# Priorcare Homes Limited

# Fernlea

## Inspection report

114 Sandon Road
Meir
Stoke-on-Trent
ST3 7DF
Tel: 01782 342822

Date of inspection visit: 18 May 2015
Date of publication: 21/07/2015

## Ratings

| Overall rating for this service | Requires improvement |
|---|---|
| Is the service safe? | Requires improvement |
| Is the service effective? | Requires improvement |
| Is the service caring? | Requires improvement |
| Is the service responsive? | Requires improvement |
| Is the service well-led? | Requires improvement |

## Overall summary

We inspected Fernlea on 18 May 2015 and it was unannounced.

Fernlea is registered to provide accommodation for up to 13 people who primarily have a physical disability or learning disability. At the time of our inspection there were 11 people who used the service.

The service had a registered manager. 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. At the time of the inspection the registered manager had been managing another service that the provider owned and had not been involved in the management of Fernlea for a period of 12 months. This had been raised with the registered manager and we were told that they had applied to de-register but we had no record of this on our system.

Risks to people's health and wellbeing had been assessed but plans to keep people safe were not always followed, which meant that they were at risk of unsafe care and treatment.

# Summary of findings

People were not protected from potential abuse as the provider had not recognised areas of unsafe practice.

There were insufficient numbers of staff to keep people safe and provide the right care at the right time. People's individual care needs and preferences were not always met. When staff had the time they supported people with care, compassion and respect. However, we saw that the staff did not always have the time to consistently support people in this manner, which had an effective on people's dignity.

We found that records relating to people's care, including their medicines were not always accurate and up to date and medicines were not always managed safely. This meant accurate records were not maintained.

Activities were provided but these did not meet people's preferences. We found that people's personal care needs and preferences were not always met.

The provider did not have effective systems in place to assess and monitor the quality of the service provided. Areas of concern that had been identified by the local authority had not been acted on in a timely way.

The provider did not always inform us of incidents that occurred at the service. This meant we were not always aware of reportable incidents and the provider was not promoting an open and transparent culture.

People told us that the quality of the food was good and they were given meal choices. We saw that assessments were in place to ensure that risks of malnutrition were reduced, but improvements were needed to ensure that people's nutrition needs were monitored consistently.

Some people who used the service were unable to make certain decisions about their care. We found that mental capacity assessments had been carried out in accordance with the Mental Capacity Act 2005. We saw that decisions were made in people's best interests when they are unable to do this for themselves.

People were supported to access other health care professionals, such as doctors and dentists, which meant people's health needs were met effectively.

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

# 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?**
The service was not safe. People were not protected from unsafe care because risks were not managed appropriately. There were not enough staff available to meet people's needs. Infection control and medicines were not always managed safely.

**Requires improvement**

**Is the service effective?**
The service was not consistently effective. People were supported with their dietary needs, but where this needed monitoring this was inconsistent. Staff understood their responsibilities under the Mental Capacity Act 2005 and people were supported to make decisions in their best interests.

**Requires improvement**

**Is the service caring?**
The service was not consistently caring. Staff were caring and gave people choices in their care, but some improvements were needed to the way that staff promoted people's dignity.

**Requires improvement**

**Is the service responsive?**
The service was not consistently responsive. Activities were provided but these did not meet people's preferences. We found that people's personal care needs and preferences were not always met. The provider had a complaints procedure available to people who used the service.

**Requires improvement**

**Is the service well-led?**
The service was not well led. The provider did not have effective systems in place to assess and monitor the quality of the service provided. Areas of concern that had been identified had not been acted on in a timely way. The registered manager had been managing another service that the provider owned and had not been involved in the management of Fernlea for a period of 12 months.

**Requires improvement**

# Fernlea

**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 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.

This inspection took place on 18 May 2015 and was unannounced. The inspection team consisted of two inspectors.

We reviewed the information we held about the home, which included information we had received from the service, such as notifications. We also spoke with commissioners and health professionals to understand their experiences of the service. The service had been subject to a large scale investigation (LSI) by the local safeguarding authority because they had concerns with the way that people were receiving their care. We attended a meeting to discuss these concerns with the local authority after our inspection.

We spoke with six people who used the service, three relatives, five care staff, the care manager and the provider. We viewed five records about people's care, which included risk assessments, care plans, medication and how the care had been provided. We also looked at records that showed how the service was managed, such as quality assurance audits.

Requires improvement

# Is the service safe?

## Our findings

Risks to people's safety were assessed. However, these risks were not always managed safely. One person was at risk of choking and the risk plan stated that they needed a soft diet and close supervision from staff when they were eating to ensure that that they didn't choke. During the lunch period we saw this person eating their food and we did not see staff closely supervising this person. We saw a member of staff quickly enter the room and then they left the person unsupervised. We spoke with staff who told us, "The person is with other people who use the service and could alert the staff if the person needed any support or was in difficulty". This meant that this person was not supported safely where risks had been identified.

People we spoke with told us they were happy and felt safe. Staff we spoke with told us how they would recognise and report any concerns they had if they suspected abuse. However, following our inspection we spoke with local authority commissioners who informed us of serious safeguarding concerns that they had within the service. These concerns had not been recognised by the staff, manager or provider as potential abuse, which meant people were left at risk of unsafe care.

This meant that the provider did not have effective systems in place to ensure that risks to people's health and wellbeing were assessed, monitored and managed. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us that there was not always enough staff available to meet their needs. One person said, "I would like a bath every day, but there isn't enough staff". Another person told us, "I would like to go out more and spend a bit more time out of the home, it gets boring. I can't go out when there are only two staff on though". We saw that staff did not always have time to sit and chat and support people with the interests and hobbies that were important to them. Staff told us that they were rushed and they found it difficult to undertake all the tasks that they needed to. One member of staff said, "We are really pushed as we have to clean, cook and look after people. We try our best and make sure people are looked after. If we had more staff we could support people to go out to places that they enjoy, like the cinema and out for lunch". Another staff member said, "There is a lot we have to do and we try our best but something falls behind. It is never the care but the cleaning gets put to one side if we don't have time as people come first".

One person needed support to undertake meaningful activities and the Speech and Language Therapist had advised that they would benefit from sensory activities. The records we viewed and staff told us that this person was not supported to undertake these activities. We spoke with a staff member who told us that they felt this person needed a higher level of support and they were bored but there wasn't enough time to support them with meaningful activities.

One person we spoke with told us how they would like a shower more often but they were unable to because there were not enough staff available. This person said, "It is important to me to have a shower, I would have one every day if I could but there are not enough staff. It offends me if I don't get a shower". Staff told us they gave this person a bath when there were enough staff available, but they are unable to support them to have a bath every day. We looked at this person's records and they detailed how it was important for this person to have showers for their personal needs and also for their dignity. We looked at the records which showed that this person had not received regular showers as requested and in a six week period they had only received six showers. Staff we spoke with were unable to confirm whether this person had received this amount of showers or whether the records were incorrect. This meant that this person did not receive care that met their preferences or assessed personal care because there were not enough staff available.

We asked the manager how staffing levels were assessed and we were told "It's always been like this. I don't know you will have to ask the provider, I don't do this". When we spoke with the provider they could not show us evidence of how they assessed the staffing levels against people's needs to ensure they had sufficient staff available to support people. There was no evidence to show that staffing levels changed when people's needs changed. The provider told us they had not been able to increase staffing levels due to financial resources.

This meant that that was not always sufficient staff available to meet people's needs. This was a breach of Regulation18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires improvement

# Is the service safe?

We found that the environment of the home was not clean. We saw that carpets were dirty and needed cleaning and there was a unpleasant smell in some areas of the service. Before the inspection we had been informed that the service had received an infection control visit and had been asked to make improvements to areas of concern such as; removal of the sluice from the laundry room and replacement of carpets. We were told by the manager and provider that they were in the process of making these improvements.

We saw that the kitchen was unclean in areas. There were cleaning schedules in place for kitchen cleaning which had been signed as being completed for the cleaning of appliances. When we checked this had not been carried out effectively and there were still areas that were unclean. We found that there was food splashes on tiles, floors and there was a sponge and cloth being used that was dirty and a risk to infection control. Following the inspection we spoke with the Environmental Control Officer to alert them of our concerns.

People told us that they were supported to take their medicines. We saw a staff member administering medicines to people in a safe way. For example; the staff member checked the medicines needed, supported people to take these and recorded when the medicines had been taken. People told us that staff provided medicines when they needed them, for example, when they were in pain. Staff who administered medicines were aware of why people needed 'as required' medicines, but we found that there was no written guidance for staff to follow. Staff and the manager told us they agreed that it would be helpful to have these recorded, which would ensure that these were administered in a safe and consistent way.

We found that the amount of medicines stored within the home did not match the amounts recorded on the medicine administration records (MARs). We checked seven people's MAR's against the medicines in stock and found that four did not balance. We found that people had more medicines in stock than detailed on the MARS, which meant that we could not be assured that these people had received their medicines as prescribed by their doctor. The manager and deputy manager told us that they had carried out weekly stock checks but these did not tally with the amounts we counted were in stock.

Requires improvement

# Is the service effective?

## Our findings

Staff we spoke with told us that they had recently been offered training. Staff said they felt they would benefit from some specific training such as; learning disabilities, behaviour that challenged and multiple sclerosis. Staff told us that they felt that they could support people who had specific condition more effectively with specific training. Staff gave examples of training they would benefit from such as; learning disabilities and multiple sclerosis. We saw that there was a training matrix in place but this contained gaps in essential training and the provider showed us a schedule of planned training for staff to attend.

People we spoke with told us that there was enough to eat and they were given meal choices. We saw that staff offered people a choice of meal for their lunch although the choice of meals consisted of one hot choice or sandwiches. There was a picture menu in the lounge area but this was not up to date and was not being used. Staff told us that they no longer used this because there were pictures missing, but it had been an activity that two people had previously enjoyed completing and helped people to understand the choices available to them. People were offered drinks throughout the day and people were given individual cups and mugs. Where required, these were adapted to meet people's needs and promote independence. The records we viewed showed that where staff needed to monitor people's dietary intake this had been completed, but there were some gaps in the recording, which meant on certain days we could not be assured that people had received sufficient amounts of food and fluids.

People told us that they consented to their care and they were asked permission before staff helped them. One person said, "Staff always ask me before they help me. I have refused to go to the dentist and they listened to me". We saw staff asking people before they supported them with their needs. Systems were in place to protect people's rights where they were unable to make decisions for themselves. We saw that mental capacity assessments had been undertaken to ensure that decisions made on behalf of people who lacked capacity were carried out in their best interests. Staff we spoke with had some knowledge of their duties under the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS), although they had not received training at the time of the inspection. The Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS) set out requirements that ensure where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. One person had a Deprivation of Liberty (DoLS) in place which had been authorised by the local authority. Staff knew that this person was restricted, why this restriction was in place and how they needed to be supported.

People we spoke with told us that their health needs were met and they received support from health professionals when required. One person said, "The doctor is visiting me tomorrow. He comes every week to check up on us". We saw that one person was supported to visit the dentist on the day of our inspection. The records we viewed showed that people's health needs had been considered. We saw that one person had received a full health check and issues that had been identified with their health needs had been acted on.

Requires improvement

# Is the service caring?

## Our findings

We observed that there were long periods throughout the day when people received little interaction with staff. We saw that when staff had time to interact with people this was mostly a positive experience. For example, we saw that some staff were chatting to people when providing support and making people feel at ease. However, people did not always experience positive interactions. For example, one person who had communication difficulties was supported with their lunch by staff as they were unable to eat independently. We saw that this person was not offered any encouragement or asked if they were ready for any more food, which meant this person did not receive positive engagement at lunchtime.

We saw that staff did not always promote people's dignity. The records we viewed did not always demonstrate that staff supported people with dignity. For example, the manner that staff had recorded people's behaviour was childlike and undignified. We fed our concerns back to the manager and provider who stated that they would discuss this with staff.

People we spoke with told us that staff were caring. One person said, "Staff are nice and they talk to me" and "The staff are wonderful, I've never met a bad one". Another person said, "There really isn't anything the staff won't do for you".

People told us that they were treated with dignity and staff spoke with them in a respectful manner. We saw that staff were discrete when they asked people if they needed supporting with their personal hygiene. We saw staff talking to people face to face and respecting their privacy when they wanted to be in their personal rooms.

People we spoke with told us that staff gave them choices in their daily care and listened to them. One person told us, "I like to go to my room and I can get up and go to bed when I want. The staff know I like my own time but come and see I'm okay". We observed staff asking people what they wanted to eat, where they wanted to sit and how they wanted their care to be carried out. Staff waited and gave people time to make choices and listened to their wishes. We saw that staff knew what people's likes and dislikes were. For example, staff told us that one person chose to sit in a comfy chair. The person confirmed this and we saw staff support them to be comfortable throughout the day. Another person told us that they chose to remain in their wheelchair as it gave them more independence to do what they wanted, when they wanted and staff respected their wishes.

Requires improvement

# Is the service responsive?

## Our findings

People we spoke with told us that they participated in some interests and hobbies and most people said that they would like to be able to be involved in more activities. One person we spoke with told us that they had requested to go swimming as this was an activity they enjoyed. The person also told us that this would also help to alleviate some of their pain. They said, "I asked about this some time ago, but I was told that they would need extra staff and someone that is a rescuer". The provider told us that they had tried to find a swimming baths that had specialist equipment but had not been successful.

Another person told us that there was not always enough staff available and they would like to get out of the home environment more as it could get "boring". The manager told us that a member of staff had been asked to carry out activities with people on three afternoons a week. We saw that people were sitting in the lounge and dining area in the morning with the television switched on. We spoke with the people in the lounge and only one person told us they were interested in the programme but people had been assisted to sit by the television. One member of staff was playing a board game with a person and two people had their nails painted in the afternoon. People told us and the records we viewed showed that people were supported to go shopping, access community centres and have their haircut but we could not see that people had been supported to undertake activities that were recorded as their preferences.

We saw that one person spent time moving and shuffling across the floor. Staff told us and the records showed that this person enjoyed walking round the home and enjoyed putting their hands in water. We saw this person was supported in line with their preference to walk around the home once during our inspection and it was evident that they enjoyed this. Staff did not support this person to undertake this activity enough times to meet their needs. We also found that advice provided by the Speech and Language Therapist that this person would benefit from sensory items which included items to taste, smell and touch. Staff said that they didn't have enough time to support this person and they felt that they needed one to one staff support to meet their needs effectively.

We saw that one person's finger nails were long and some were sharp. We asked the person about their nails and if they wanted them to be cut. They responded by showing us their nails and nodding. We asked staff why this person's nails had not been trimmed and we were told that the person's nails clippers had been lost. Staff told us that they hadn't been replaced but they would make sure arrangements were made to purchase nail clippers for this person. This meant that staff were not responsive to people's needs.

This meant that people's care was not always provided in accordance with their preferences and needs. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they knew how to complain and that they would feel comfortable complaining if they needed to. One person said, "I would tell staff if I was unhappy with the way I was being treated or if they had done something I didn't like". Another person said, "I'm happy here, I feel content but I would tell the staff if I didn't". Relatives we spoke with said they were confident that action would be taken if they raised any concerns. We saw that the provider had a complaints policy in place and kept a log of any complaints received. There was only one complaint recorded and it was unclear what action had been taken. The manager who told us in detail what actions had been taken, but agreed that the actions needed recording.

Requires improvement

# Is the service well-led?

## Our findings

The provider did not have a system in place to ensure that there were sufficient staff available to meet the needs of people. We found that there were insufficient staff available which impacted on staff interaction with people, provision of meaningful activities and the cleanliness of the service. The provider told us they did not have a system in place to assess people's dependency needs and they were doing the best they could with the resources they had available.

We found that the provider had implemented some systems to monitor and assess the service, but these were not effective. We identified that there were still concerns with regards to the cleanliness of the service, despite these being raised with the provider by the local authority. We found that cleaning schedules had been implemented but we found that some of the duties had not been carried out effectively. For example, the kitchen schedules had been signed as completed but we found that equipment and areas in the kitchen were not clean. We asked the manager how they ensured that staff carried out the required duties, but we were not assured that this would be monitored and sustained.

Systems were not in place to check that care records were up to date. People told us how they needed to be supported and staff confirmed what people needed. We found that some records were out of date and did not match what we had been told. For example; We spoke with one person about their mobility and what they would do in the event of a fire. They told us that they were unable to get out of the building themselves and staff we spoke with confirmed this. The records they stated that this person was able to evacuate the building themselves.

We also found concerns with the management and stock control of prescribed medicines. We were told by the manager, "The medicines were in a mess when I came so we have disposed of old stock and audited weekly since the 06 April 2015". The weekly audits we viewed had identified some concerns but we did not see evidence of how this had been managed. This meant that the checks in place to assess the quality of the service were not effective.

We asked to view a copy of the improvement/action plan that the provider had received from the local authority and environmental health. We were told they did not have this readily available and they would forward a copy to us within 24 hours. We did not receive a copy of the action plan, which meant that we could not be assured that they were making improvements to the quality of care provided. We spoke with the provider who told us they had not been able to keep up with the monitoring and assessing of the quality of the service provided.

People told us that they were asked their feedback at meetings that were held to discuss the menu and choice of foods. The manager showed us a questionnaire template but we were not provided with evidence that these had been circulated for people to provide feedback on the quality of the care provided. This meant that feedback from people and their relatives was not consistently sought.

We spoke with staff who gave mixed views about the management and support within the service. Staff told us that staff meetings were not held regularly and they were only held when the provider needed to inform the staff of changes. For example, when the manager changed. Not all staff had received an appraisal and supervision and staff we spoke with felt they would benefit from time to discuss their role and any concerns they had.

Staff we spoke with had a good ethos and they told us that they wanted to provide the best care they could but resources did not always allow them to do this. One staff member said, "I treat people like my family, but improvements could be made to enable people to have a better quality of life. They don't do much because of lack of staff". Staff also told us that they felt that some of the managers were approachable and they were able to raise concerns, but there were times that they felt they could not raise issues. For example, staff told us that they had raised issues with staffing but they were not listened to and felt unable to raise these issues again.

The provider did not have effective systems in place to assess, monitor and manage risks to people's health and wellbeing. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 9 HSCA (RA) Regulations 2014 Person-centred care<br><br>People's care was not always provided in accordance with their preferences and assessed needs. Regulation 9 (1) (a) (b) (c). |

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 17 HSCA (RA) Regulations 2014 Good governance<br><br>The provider did not have effective systems in place to ensure that risks to people's health and wellbeing were assessed, monitored and managed. Systems in place to assess, monitor and improve the quality of care were not effective. Regulation 17 (1), (2), (a), (b), (c), (e) and (f). |

**The enforcement action we took:**
We served a warning notice to the provider telling them to make immediate improvements to the quality of care.

| Regulated activity | Regulation |
|---|---|
| Accommodation for persons who require nursing or personal care | Regulation 18 HSCA (RA) Regulations 2014 Staffing<br><br>There were not sufficient numbers of staff deployed to meet people's assessed needs and preferences. Regulation 18 (1). |

**The enforcement action we took:**
We served a warning notice to the provider telling them to make immediate improvements to the quality of care.