to apply products.

Furthermore, we have recommended that all rooms are identifiable with room numbers and / or names so that staff and people using the service are able to orientate around the home and to help locate rooms.

We found that the appropriate checks had been made to ensure that prospective employees were suitable to work with vulnerable adults.

Staff also had access to training in infection control and personal protective equipment such as hand sanitisers, gloves and aprons were also in place.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Care plans did not always identify the holistic needs of people using the service and supporting documentation had not consistently been completed and reviewed to a satisfactory standard

Staffing levels were not always sufficient to ensure people received appropriate levels of care and support.

Is the service well-led?

Requires Improvement

The service was not always well led.

There was no registered manager in place and the home had not benefitted from consistent leadership and direction.

Quality assurance systems had been established so that the service could be monitored and developed. There were arrangements for people who lived in the home and their relatives to be consulted about their opinions of the service however the process was in need of review.

Ferndale Court Nursing 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 checked whether the provider was 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.

We undertook a focussed inspection of Ferndale Court Nursing Home on 25 September 2017. This inspection was completed because the Commission had received information of concern regarding the standard of care and treatment provided to people using the service and the overall management of Ferndale Court.

We inspected the service against two of the five questions we ask about services: is the service safe and is it well led? This is because the concerns we received related primarily to the safety and governance of the service.

The inspection was undertaken by two adult social care inspectors and an inspection manager. Representatives from the local authority and clinical commissioning group were also visiting the home that day and we took their views and feedback into account in the writing of this report.

Before the inspection we reviewed the information we held about the home, this included liaising with the local authority's contracts monitoring team.

During the site visit we spoke with the area director; peripatetic home manager; one nurse; one unit manager; three senior care assistants; seven care assistants; two night carers; two agency staff; an activity coordinator; a maintenance person; administrator and two visiting health care professionals. We also spoke with four people using the service and one visiting relative.

We looked at a range of records including four files belonging to people who used the service. This process is called pathway tracking and enables us to judge how well the service understand and plan to meet people's care needs and manage any risks to people's health and well-being.

Other records reviewed included: three staff files; seven daily care records; minutes of meetings; rotas; complaint and safeguarding records; medication; maintenance and a range of audit documents.

Requires Improvement

Is the service safe?

Our findings

We asked people who used the service or their representatives if they found the service provided at Ferndale Court Nursing home to be safe.

We received mixed feedback from people using the service, their representatives and staff regarding the safety of the service and staffing levels.

For example, two people using the service spoke highly of the service. Comments received included: "It's better than being in the Adelphi" and "I went into two other homes in Widnes before coming here and I like it here the best."

Conversely, we received comments from people using the service, staff, relatives and visiting health care professionals which raised concerns regarding the staffing levels and the responsiveness of the service. For example, comments received included: "If I press the call bell it all depends how many staff are on as to how quick they come"; "I don't feel there are enough staff"; "If we both have to help there is no-one on the floor"; "There are not always enough of them [staff]" and "They [staff] follow advice but there is never anyone on the unit. They are always somewhere else."

At the time of our inspection there were 50 people were being accommodated at Ferndale Court Nursing Home who required different levels of care and support.

We looked at the staffing rotas for Ferndale Court with the peripatetic manager in order to review the numbers of staff on duty. We noted that there were usually two nurses and five care staff members between 8 am and 8 pm on the nursing unit and a senior carer and three care staff members on the residential unit. At night there was one nurse and two care staff members on the nursing unit and one senior carer and two care staff on the residential unit.

The peripatetic manager was not included in these numbers. In addition to the above there were separate ancillary staff including an activity coordinator, an administrator, kitchen, cleaning and laundry staff plus the home's maintenance person.

The peripatetic manager told us that monthly dependency assessments were completed for each person using the service and that where significant changes were identified this was raised with the area director who in turn would bring the issue to the attention of a 'colleague deployment team' based in Darlington who were responsible for updating 'staffing grids' and staff deployment tools in homes operated by HC-One.

At the time of our inspection, there were vacancies for one registered nurse and two bank workers to cover any absence within the team. The peripatetic manager told us that this was a significant improvement as the home had previously been using 324 hours of agency staff. The projection for the week of our inspection was 16.5 hours.

Despite the above systems being in place, we observed that the needs of people using the service were not always being appropriately met. Direct observation, together with information received from relatives, people using the service, staff and a visiting health care professional highlighted concerns regarding the accessibility and number of staff deployed within the service.

For example, at 12:55 pm, we observed that 16 people were still in bed and it was not clear why this was. Likewise, we noted a person using the service asked a member of the inspection team at 10:10 am if they could summon the assistance of a member of staff on their behalf as they needed to access a toilet. We immediately spoke with a member of staff however it took 30 minutes before a member of staff returned to help the person.

This is a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that, sufficient numbers of suitably qualified, competent skilled and experienced persons were not being deployed effectively.

We checked if there were satisfactory arrangements in place for the management of medicines within Ferndale Court. We noted that the provider had developed a suitable policy for staff to reference on the administration of medication which included controlled drugs, the disposal and storage of medicines and for PRN (as required medications).

A list of staff responsible for administering medication, together with sample signatures was available for reference. Staff spoken with confirmed they had received medication training.

Medication was securely stored in a dedicated storage area and a daily sample of stock audits were undertaken to ensure all medication pertaining to people was routinely checked. Monthly medication audits were also undertaken to ensure oversight and scrutiny of medication within the home.

Records viewed indicated that the NHS Halton CCG Medicines Management team had viewed the medication administration records (MAR) in the home during August 2017. They found that 38 of the PRN medicines for 18 residents required attention; that four medicines had been administered differently to the prescribed directions for three residents; two medicines with 'as directed' or unclear directions required action for one resident and that three allergy statuses were not accurate on the pharmacy printed MAR (when compared with the profile sheet within the MAR folder). The peripatetic manager informed us that action had been taken in response to the issues raised.

We checked a sample of medicines and MAR and found that on the whole people were receiving their medications as prescribed. We also checked the arrangements for the storage, recording and administration of controlled drugs (drugs subject to tighter legal controls because of the risk of misuse) and found that these were satisfactory. However, we found gaps in the monitoring of the fridge and room temperatures and that the recording of the application of topical creams needed strengthening as the instructions were vague.

We recommend that records relating to the application of topical creams are reviewed to ensure they provide detailed information to staff on where and how to apply products.

We looked at the personal files of seven people who were living at Ferndale Court. We noted that each person had a range of care plans together with supporting documentation which included a range of risk assessments. Personal emergency evacuation plans were also in place to ensure an appropriate response in the event of a fire.

Despite the above information being in place, we found these were not sufficiently detailed. For example, care plans did not always address the holistic needs of people using the service such as behavioural challenges or psychological needs or identify all relevant information such as the type of mattress to be used, the required setting or the positioning needs of people.

Furthermore, care plans and associated records were not always reviewed appropriately and some staff were therefore not clear about people's support needs. Monitoring charts viewed were also completed to a very poor standard and we noted that a few charts had been recorded in advance. Additionally, we observed that 16 people were still in bed after mid-day and it was not clear why these people were still in bed.

This is a breach of Regulation 17 (1) and (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that, the registered person had failed to maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user.

We also noted that a number of rooms within Ferndale Court had no names or numbers on the doors. This does not help people to identify their rooms easily and is potentially unsafe practice for agency staff that do not know the residents' needs as well as experienced staff. The absence of this information may also place people at risk in the event of an emergency.

We recommend that all rooms are identifiable with room numbers and / or names so that staff and people using the service are able to orientate around the home and to help locate rooms.

Records of any accidents and incidents had been recorded for each individual. The provider continued to use an electronic database known as 'datix' to capture information such as accidents and incidents, complaints, safeguarding incidents and slips, trips or falls. This system enabled management information reports to be generated for analysis and review so that any recurring trends such as incidents by category; locations; time bands; level of harm and severity of issue could be identified and linked to people using the service.

We saw that there was plenty of specialist equipment available to meet people's needs, including hoists, airflow mattresses and cushions to reduce the likelihood of pressure ulcers.

The provider had also developed a comprehensive range of policies and procedures to ensure safe working practices. There was an emergency contingency plan in place if the home had to be evacuated in an emergency, such as a fire. People living in the home had Personal Emergency Evacuation Plans [PEEPS] within their care plan. These provided details of any special circumstances affecting the person, for example if they were a wheelchair user. There was an on call system in place in case of emergencies outside of office hours and at weekends. This meant that any issues that arose could be dealt with appropriately.

We looked at the personnel files of three staff members to check that effective recruitment procedures had been completed. In all of the files we found that the appropriate checks had been made to ensure that prospective employees were suitable to work with vulnerable adults. Checks had been completed by the Disclosure and Barring Service (DBS). This check aims to help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Files also contained application forms, interview notes, references and proofs of identity including photographs. All the staff files we reviewed provided evidence that the checks had been completed before people were employed to work at Ferndale Court. A system was in place for checking monthly that the

registration of any nurses working in the home was maintained. (Registered nurses in any care setting cannot practice unless their registration is up to date.)

A corporate safeguarding policy and procedure had been developed by the provider to ensure that any concerns that arose were dealt with openly and people were protected from potential harm. The staff working in the home were aware of the relevant process to follow and how to raise concerns if they had suspicion or evidence of abuse.

A copy of the local authority's adult protection procedure was also available for staff to reference. Staff members confirmed that they had received training in protecting vulnerable adults. Staff members were familiar with the term 'whistleblowing'. (Whistleblowing is an option if a member of staff thinks there is something wrong at work but does not believe that the right action is being taken to put it right.) This indicated that staff were aware of their roles and responsibilities regarding the protection of vulnerable adults and the need to report potential incidents of concern.

We looked at the electronic safeguarding records for the service. The safeguarding log highlighted that there had been 23 safeguarding incidents recorded in the last 12 months. Records viewed confirmed that safeguarding incidents had been referred to the local authority safeguarding team in accordance with local policies and procedures. No whistle blower concerns had been received by the Care Quality Commission (CQC) in the past twelve months.

Prior to our inspection, Halton Borough Council's Quality Assurance Team provided CQC with information on safeguarding incidents with Ferndale Court from December 2017 to June 2017. Records highlighted a number of issues regarding the standard of care provided to people using the service, some of which were also identified during this inspection such as the completion and review of care plans and associated records.

The provider had developed policies and procedures on infection control to provide guidance to staff on how to manage and monitor the prevention and control of infection. Staff also had access to training in infection control and personal protective equipment such as hand sanitisers, gloves and aprons were also in place.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection, Ferndale Court did not have a registered manager in place. A peripatetic manager remained in day-to-day charge of the home that had been based at Ferndale Court since July 2017.

At our last inspection, we noted that there had been at least five managers working in the home in the last three years and there had been a number of changes in the registered provider's area management arrangements.

We were introduced to a new area director during our inspection who had attended at short notice to provide support to the management team. The area director informed us that a new manager had been appointed to manage the home that was due to start working at Ferndale Court in November 2017 upon completion of a two-week induction.

The management team were helpful and supportive to the inspection team during our inspection. Likewise, the management team and senior staff were observed to be attentive, caring and helpful in their interactions with staff and people using the service.

Staff spoken with during the inspection told us that they knew who the peripatetic manager was and that she had a visible presence in Ferndale Court. We were informed that the peripatetic manager undertook daily 'home manager walk rounds' to maintain an overview of the service and observed senior staff handing over key information to staff during shift changes.

The provider (HC-One Limited) had developed a 'Quality Assurance Policy and Framework'. The quality assurance framework had four tiers of interrelated processes which included: a home based system known as 'Cornerstones'; a regional support team quality assurance process; quality assurance process following external scrutiny and a quality assurance overview by the provider. The policy indicated that surveys of key groups were an essential part of the quality assurance framework.

Another element of Cornerstones was the on-going monitoring of the home via the company's computerised monitoring system called datix. Key clinical indicators such as pressure ulcers, weight loss, infections, hospital admissions, falls and deaths were routinely monitored monthly.

We looked at a number of records relating to the provider's quality assurance policy and framework and noted that the completion of 'area director home visit reports' was slightly behind schedule due to the post being vacant for a period of time. We received assurance from the new area director that he would take action to ensure that these audits were completed in the future to ensure the home is monitored, performance appraised and reviewed and necessary improvements were made.

We saw that a representative from the provider's service quality inspection team had undertaken a recent 'cornerstone audit' and a 'cornerstone plus inspection tool'. The home had not scored well in certain areas and an action plan had been developed to improve performance across all areas assessed.

We were informed by the peripatetic managed that Ferndale Court had been placed on a 'project plan' which is developed when a home within HC-One Ltd has significant issues.

A 'home level audit' calendar was in place which outlined the frequency of audits to be undertaken throughout the year. We saw that a range of audits were undertaken throughout the year for topics such as medicines; care files audits; infection control; catering; falls and health and safety. However, we saw that the most recent infection control audit provided to the inspection team was incorrectly dated and the scores had not been completed. The previous version dated 24/07/2017 highlighted an overall score of 72%. We also noted that care plans viewed showed no evidence of service user involvement, capacity assessments, best interest decision making processes or deprivation of liberty safeguards and these shortfalls had not been identified via the audit processes in operation.

We asked to view all surveys and feedback received from people using the service and their representatives in the last 12 months. The peripatetic home manager told us that surveys were distributed during June 2017 and provided us with four reports. Three were for feedback from relatives and their comments and one was for feedback from residents. The findings of the survey were displayed on the noticeboard in reception together with actions that the service intended to take to address any issues raised.

The feedback results indicated that only nine relatives and one resident had completed the surveys which contained questions relating to: the overall impression of the care home; environment; lifestyle; décor and maintenance; staffing; dignity and respect; complaints and management and communication. The responses were ranked into four areas - outstanding, good, requires improvement and inadequate.

Given that Ferndale Court is registered to accommodate up to 58 people with a diverse range of needs, the response rate was poor for each survey type. Consequently, this information did not enable the provider to obtain a detailed picture of satisfaction levels within the home. An action plan was in place for the feedback received from relatives.

The feedback received from relatives indicated that people had raised concerns regarding the number of staff on duty; visibility of management and staff; the temperature of food; missing personal belongings and the condition of some windows and carpets. An action plan was in plan to address the concerns. Positive comments regarding the standard of care provided was also received by the provider.

We raised concern about the effectiveness of this system with the peripatetic manager as the response rate was very low.

This is a breach of Regulation 17(1) and 17(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in that, although there were systems in place for assessing and monitoring the service to improve quality, these were not being operated effectively.

We met with the maintenance person and sampled a number of test and / or maintenance records for Ferndale Court relating to: electrical wiring; gas safety; hoisting equipment and slings; portable appliances; fire alarm system; fire extinguishers and passenger lifts. Evidence of recent servicing for the passenger lift, hoists and slings and the fire extinguishers could not be located. We were provided with evidence that attempts had been made to contact a contractor to service the fire extinguishers prior to and during our inspection.

Systems were also in place to record, monitor and act upon any complaints received. Complaint records viewed indicated that there had been eight complaints in the past 12 months. Issues raised covered a range

of areas such as: the standard of personal care provided; management of medicines; missing belongings; cleanliness of the environment and management presence.

People could also provide feedback through carehome.co.uk. We looked at the website and saw that there had been six reviews of the home in the last year, all of which were generally positive and everyone said they would be either likely or extremely likely to recommend the home. One person rated the management of the home as poor.

Staff, resident and relative meetings were also coordinated periodically in addition to service reviews with people using the service.

Prior to our inspection, the local authority shared with us a number of concerns regarding the standard of service provided at Ferndale Court. The concerns covered a range of areas such as: governance and staff culture; care quality; records management; rotas and staffing; medicines management; meal time experience and environmental safety. Further information on our findings is recorded in the safe domain of this report.

The registered person is required to notify the CQC of certain significant events that occurred in Ferndale Court. We noted that the peripatetic manager had kept a record of these notifications. Where the Commission had been notified of safeguarding concerns we were satisfied that the appropriate action had been taken.

Information on Ferndale Court had been produced in the form of a Statement of Purpose and an information brochure to provide people using the service and their representatives with key information on the service. The information was on display in the reception area of the home for people to view.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered provider had failed to ensure that effective systems were in place to assess, monitor and improve the quality of the service. Furthermore, the registered person had failed to maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to the service user.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing The registered person had failed to ensure that sufficient numbers of suitably qualified, competent skilled and experienced persons were being deployed effectively.