

HC-One Limited

Ferndale Court Nursing Home

Inspection report

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Date of inspection visit:
27 September 2018
28 September 2018
02 October 2018

Date of publication:
22 November 2018

Ratings

Overall rating for this service	Inadequate ●
Is the service safe?	Inadequate ●
Is the service effective?	Inadequate ●
Is the service caring?	Inadequate ●
Is the service responsive?	Inadequate ●
Is the service well-led?	Inadequate ●

Summary of findings

Overall summary

This full comprehensive inspection took place on 27 and 28 September 2018 and 2 October 2018. The previous inspection took place on 25 September 2017. The inspection was a focused inspection to check if the service was safe and well-led. We found breaches of Regulations 18 Staffing and 17 Governance of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve and meet the breaches in Regulations 18 Staffing and 17 Governance of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

The provider's action plan had all actions signed off by the previous registered manager dated 21 December 2017. This meant that the provider confirmed to us in their action plan that they would have completed all their actions to meet the legal requirements of Regulations of 18 Staffing and 17 Governance of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014 by 21 December 2017.

On this inspection we found the provider had not ensured that sufficient numbers of suitably qualified, competent skilled and experienced persons were being deployed effectively. The registered provider had also failed to ensure that their systems were being implemented or followed effectively 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 complete record of complaints.

We found the provider had not met their legal responsibility to meet the breaches from the last inspection namely, Regulation 17 Governance and Regulation 18 Staffing of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014 by 21 December 2017. This was due to the provider's governance systems not being effective in ensuring continuous improvements were being made or sustained. Staffing numbers/deployment of staff was having an impact on the care delivery for people living at the home. In addition to these continued breaches of the regulations we also found the provider was in breach of Regulation 9, 10, 11, 12, 13, 14, 15 and 16 on this inspection.

You can see what action we told the provider to take at the back of the full version of the report. Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Ferndale Court Nursing Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The care home provided care and treatment for up to a maximum of 58 people. Ferndale Court Nursing Home has two floors with a passenger lift up to the first floor. People living at the home required nursing or

residential care. There were people receiving care who were living with dementia.

A registered manager who was present during our inspection had registered with us on 10 May 2018. 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 service was not always ensuring people received a safe level of care. Staffing numbers/deployment of staff was not effective in always meeting people's care needs. For example, we observed one person had not had personal care in a timely manner.

People's dignity was not always being upheld with a mixed approach observed by staff. Some staff were heard speaking over people whilst rushing the care being delivered. One warm, positive, interaction was observed between staff and a person living at the home.

People were not always receiving enough to eat and drink which we viewed in the records and from our own observations.

Only one person was receiving End of life care at the time of our inspection. We found they were not receiving person centred care which was taking into account their wishes or preferences.

We had concerns regarding the cleanliness of the first floor within the home and regarding repairs not being actioned in a timely manner. The provider took action and by the third day of the inspection the home smelt fresher and actions were taken to make repairs as quickly as possible.

The staff we spoke with told us they wanted to deliver person centred care but they were unable to due to the increasing high dependency needs of people and because there was not enough staff. We observed task led care being provided on this inspection.

We observed unsafe moving and handling techniques used by staff on this inspection. We found 20 staff's training in moving and handling had expired.

Staff were not receiving regular supervision or appraisals. We found staff had received an induction.

The service had a Mental Capacity Act 2005 policy in place however, we found there was no Mental Capacity Act 2005 framework in place within the records for people who lacked capacity or who had fluctuating capacity to be supported in making decisions.

Not all appropriate Deprivation of Liberty authorisation applications had been sent to the local authority. We also found there were a high number of statutory notifications not sent to the Care Quality Commission which is a legal requirement.

The provider's own safeguarding system was not being followed consistently to always ensure people were being protected from alleged abuse. For example, we observed unexplained bruising/marks which had not been recorded or reported to the safeguarding authority. We found 21 staff's safeguarding training had expired. The provider responded to our concerns immediately. They checked everyone living at the home and completed a body map.

We found there were complaints being made within the home with no record of the actions being taken by the registered manager.

There were not enough activities for people within the home and people were not being provided with enough stimulation. The design of the premises and the building's interior was not providing a homely environment for people.

There were quality audits being completed within the home by the registered manager and the provider, however, they were not effective in ensuring actions were completed to ensure improvements were being made.

During the inspection we found medicines were being managed and stored appropriately however, we were provided with notifications following the inspection informing us of some medication errors highlighted to them by a visiting nurse. The provider confirmed to us how they were dealing with these errors.

Recruitment files we checked demonstrated robust practices including Disclosure Barring Service (DBS) checks being undertaken.

Advocacy services were in place within the home. Relatives meetings were being undertaken alongside the local authority.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration. For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

The provider's own safeguarding system was not being followed.

Sections of the home were dirty and had a strong malodour.

Not enough staff were deployed to always provide people with the care, stimulation and interaction they needed.

Inadequate ●

Is the service effective?

The service was not effective.

Mandatory staff training had expired and staff were not receiving regular supervisions/appraisals.

The service was not working within the Mental Capacity Act 2005 Framework.

People were not always receiving enough to eat and drink.

Inadequate ●

Is the service caring?

The service was not caring.

Staff approaches/attitudes towards people were mixed.

People's dignity and independence was not always upheld.

Advocacy services were being provided within the home.

Inadequate ●

Is the service responsive?

The service was not responsive.

The End of Life Care was not person centred.

People were not receiving enough activities to provide enough stimulation and interaction.

The complaints system was not robust.

Inadequate ●

Is the service well-led?

The service was not well-led.

The governance systems were not effective.

Where quality audits being undertaken had highlighted concerns, actions were not always being recorded.

Not all the concerns we found on this inspection were being identified through the registered manager's quality checks we viewed.

Inadequate ●

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 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 was brought forward in part due to the Commission receiving information of concern amounting to allegations of neglect. The specific allegations of neglect were being investigated by the local authority and an allegation of serious assault was referred onto the police. The information shared with the Commission indicated potential concerns about the management of alleged safeguarding concerns occurring at the location which were risks examined on this inspection.

This unannounced inspection took place on 27 and 28 September 2018 and 2 October 2018. The inspection team consisted of two adult social care inspectors, an expert by experience and a specialist nurse advisor on the first day, one adult social care inspector on the second and third day of our inspection. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we gathered as much information as possible about the service including the last provider information return sent to us on 3 March 2015. We had not asked the provider to send us one since then.

During this inspection, we spoke with 12 people living at the home, 16 staff including the managers, 9 relatives/visitors and one healthcare professional visiting the home. We undertook observations, pathway tracked 3 people which involved viewing all their records, looked at 10 care plans and completed a short observational framework (SOFI) for inspection. This is a method we use to assess people's care who are unable to converse with us. We liaised with the local authority and commissioners of the service prior,

during and following the inspection.

Is the service safe?

Our findings

On the last inspection on 25 September 2017 the domain Safe was rated Requires Improvement. This was due to a breach of Regulation 18 Staffing of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014 due to not enough skilled and competent staff being deployed effectively. On this inspection we found the provider had not met the legal requirement to meet this breach. The provider remained in breach of Regulation 18 Staffing of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

We asked people if they felt safe and reviewed the systems in the home to check if they were keeping people safe. One person told us, "There isn't enough staff, they are too busy." A second person said, "I have to wait for the toilet. It was 7.15pm. I was left on the toilet for 2.5hours. I was buzzing and buzzing. It was 8.40pm when they came to get me. The staff who went off at 8pm, didn't tell the staff who were coming on", and a third person we spoke with said, "I know staff come in at night to check on me."

We checked staffing levels on this inspection, viewed the rotas, call bell response times and the dependency tool. The staffing levels reduced in the afternoons from 2pm. There were six care staff reducing to five as of 2pm on the first-floor nursing unit where there were 33 people needing care. On the ground floor there were 21 people needing care with two senior carers and three care staff dropping down to two senior carers and two care staff at 2pm. We completed a short observational framework for inspection (SOFI) and spoke with staff about whether there were enough staff to meet people's care needs. The staff we spoke with raised concerns the staffing numbers were not always meeting people's needs. They informed us staff on the first floor were frequently deployed to the ground floor or staff went to accompany people for appointments leaving less staff to deliver care within the home. During our inspection we observed a person who required 24-hour nursing care had not had all their personal care needs met by the afternoon due to there not being enough staff on the nursing unit that morning. Another person's records stated they had not received their hourly welfare checks as stated in their care file.

We found the print out response times for call bell response times were being calculated in seconds and not minutes which the provider had been aware of. The call bell response times were deemed unreliable as some response times seen were for a significant number of hours with one at 24 hours and another at 42 hours. However, we could not exclude the possibility some response times may have been accurate as we viewed some which were 2.5 hours, 1.5 hours and people had reported waiting this long for staff to respond. The registered manager told us they had an issue with staffing within the home regarding the use of agency staff. They were finding agency staff were either not arriving when scheduled to or the agency were sending a different staff member to who was named on the rota. The SOFI had been undertaken within a communal lounge for a period of 35 minutes and we found there had been no staff interactions with people in the lounge for the duration of our observation. We raised concern there were not enough skilled, experienced staff on duty to provider people with the care, stimulation and interaction they needed to maintain their health and wellbeing.

This is a Breach of Regulation 18 Staffing of the Health and Social Care Act Regulations 2008 (Regulated

Activities) 2014.

We looked into whether the care being delivered and systems in place were safe for people. Risks were being identified and were viewed within the care plans we checked, such as choking, malnutrition, pressure areas, mobility and personal emergency evacuation risk assessments. However, not all risks were being managed safely.

On the first day of our inspection we raised concern with the provider we had observed one person being "drag" lifted, a technique which posed high risks for the person. We raised this with the provider and registered manager and asked for a safeguarding concern be sent to the safeguarding authority. When we returned to the home we were informed by a staff member they were continuing to support the person in this way, demonstrating the registered manager and provider were not learning from incidents. We found there was a system in place to report and record incidents but not all had been notified appropriately with no evidence of learning taking place from the incidents. Staff had not been advised they were supporting someone in an unsafe manner which could hurt or injure them.

This is a Breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

The registered manager and provider had not followed their own safeguarding system. We raised concern regarding one person who had visible marks on their skin which had not been recorded in their records or 'body mapped'. The person could not recall when the bruises had appeared or why. Despite this, the provider had not requested a general practitioner to assess the marks and they had not ensured there was a clear contemporaneous record to explain when the marks first appeared. We expect the provider to follow the safeguarding policy and record/body map all marks and report all unexplained bruising to the Safeguarding Authority. This had not been actioned by the registered manager/provider. We found a second person who told us they had been pulled by a staff member resulting in a dressing being applied on their arm/bruise. Upon checking the person's records, we found no record of the marks/bruise in the person's care records to explain when they appeared. The provider acted immediately upon us raising concerns with them. They confirmed they checked all existing body maps and completed a body map for everyone within the home during the inspection.

This is a Breach of Regulation 13 Safeguarding People from Abuse and Improper Treatment of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

We undertook a tour of the home on the first day of our inspection and found a strong malodorous smell on the first floor nursing unit. We observed domestic staff were in the home cleaning during our inspection. The equipment seen, such as wheelchairs, were dirty and areas of the dining room such as worksurfaces/cupboards had tea stains on them and were sticky when touched. There was stagnant stained water in the communal dining room sink with a plastic beaker, cutlery and other dishes in the water. We observed a mouth swab had been left on one person's cabinet at the side of their bed and their toothbrush inside dirty water. The waste bins we viewed had pieces of card placed inside one bin for contaminated waste products and another bin was observed not to have any bin liner in place. Another person's room had an odour with a dry incontinence pad seen left on the floor in their bedroom. The sluice room on the nursing unit had no aprons in the apron dispenser and an en-suite bathroom had no soap in the soap dispenser.

Staff were seen delivering care without the appropriate personal protective equipment and one staff member on duty was not wearing a uniform. This means the standard of cleanliness and poor practices were placing people at risk of issues related to infection control. The provider took immediate action and

the cleanliness had improved when we returned.

This is a further Breach of Regulation 12 Safe Care and Treatment of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

The premises were not always being maintained adequately. We found a hole in one person's ceiling following a leak which had been repaired. The person who was living with dementia told us they had not slept for fear of what may come out of the hole in their ceiling. There were other concerns related to the premises such as a toilet/bathroom door which did not lock as the lock needed repairing. The maintenance staff member told us they were aware of the faulty lock. Despite them knowing about it they had not actioned ordering/purchasing a new lock. Upon checking a call bell we found it did not activate. We asked the provider to assess this and they found the wires had come loose. This was repaired immediately on the inspection. We asked the provider to repair all the issues we found in relation to the premises and they actioned them immediately. However, if not for the inspection, these issues had not been escalated within the home appropriately to ensure the provider was doing all that was reasonably practicable to ensure the premises was of a good standard for people. The maintenance system within the home was not robust enough to ensure all repairs were recorded and checked to ensure they were being completed.

This is a Breach of Regulation 15 Premises and Equipment of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

The medicines management systems and practices were checked during this inspection. Medicines which required to be stored in fridges had daily temperature checks seen recorded. Fridges were clean, tidy and appropriately stocked. Opening dates were clearly displayed on specific boxes of prescribed medications. We found all medicines stocked were stored correctly or were within date. Oxygen warning signs were visible on clinic room door. However, the oxygen signs on bedroom doors where people were being administered oxygen were pieces of paper sellotaped on the door which were at risk of being torn.

We checked the controlled drugs prescribed for people. Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines or controlled drugs. The Controlled Drugs register had been appropriately signed and a random sample of stock checked was correct in accordance with the register. The medicine administration records had personal photographs identifying the appropriate person. The medication administration records (MARS) we viewed had been completed appropriately. We viewed there were pro ra nata (as and when) prescribed medicines being administered with protocols in place. We also observed a medication round and found the nurse followed appropriate protocols to administer prescribed medicines.

We checked recruitment practices and found the three staff files we looked in had a Disclosure Barring Service (DBS) check in place. This is a check to ensure the provider is aware of any previous convictions prior to a staff member starting to work within the home. The provider had undertaken a risk assessment for one staff member's previous conviction. This meant we could see the provider had considered if the staff member was a risk to vulnerable people. All three staff files contained an interview document and appropriate references.

Is the service effective?

Our findings

We asked people if they were provided with choices. One person told us, - "There is a choice, you are asked when it (meaning food) comes. Another person said, "I like my cup of tea in my china cup. They keep giving it to me in a plastic baby cup. I hate it, I won't drink it." A third person we asked told us, "No I don't choose really, no one listens."

We looked into the system of obtaining lawful consent. 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

The care plans we viewed for people who lacked mental capacity or who had fluctuating capacity had no Mental Capacity 2005 framework. This meant we could not see a system in place in people's care plans where the provider was recording consent had been sought. There was also no confirmation of the person's difficulties in providing consent with details who may be best to support them in making difficult decisions. This is referred to as best interests' processes which is a legal requirement under the Mental Capacity Act 2005. We viewed the provider's DoLS tracker and found there were gaps where it was not clear if the provider had renewed the DoLS or not. We asked the provider to take action which they did immediately on the inspection. The provider undertook an audit which highlighted specific gaps where the Mental Capacity Act 2005 legislation had not been followed appropriately such as in relation to consent and the use of bedrails.

This is a Breach of Regulation 11 Consent of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

Staff were receiving an induction including shadow shifts. We checked staff training by viewing training records in staff files and the training matrix. We raised concern with the registered manager and provider that not all staff training was in date. There were a significant amount of staff whose training in moving and handling, dignity and safeguarding had expired. For example, there were 21 staff who were not compliant in safeguarding training and 20 staff who were not compliant with moving and handling training. We found competency checks in administering medicines were being recorded. We found no other areas of competency were being recorded. This means the provider was not following a system of checking if staff had understood their training to ensure effective practices were being followed. We checked how much support staff were receiving by way of supervision. Of the three staff members we spoke with, one had not heard of supervision, the second said had not had supervision at all and the third said they could not recall the last time they had supervision. When we asked for the supervision matrix/log for 2017 we were told by the registered manager there was no record/matrix for 2017. We viewed a supervision matrix for 2018 which

evidenced two group supervisions had been undertaken, one in January 2018 and the second on 11 May 2018. Only two staff had received a one to one supervision since the last inspection in September 2017.

This is a Breach of Regulation 18 Staffing of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

We observed the lunch time experience for people and looked at how people were being supported to eat and drink. The dining room experience was rushed with staff seen delivering task orientated care to ensure they were serving people's food as quickly as possible. We viewed the charts in people's rooms which were being completed by staff to record how much the person had eaten or had to drink in a 24-hour period. One person's records illustrated they had not had anything to eat or drink since 8.30am when we checked them at 1.45pm.

We also received concerning information from relatives and the local authority during our inspection raising concern people were not having enough to eat and drink. These concerns were being investigated by the Local Authority. The choice being offered for lunch was soup or sandwiches. We observed people's food and drinks were not always within reach. Records we viewed confirmed people were not being offered snacks after their tea time meal at around 5pm. The registered manager confirmed food was not offered after the tea time meal and supper was not being offered. For people who needed support to eat and drink they were not supported enough to provide them with the maximum opportunity for them to have their nutritional needs met. We observed food and drinks for two people, who needed support to eat and drink had been left on their table. One person's food was served at 12.46pm which consisted of sandwiches, a cup of tea and a supplement drink. At 1.16pm their sandwiches were taken away, the cup of tea still there which was now cold. Another person's soup and sandwiches were served at 12.46pm but 30 minutes later they were still there; the soup was cold. We were therefore, concerned people were not being provided with the optimum opportunity of having enough nutrition or fluids to always maintain their health.

This is a Breach of Regulation 14 Meeting Nutritional and Hydration Needs of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

The interior of the home had sections which had been decorated in a way which was stimulating and creative for people such as the home's cinema room. This room was open for anyone to enter with seating and a screen to replicate a cinema/films room. However, this was not seen used for that purpose during our inspection. There were some bedrooms which had personalised plaques on the doors with one person's favourite football team next to their name, other bedroom doors were bare as were some bedroom walls. The dining room did not have a homely appearance with a sign on the wall stating, "Respect Our Staff". We asked the registered manager to remove these signs which were also along corridors within the home as it created a working environment and not a homely environment.

Healthcare professionals were visiting people living at Ferndale Court and people were being supported to access their healthcare appointments. We viewed in the records there had been visits from speech and language therapists, general practitioner's, social workers and other health and local authority services.

Is the service caring?

Our findings

People who were able to speak with us were asked for their views about how they were being cared for. One person said, "Staff are ok, it depends on who is on." A second person said, "I like staff, some are nicer than others" and a third person told us, "I have a pad on in the night. Staff check through the night to see if it is dry. I don't need a pad. I'm not incontinent, I don't need one. My daughter has told them but they still put it on". A fourth person told us, "Sometimes I'm in pain in the night. I ask for pain relief. Some staff shout at me, it is a while ago now, it has got better". A fifth person told us "The (description of job role) who works here is very nice, they look after me more than the care staff", A sixth person told us "all staff speak to me in kind way". Another person who we approached said - "They won't want you to talk to me, they will not like it".

Our observations of interactions between staff and people living at the home were mixed, with some positive interactions seen and some negative interactions. For example, we observed one staff member raising their voice so a staff member could hear them from across the room, across people eating their lunch. A positive interaction was seen between a person living at the home who placed their arms out to a staff member who reciprocated and hugged them.

We found some people appeared unkempt in their appearance such as with dirty long finger nails, clothing with breakfast food on them in the afternoon and another person who had not been supported to have a wash or had their hair brushed. Some people's bed linen was stained and was not always fitted appropriately. One person who had a pressure mattress had only a valence sheet over the mattress which had not been fitted. Another person had important certificates on their wall, one of which they said was missing as a staff member had knocked it off their wall in their bedroom some weeks previously. The glass within the frame had broken. This had not been replaced to ensure the certificate was secured back in place on the wall. We were therefore, concerned people's dignity and respect for people's belongings was not always being upheld. People's human rights were not always being upheld or adhered to as their basic care needs were not always being met.

There were signs around the home stating, "Keep Calm and Respect Our Staff" which were not promoting the dignity of the people living at Ferndale Court. The signs were not respecting people's right to Ferndale Court being their home and not a work place where staff were imposing how they wished people to behave. The registered manager agreed with this and removed them on the inspection.

This is a Breach of Regulation 10 Dignity and Respect of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

We observed during the inspection the care delivery was task orientated. We observed staff were constantly moving from one person to another with limited opportunity for staff to spend time speaking to people. When we raised this with staff, they confirmed they wished to spend time talking with people. They were concerned some people who needed social interaction were not having their needs met. We were therefore, concerned people were not being provided with enough opportunities to speak with staff to have their views heard or to have their emotional needs met. All staff we spoke with explained this was due to them not

having the time. The provider was not promoting a caring approach to care delivery where staff had time to spend with people and listen to people.

Advocacy services were being provided within the home. However, as people's ability to make decisions was not being recorded, there may have been people who required advocacy within the home who have not been recognised as needing advocacy services.

Is the service responsive?

Our findings

We looked at how people were cared for and if care was person-centred according to people's wishes, likes and dislikes. One person told us, "Each day is different. This morning I was got up at 8.30am. Other days it can be 12pm. A second person told us, "I like my cup of tea in my china cup. They keep giving it to me in a plastic baby cup. I hate it, I won't drink it," and a third person told us, "I get up when staff get to me up". A family member had placed a note on a person's person door stating - "My Mum needs to get up at 9am. It is not good for her to stay in bed for a long time".

Another relative had placed a list on another person's door of things which were important for the person to receive person centred care. They had arranged for a privately employed carer to come into the home for a set number of hours each day due to their concerns the person was not receiving care when they needed it.

We raised concern person centred care was not being provided for people according to their care needs, preferences and wishes. One person's food and fluid charts had been discontinued on 18 September 2018. When we raised this with the provider they acknowledged the person did need their food and fluid intake monitoring and this monitoring would be put back into place immediately.

We found where people's wishes were known, they were not always being adhered to in a person-centred manner. For example, one person told us how they preferred not to receive personal care from a male carer and preferred female care staff to support them. The person told us their wishes were taken seriously and they no longer received male carers but a sign had been placed on the bedroom door for all staff to see. This meant the provider had taken notice of what the person's preference was but they had not implemented it in a way the person was comfortable with.

Ferndale Court Nursing Home were providing end of life care for people at the time of our inspection. We viewed an end of life care plan for one person and found their oral care plan had not been implemented from their admission into the home and was implemented some weeks later. This meant staff following their care plan would not have known to provide oral care. The end of life care plan did not confirm any wishes in relation to how the person wished to receive their care approaching the end of their life. Staff we spoke with confirmed the person was fearful as they had awareness they were approaching the end of their life. However, we could not see the person's emotional or psychological needs being assessed with consideration to referrals for support for them.

This is a Breach of Regulation 9 Person Centred Care of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

We looked at whether there were enough activities and stimulation for people and found there was not enough stimulation or activities for their health and wellbeing. One person who could converse with us said, "There isn't much to do". There was an activities coordinator for the home but the range of activities being offered were not meeting the needs of all the people living at Ferndale Court Nursing Home. For example, we found people who were living with dementia were spending a considerable amount of time alone with

no stimulation. The activities we did observe included the priest conducting a service in the lounge for people who wanted to join in and an activity coordinator doing a session on remembering films and music tracks. We also observed a coffee morning to raise money for a local charity.

We asked people if they had needed to make a complaint. One person told us, "There is no point complaining, no one listens, nothing gets done." A relative told us, "The care is poor. I have made numerous complaints it's no use. Nothing changes". We looked into the complaints system and found not all complaints received had been dealt with appropriately. The complaints system had not been followed with a contemporaneous record of all communications with the complainant, record of meetings and outcomes. We found some complaints which the registered manager was aware of were safeguarding concerns which had not been reported to the local authority.

This is a Breach of Regulation 16 Complaints of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

Is the service well-led?

Our findings

The governance arrangements at the home were that the provider's Area Director and an Area Quality Director were having input into the home at the time of our inspection to support the registered manager to improve the standards of care within the home.

The quality audits we viewed had identified concerns within the home but we could not always see actions when concerns were found. For example, we viewed one out of hours quality check undertaken on 2 May 2018 which stated "(initials of person) Residential unit – fingernails long and dirty", "upstairs nurse station door open – confidential information available". There were no actions seen from these concerns and we found evidence of these issues and concerns continuing during our inspection. This meant the audits being completed were in isolation as there was no evidence of a further detailed action plan detailing what actions were taken to resolve the concerns found to drive continuous improvements across the home. When we made a comparison of the registered managers own quality checks and those of the Area Director's checks we found a disconnect between the two, with no evidence the concerns being highlighted were being worked on within a joint plan.

The provider's own internal inspection report we viewed dated 11 April 2018 confirmed the provider was aware the registered manager had not reported all safeguarding concerns appropriately. An example of this which we viewed in the internal inspection report described how there had been a serious choking incident that had required abdominal thrusts to be performed. The incident had not been recorded as an incident and there was no evidence of a safeguarding referral. Therefore, the provider was aware in April 2018 there were concerns regarding the safeguarding system not being followed by the registered manager. We would have expected the provider to then take action to ensure there was oversight and supervision of the registered manager and support provided to ensure they were always following the safeguarding system and policy. We found the provider was also aware there were staff who's training was not up to date however, we found the provider had also not taken action quickly enough to address this concern. There were 21 staff who were not up to date with safeguarding training at the time of this inspection.

On this inspection we found evidence staff were not always following safe practices in relation to Safeguarding and moving and handling which were placing people at risk of abuse or harm. We found no record of one person's bruise and mark on their arm which they told us had been due to a staff member handling them roughly. We also found no body map or record of another person's marks on their arms to confirm when they had appeared, size of the marks and position of them to monitor their skin changes. If not for this inspection and our request for a medical assessment of the marks, the provider had not taken action to either seek medical advice as to what may be the cause of the marks or recorded them.

As our inspection was undertaken approximately, 5 months following the internal inspection carried out by the registered provider, the Commission remain concerned the governance arrangements and leadership of the home was not effective enough to drive improvement and put timely actions in place to ensure everyone living at the home were not being placed at risk of harm.

This is a Breach of Regulation 17 Governance of the Health and Social Care Act Regulations 2008 (Regulated Activities) 2014.

We viewed monthly home visit reports were being undertaken by the provider such as the report dated 27 July 2018 which detailed the same issues as reported in May 2018. For example, it stated "resident's files stored in nurses' stations but doors propped open", "fingernails needed attention". We could therefore, see the same concerns being noted with no actions listed to confirm what was being done about the concerns found and who was taking responsibility for dealing with the concern with a time in which the concern would be addressed by.

We viewed the incidents, accidents and safeguarding files on this inspection and found evidence there were concerns of incidents/events within each file which had not been dealt with appropriately. For example, we found examples of incidents which were safeguarding concerns which had not been reported to the Safeguarding Authority. Therefore, we found the Safeguarding system had not been followed to always protect people from abuse. On the inspection we asked the provider to undertake a review of all their incidents and confirm how many they could identify had not been reported to the Safeguarding Authority and to CQC. Following this audit the CQC received 31 statutory notifications, 29 of which were of retrospective incidents which had not been reported appropriately to CQC.

The provider is required by law to notify the Commission of specific events occurring at the home. We found numerous incidents and safeguarding concerns which the Commission had not been notified as required. This is a criminal offence under the Health and Social Care Act 2014.

We asked the registered manager what the biggest challenge was within the home and they responded it was related to agency staffing. On this inspection we found multiple issues and concerns which the registered manager and provider were aware of however, the registered manager and provider had not communicated they had found some of the same concerns as found on the inspection until we met with the provider following the inspection. Therefore, the transparency and lack of openness had contributed to the culture within the home. We found the culture was introspective, not always reporting concerns and issues appropriately.

We were informed by the provider the registered manager had resigned with immediate effect on 5 October 2018 as the registered manager for Ferndale Court, and the provider accepted their resignation. The provider confirmed a new manager was being brought into the home.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People's preferences and wishes were not always being sought or adhered to.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect
Treatment of disease, disorder or injury	People's dignity was not always being upheld or respected.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent
Treatment of disease, disorder or injury	People's consent was not always being sought in line with the Mental Capacity Act 2005 legislation.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs
Treatment of disease, disorder or injury	People were not being provided with the optimum opportunity of having enough nutrition or fluids to always maintain their health.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 15 HSCA RA Regulations 2014 Premises and equipment

Treatment of disease, disorder or injury

The provider had not ensured that all that was reasonably practicable was being actioned to ensure the premises was always maintained safely in relation to infection control, call bells and repairs needed.

Regulated activity

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation

Regulation 16 HSCA RA Regulations 2014
Receiving and acting on complaints

The complaints system had not been followed with a contemporaneous record of all communications with the complainant, record of meetings and outcomes.

Regulated activity

Accommodation for persons who require nursing or personal care

Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA RA Regulations 2014 Staffing

The provider had not ensured there were enough trained staff deployed to deliver care for people when they needed it.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	The provider had not ensured their systems and processes had been followed to ensure people were always receiving safe care and treatment.

The enforcement action we took:

We served a notice of decision to impose an additional condition on the provider's registration to prevent new admissions into the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment
Treatment of disease, disorder or injury	The provider had not ensured their systems and processes had been followed to ensure people were always protected from abuse or improper treatment.

The enforcement action we took:

We served a notice of decision to impose an additional condition on the provider's registration to prevent new admissions into the home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	The provider had not ensured the leadership and governance was robust enough to ensure systems and procedures were always being followed appropriately.

The enforcement action we took:

We served a notice of decision to impose an additional condition on the provider's registration to prevent new admissions into the home.