Eldercare (Halifax) Limited

Fernside Hall Care Home

Inspection report

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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?	**Inadequate**

Summary of findings

Overall summary

This inspection of Fernside Hall took place on 9 November 2015 and the visit was unannounced. Fernside Hall is registered to provide residential care for up to 24 older people and there is a passenger lift available. The accommodation is arranged over three floors. There are two lounges and a dining room on the ground floor and a kitchen/sitting area on the first floor. There are 20 single bedrooms, 18 of which have en-suite toilet facilities and two double bedrooms with en-suite facilities. At the time of our inspection there were 19 people using the service.

Our last inspection of Fernside Hall took place on 19 February 2015 and found breaches of regulations in regard to staffing numbers and inadequate maintenance of the home. We also recommended that the provider ensure they have systems in place to ensure they have oversight of the management of the service.

The previous registered manager of Fernside Hall deregistered with the Commission in September 2015. The manager at the time of our visit had been in employment at the service for approximately five months. They told us they would be applying for registration with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider. Since the inspection the manager has left the service.

People who lived at the home told us they felt safe and staff had a good understanding of their responsibilities in keeping people safe. However, the service did not monitor accidents and incidents well which meant that they were not doing everything possible to mitigate risks to people who lived at the home.

Staffing was adequate but better deployment of care staff was needed to make sure staff were always available to people.

Procedures for recruitment of new staff were not always followed to make sure staff were safe to work with vulnerable people.

Staff felt that the training they had received was good but not all staff had received the induction and training they needed to support them in their roles.

People told us, and we saw, that the food provided at the home was of a good standard. However staff had failed to make sure that all of the people who lived at the home received the nutrition and hydration they needed to maintain their health.

Staff demonstrated a caring attitude but we found that people's dignity was not always respected.
Care plans did not demonstrate a person centred approach to care and were not up to date. This had been recognised and new care plans were in the process of being developed.

People told us they enjoyed the activities at the home although the working hours of the activities coordinator restricted the opportunity for planned activity.

There was a new manager at the home and staff told us they had confidence that they would they would make improvements to the service. There was a lack of regular quality auditing by senior management.

Systems were not in place to protect money being held at the home on behalf of the people who lived there.

Systems for auditing the quality and safety of care were not adequate.

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

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.

Accidents and incidents that happened in the home were not being appropriately reported, managed or analysed to assess and mitigate risks to people living at the home.

Systems for managing medicines were safe but some improvements were needed.

Staffing levels were adequate but staff deployment needed to be reviewed.

Robust recruitment procedures were not always being followed to make sure staff were suitable to work with vulnerable people.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received the induction and training they needed to support them in their role.

The food served at the home was of a good standard but staff had not always made sure that the nutritional and hydration needs of people living at the home were met.

People's health care needs were met.

Is the service caring?

Requires Improvement

The service was caring but some improvements were needed.

People told us staff were caring toward them.

Staff did not always consider the dignity needs of people living at he home.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Assessments of need were not up to date and care had not always been planned or reviewed with a person centred approach.

People told us they enjoyed activities at the home.

People told us they would complain if they needed to.

Is the service well-led?

Inadequate

The service was not well led

Systems for auditing the quality of service were not robust.

Some records in relation to care were not accurate.

The provider had failed to notify the Commission of incidents which had happened in the home as required by regulation.

Fernside Hall Care Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to provide a rating for the service under the Care Act 2014.

We inspected Fernside Hall on 9 November 2015 and the visit was unannounced. Before the inspection we reviewed the information we held about the home. This included information from the provider, the local authority contracts and safeguarding teams. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

The inspection team consisted of two inspectors and an expert by experience with experience in older people and older people living with dementia. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

On the day of our inspection we spoke with eight people who lived at Fernside Hall, one person who was visiting their relative. We also spoke with five members of care staff, the chef, the acting manager and the regional manager.

Some of the people we spoke with had complex care needs and were not able to express their views to us. We therefore spent time observing care in the dining room and lounges to help us understand the experience of all of the people living at the home

Requires Improvement

Is the service safe?

Our findings

During our inspection we asked people if they felt safe, they told us that they did and staff looked after them, one care staff member was heard asking a person, "Do we take care of you?" The person responded in a positive voice saying, "Yes, yes you do".

Staff we spoke with demonstrated a good understanding of safeguarding and how to report any concerns they may have. They were also aware of the whistleblowing procedure and said they would use it if they had any concerns. However, when we looked at training records we saw of the twenty four staff working at the home, only seven had received up to date safeguarding training.

As part of our inspection process we liaised with the local authority contracts and safeguarding teams to gather information to inform our inspection. In doing this we became aware of some safeguarding issues which had happened in the home that had not been reported to us as required by regulation.

During our visit we looked at how accidents and incidents were reported and managed. We saw records of three accidents that had happened in the home which again, had not been reported to us as required by regulation. We saw accident forms had been completed but had not been signed off by the manager. The area manager told us accidents and incidents were recorded in the home and were sent for analysis to head office. When we looked at the analysis records we saw two of the three accidents we had looked at had not been included on the analysis record. The area manager told us they had not been made aware of these accidents. We were also made aware, by the local authority, of a further accident which had not been reported to us.
Following our inspection visit we asked the provider to look into this. They told us, "These matters were not addressed in accordance with procedures at the time."
This meant that accidents and incidents that happened in the home were not being appropriately reported, managed or analysed to assess and mitigate risks to people living at the home.

This was a breach of the Regulation 12 (2) (a and b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that people did not have personal emergency evacuation plans (PEEPS) in place. This had been recognised and an emergency PEEP for all of the people living at the home had been put in place until individual ones could be developed..

We saw care plans relating to people's safety within the care files we looked at and saw equipment such as bed, chair and door sensors had been put in place where needed to maintain people's safety. However we could not be sure this equipment always had the desired effect. For example, whilst sitting in the quiet lounge, we heard an alarm sounding. We saw the alarm was plugged into the wall in that room. We alerted the manager who told us it was a bed or chair sensor alarm. We asked the manager how staff would know it was going off as it could not be heard outside of that room and there were no staff present. The manager said that staff usually carried the alarm around with them as it was not linked into the call system. The

manager said the alarm had sounded on this occasion because staff had supported a person using a chair sensor to move from the room. We were concerned, had the person fallen from their chair whilst the alarm was in the room, staff would not have heard it and therefore would not have responded.

During our visit we looked at the systems in place for the receipt, storage and administration of medicines.

We saw medicines were stored in a locked trolley and fridge. Temperatures of storage were recorded on a daily basis to make sure they were safe. We saw amounts of medicine received at the start of the medication administration record (MAR) sheets had not been recorded for two of the boxed medicines we looked at. This meant it was not possible to check the amount of medicine still available concurred with the amounts received and administered.
We checked two people's 'as required' medicine and saw staff had maintained a countdown of the amount of tablets after each administration. However, when we checked the amount still available for one person we found there to be six less tablets than indicated by the countdown. This indicated staff were not counting the tablets but just following on from the previous record. For all 'as required' medicines, staff were required to complete the reverse of the MAR saying why the medicine had been given and what the outcome was for the person. This had not been completed on one of the MARs we looked at. This meant staff were not always following the recording protocol for PRN medicines.

We recommend that the service considers the National Institute for Health and Care Excellence (NICE) Guidelines for Managing Medicines in Care Homes.

On the day of our inspection we saw one of the senior care assistants was completing their competency assessment in administration of medicines following their medication training. This meant processes were in place to make sure staff administering medicines had been assessed as competent to do this safely.

Care staffing levels were arranged at four staff throughout the day and three staff at night. Care staff were supported by the manager, an administrator, cleaning and catering staff and an activities organiser who worked four hours a day on weekdays. We asked people living at the home if there were enough staff to give them the support they needed. All of the people we spoke with thought there were. One person said, "Yes the staff are kind". All of the staff we spoke with felt that there were enough of them to meet the needs of the people currently living at the home.
We saw staff were usually available in communal areas, however there were times when, due to completing other tasks, the availability of staff was reduced. An example of this was after lunch when care staff had to wash up all the crockery from the meal.

We recommend that the provider considers the deployment of staff to make sure care staff are not taken away from supporting people living at the home.

We asked people if they thought the home was clean. One person commented that 'it used to be.' There was some evidence of food debris around some of the lounge chairs and lodged in the chair leg raisers. Some areas of the home looked tired and needed redecoration; we also noted some stained carpets in bedrooms. The manager informed us that some redecoration had been done but more was on the 'to do list'.

We looked at three staff recruitment files to see if procedures were followed to make sure staff were safe to work with vulnerable people. We saw that references had been obtained and notes of interviews had been taken. In two of the files we were unable to find evidence that the provider had seen the full Disclosure and Barring Scheme (DBS) disclosures. The manager told us that they had asked the people concerned to bring

their DBS disclosures in for them to see.

This meant that staff had started work at the home without the provider having made thorough checks to make sure they were suitable to work at the home.

This is a breach of the Regulation 19 (3)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service effective?

Our findings

Staff we spoke with told us the training they had received was good. However, we saw from the training matrix that some staff had not received the training they needed to support them in their role. For example, the training matrix showed fifteen of the twenty four staff at the home had not completed fire training, seventeen were not up to date with safeguarding training, eleven had not completed mental capacity act and deprivation of liberty safeguards training and nine out of seventeen care staff had not received up to date moving and handling training. The lack of moving and handling training was evident in the way we observed staff supporting people at times during our inspection.

None of the three staff files we looked at contained any evidence of induction training. The manager and area manager told us staff were booked on an induction course in December 2015. This however would be four months after two of the staff had started working at the home and meant that induction training was not delivered in a timely manner.

The area manager told us that all new staff were to follow the common induction standards training and showed us evidence of training booked for all staff.

The lack of up to date training demonstrated a breach of Regulation 18 (2) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.
All of the staff we spoke with told us they found the manager to be approachable and supportive and all had received supervision since the new manager started.

We asked people if they enjoyed the food and drinks at the home. They told us, "The chef knows what I like, my egg sandwich was good." Another person commented on their breakfast, "My bacon sandwich was lovely."

We spoke with the chef who told us they produced a four weekly menu cycle based on ideas gathered from people who lived at the home. We saw people served with the breakfast of their choice such as a full cooked breakfast or egg or bacon sandwiches. We saw the chef served lunch and asked people for the preferences as it was served. The chef told us they checked what people were leaving on their plates and what they appeared to be enjoying as they felt people might not like to say if they didn't like something. We saw the quality of food was good and it was evident that the chef took pride in their work and understood the importance of people having food they enjoyed.

We noted although the chef was informed of special diets, they were not informed by care staff of people who were losing weight. We saw from records that three people had been losing weight. One person had lost 4kg in a period of four months. This had not been included in the person's care plan and food and fluid intake charts had not been put in place as directed by the nutritional assessment. Another person who had lost 3kg in a two month period did have intake charts in place but the weight loss had not been mentioned within the care plan and the nutritional risk assessment had not been updated for over a month. Staff had referred this weight loss to the GP who had asked for the person to be weighed weekly. There was no record

to show this had been done. We looked at the intake charts for seven days for this person. We saw six of the seven charts did not record any dietary intake from lunchtime onwards and one recorded the only dietary intake as a bowl of cornflakes and two biscuits for the whole day. The charts had not been monitored or reviewed which meant there was no overview of the person's nutritional intake.

One person's weight records showed wide fluctuations; for example a loss of 6kg in a period of eight days and then a gain of 4kg in seven days, but there was nothing in place to explain this. The senior care assistant said this could have been due to water retention and this had been referred to the district nurse, however this did not account for the further weight loss recorded for this person. At lunchtime we saw this person refuse the plated meal brought to them. The manager asked what they would like instead and brought them a cracker with cheese and pickle on it. As the person tried to eat it we saw the cheese and pickle fall off the cracker. A member of care staff picked it up and put it in the bin but did not offer the person any more. This meant the person had one cracker for lunch.

This meant there was a failure to assess and mitigate the risks associated with people not receiving adequate nutritional and hydration and is a breach of Regulation 12 (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

The Care Quality Commission (CQC) monitors the operation of the Mental Capacity Act 2005 (MCA) and specifically on the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.
People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. 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.

We asked people living at the home if they were restricted in any way. They told us no, they could come and go as they wished with visitors or on their own, we saw one person on the street outside spending some time in the local area before coming inside for a hot drink. Another person said "I get lots of visitors, I went out shopping with (daughter) and we bought Christmas presents".

The manager told us one person living at the home was subject to a DoLS. We saw the paperwork was in place for this and noted there were no conditions applied. However, when we looked at the care records for this person we saw the DoLS was not referred to in respect of the person's care and support. We also noted the person, although assessed as lacking mental capacity, had signed their consent for several areas of their care without any reference to how this consent had been obtained. We saw little evidence of people being involved in their care planning and review although the manager told us that new care plans were being developed with the full involvement of people who lived at the home or, where appropriate, their relatives.

Mental capacity assessments were in people's care files and had been completed. However they did not cover the five principles of the MCA and were not decision specific. We found the information recorded in them to be vague and lacked meaning.
The area manager told us they had recognised this and said work would be done to make sure each person

had a mental capacity assessment completed properly by the end of the week.

Two of the staff we spoke with demonstrated an understanding of MCA and DoLS and knew that one person living at the home had a DoLS in place and why. However a third member of staff told us they knew "nothing about it."

Care records showed that healthcare professionals were involved in people's care as needed. We spoke with a member of the district nursing team who told us that staff worked well with them. We saw that a GP visit had been requested for a person who had told us they had not felt well the previous night. This showed that timely requests were made to make sure people's healthcare needs were met.

Requires Improvement

Is the service caring?

Our findings

We asked people if staff were caring and respected their privacy and dignity. One person said, "They look after us" and as a member of staff walked past another person said to them, "I love you, you're one in a million". A visitor told us that they were, "Honestly, very happy with my relative's care". They said, "I come at different times of the day and I'm always made welcome".

We saw some warm interactions between staff and people who lived at the home and saw staff generally responded to people's needs promptly. However, this was not always consistent. For example, when we spoke with people sitting in the lounge after breakfast, they told us they felt cold. We mentioned this to a member of care staff who said, "Yes it is chilly but it will be boiling in an hour" and then left the room. We then told the manager about people feeling cold who immediately arranged for staff to bring blankets for people and put on an additional heater. The manager also said they would speak to the handyman about the heating.

We saw some examples of staff not always considering people's dignity needs. For example one person told us they would like to have a shave and needed staff to help them. We noted this person had not had a shave when we left in the late afternoon. We saw people were not always supported to change their clothing or wipe their hands and faces after food spillages. One person had egg yolk on their chin and clothing after breakfast and we saw it was still there at lunchtime.
We saw some good examples of staff looking after people's personal belongings and keeping their bedrooms looking nice. However, we looked in one room which was arranged as a double but the manager told us one of the occupants had died two weeks previously. We saw the person's bed had been removed from the room but the bedding taken from the bed was thrown over a chair and a commode and other equipment used by the person was still in the room. We also noted the deceased person's dentures were on the wash basin in the shared en-suite. The manager told us that they were waiting for the deceased person's relatives to come to collect their belongings. However, the way the room had been left showed a lack of regard for the person still occupying the room and the family of the deceased person.

This is a breach of Regulation 10 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

Requires Improvement

Is the service responsive?

Our findings

The manager told us they were not taking any new people into the home because a problem had been identified from a recent safeguarding meeting with the local authority that the care plans in place for people living at the home were poor.

The manager told us that new care plan documentation had been piloted at another of the provider's homes and were to be put in place at Fernside Hall. They said they had made arrangements for staff time to be dedicated to developing new care plans. The manager said two of the new care plans were in place. We looked in detail at five care plans including the two new ones.

One of the care plans we looked at had been developed with some regard to a person centred approach. For example, we saw detail of behaviours the person may exhibit to indicate how they were feeling when not able to express this verbally. We also saw the life history had been completed and the care plan had been written from the point of view of the person. However, care plans had not been reviewed to reflect people's changing needs and all, including the new ones, lacked the detail needed to guide staff in how to provide person centred and effective care. For example, one of the care plans we looked at did not give any information about the stoma care the person needed and another did not contain any detail about the person's social and recreational needs.

Assessments of need were in place but these had not always been reviewed in line with people's changing needs. For example, one person's pain assessment which gave a score of zero; had not been updated despite daily records reporting the person was experiencing frequent back pain since having a fall. The falls risk assessment and related care plan had also not been updated.

Daily records were brief and gave little detail about people's daily lives.

We looked at the care records for a person who had stayed at the home for a period of respite care. The care records did not include any assessments of need or care plans. We also noted a record of night care had been written after the date the person had been recorded as going home.

When we spoke to staff about how care was delivered they spoke of 'toileting times.' This demonstrated more of a task based approach rather than a person centred approach to care.

This demonstrated a breach of Regulation 9 (3) (a and b) of the Health and Social Care Act 2008 (Regulated Activities) Regulation 2014.

We asked people if they had access to activities, one person said, "Yes after breakfast, it varies, sometimes we do exercises, it's alright, it's good".

We saw an activities co-coordinator worked at the home for four hours each weekday. These hours covered lunchtime which meant that the period of time for people to be engaged in activities was limited. Staff told

us they often spent time doing activities with people during the afternoon.

People we spoke with told us they would speak to care staff or to the manager if they had any concerns or complaints. The complaints procedure was available on a notice board in the hallway of the home. We saw no complaints had been recorded by the home since our last inspection of the home.

Inadequate

Is the service well-led?

Our findings

The registered manager left Fernside Hall in September 2015. The new manager told us they had been in post for approximately four months and intended to apply to the Care Quality Commission for registration. Since the inspection the new manager has left the home.

The manager told us they conducted daily checks of the home but did not document these checks.

The most recent quality monitoring visit made by the area manager had been in July 2015. The report did not include any actions for improvement within the service.

We saw that monthly audits of equipment including mattresses, wheelchairs and bedrails had been completed and were up to date.

The area manager told us accidents and incidents were reported on a monthly basis through the provider's quality monitoring system. However we saw that accident forms completed in the home had not been signed by the manager and noted that some of the accidents had not been included in the monthly analysis. This meant that the auditing system was not robust.

Monitoring of people's weights was completed on a monthly basis; however we did not see evidence of any monitoring of nutritional intake records for people identified as losing weight. Monitoring had also failed to identify when weekly weights had not been done as needed.

In July 2015 the Care Quality Commission received notification from the service that money belonging to a person living at the home had gone missing. The money had in been placed in one of the homes safes by staff. This money was reimbursed by the provider and the Commission were assured that processes had been put in place to safeguard against this happening again. During the course of this inspection we were made aware of a further incident of money belonging to a person living at the home going missing from a safe. The service had not notified the Commission of this. Although the police were informed and the money was reimbursed, this showed that systems to protect the money of people living at the home were ineffective.

This demonstrated a breach of Regulation 17 (2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Environmental safety records were up to date and certificates of safety such as gas, maintenance of lifts and moving and handling equipment were all in place and up to date.

The manager told us they had organised regular meetings with staff to discuss the changes they wanted to make within the home. Staff told us they were confident that the new manager was making improvements.

Meetings with people who lived at the home had been held. We saw that some quality monitoring had taken

place in the form of questionnaires sent to relatives of people who lived at the home in January 2014; however we did not see any analysis of the results of this. The area manager told us they had discussed sending out more satisfaction surveys shortly.

It is the responsibility of registered providers to inform the Care Quality Commission, by way of statutory notifications of certain events that have taken place in the service. This includes reports of abuse of people living at the home and serious accidents. We found evidence events that had happened which the provider had failed to report.

This was a breach of the Regulation 18(2) (a, e and f) of the Health and Social Care Act 2008 (Registration) Regulations 2009.

We saw an entry in the records of a person who had stayed at the home for a period of respite care dated the day after the staff handover record stated that the person had left the home. The record, made by the night care staff stated that the person was in bed at the start of the shift and had two hourly checks through the night. We asked the home's administrator to confirm the date the person had left the home but they were unable to do so. This meant that records of care had been made falsely.

This demonstrated a breach of Regulation 17 (2)(c) 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 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to report notifiable incidents.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care Care plans did not reflect the current needs of people and care was not always planned and delivered with a person centred approach.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA RA Regulations 2014 Dignity and respect Staff did not always consider the dignity needs of people living at he home.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Accidents and incidents that happened in the home were not being appropriately reported, managed or analysed to assess and mitigate risks to people living at the home. There was a failure to assess and mitigate the risks associated with people not receiving adequate nutritional and hydration.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Robust procedures were not being followed to make sure that staff employed were suitable to work with vulnerable people.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not received the induction and training they needed to support them in their role.

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 17 HSCA RA Regulations 2014 Good governance The provider did not have robust systems in place to monitor and improve the quality of the service provided. Records made in respect of service users were not always accurate.

The enforcement action we took:

Warning notice