Abbeyfield The Dales Limited

Fern House

Inspection report

Fernbank Drive
Bingley
West Yorkshire
BD16 4FA

Tel: 01274065090
Website: www.abbeyfieldthedales.co.uk

Date of inspection visit:
15 January 2021
19 January 2021
25 January 2021
26 January 2021
27 January 2021
28 January 2021
29 January 2021

Date of publication:
23 February 2021

Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Fern House is a purpose-built complex which consists of a residential care home providing accommodation and personal care for up to 30 older people and 49 extra care housing apartments where some people are provided with personal care from staff onsite. At the time of our inspection there were 25 people living in the care home and 35 people living in the extra care housing apartments who were receiving personal care.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service and what we found
People were not safe. Systems for recording and monitoring accidents and incidents were unsafe as they did not accurately reflect what was happening in the service. Safeguarding procedures were not followed consistently. Risks to people were not assessed and managed. Medicines were not managed safely. Lessons were not learned when things went wrong.

There was no system for calculating safe staffing levels and there were not always sufficient staff to keep people safe. We have made a recommendation about reviewing staffing levels.

There were continued breaches at this inspection with similarities to the issues found at the last inspection in relation to medicines, risk management and governance. There was a lack of consistent and effective leadership and an ineffective governance structure which meant the service was not appropriately monitored at manager or provider level. Effective systems were not in place to address shortfalls identified at the inspection and drive improvement.

Staff were recruited safely. People lived in a clean and pleasant environment. Robust infection control procedures were in place which helped keep people and staff safe during the COVID-19 pandemic.

People who used the service and relatives provided consistent positive feedback about their experience. The provider was responsive to the inspection findings and shared plans to improve their systems and processes.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection (and update)
The last rating for this service was requires improvement (published 15 January 2020) and there were two breaches of regulation. The provider completed an action plan after the last inspection to show what they would do and by when to improve. At this inspection not enough improvement had been made and the provider was still in breach of regulations.

Why we inspected
We carried out an unannounced comprehensive inspection of this service on 30 October and 26 November 2019. Two breaches of legal requirements were found. We served a Warning Notice in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and a requirement for Regulation 12. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment and governance.

We undertook this focused inspection to check they had followed their action plan and met the Warning Notice and to confirm they now met legal requirements. This report only covers our findings in relation to the Key Questions Safe and Well-led which contain those requirements.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to coronavirus and other infection outbreaks effectively.

The ratings from the previous comprehensive inspection for those key questions not looked at on this occasion were used in calculating the overall rating at this inspection. The overall rating for the service has changed from requires improvement to inadequate. This is based on the findings at this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Fern House on our website at www.cqc.org.uk.

Enforcement
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so

We have identified breaches in relation to safe care and treatment, safeguarding and governance at this inspection. 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.

We have identified a breach in relation to failure to notify CQC about significant events at this inspection and are reviewing our regulatory response outside of the inspection process.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures
The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe. And there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement

procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the 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?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-Led findings below

Fern House

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by two inspectors, a medicines inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Fern House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

This service also provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented and is the occupant's own home. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection

We gave a short period of notice that we would be making phone calls to people who lived in the care home, their relatives and people in the extra care housing scheme. This was so their permission could be sought before we made the phone calls.

The site visit to the care home was unannounced. Inspection activity started on 15 January 2021 and finished on 29 January 2021. We visited the care home and extra care housing scheme on 19 January 2021.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority, Healthwatch and professionals who work with the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We used all of this information to plan our inspection.

During the inspection

We spoke with nine people who used the service and nine relatives about their experience of the care provided. We spoke with twelve members of staff including the registered manager, quality manager, director of housing services, deputy manager, senior care workers, care workers and the maintenance person. Discussions with people who used the service, relatives and staff were conducted either on site or via telephone calls.

We reviewed a range of records. This included five people's care records and a sample of medication records. We looked at one staff recruitment file. A variety of records relating to the management of the service, including some policies and procedures, were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant people were not safe and were at risk of avoidable harm.

At our last inspection the provider had failed to ensure medicines were managed safely. This was a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider was still in breach of regulation 12.

Using medicines safely

- Medicines management was not always safe. We identified similar concerns around the recording of topical medicines and protocols for 'as required' medicine as we had found at the last inspection.
- Topical medicine administration records (TMARs) were not always in place for prescribed creams to ensure staff knew how, where and when to apply them. Where TMARs were in place these had not been completed correctly. For example, body maps not filled in, allergies not recorded, opening and use by dates not completed.
- Some people were prescribed pain patches which had specific guidance from the manufacturer regarding where and when these should be applied. Records did not evidence this guidance was being followed.
- Protocols for 'as required' medicines were not person-centred and did not provide clear directions for staff as to when they should be administered. This was particularly in relation to medicines used to calm people and manage anxiety and agitation. There were no records to show why the medicine had been given or whether it was effective.
- The provider's medicine policy needed reviewing to ensure it reflected current NICE guidance.

We found no evidence that people had been harmed however, systems were not in place to ensure medicine management was safe. This placed people at risk of harm. This was a continued breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our last inspection the provider had failed to ensure risks to people were identified and managed. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Enough improvement had not been made at this inspection and the provider was still in breach of regulation 17.

Assessing risk, safety monitoring and management

- Risks to people were not always managed safely. Assessments did not always reflect the risk level. For example, one person had fallen frequently which resulted in serious injury on two occasions but their assessment showed they were at low risk of falls.

● The service did not always update risk assessments when people's needs changed and after serious events. For example, one person's risk assessment had been updated on 6 November 2020, yet they had sustained three falls since that date and there had been no further review.
● Accidents and incidents were not always monitored. Staff did not always complete a form when people had fallen or were aggressive towards other people they lived with. This meant the management team did not have an overview of what happened at the service and decide if additional measures were required.
● Records showed hot water temperatures at some of the sinks and showers used by people in the care home exceeded 44 degrees centigrade placing people at risk from scalding. No action had been taken to address this issue.
● Records showed two fire drills had been carried out in the last 12 months involving 15 staff. Five staff told us they had not taken part in a fire drill, three of whom had been employed at the service for two years.
● Staff who supported people in the extra care housing scheme told us they were not always informed of changes in people's needs as handovers between staff were inconsistent.

The lack of robust risk management processes meant people were not protected from harm or injury. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider responded during the inspection. They confirmed that a new accident and incident process was being introduced across the service and all accidents and incidents would be reviewed.

Learning lessons when things go wrong
● People were having multiple falls yet there was no evidence of learning or action taken to prevent repeat events.
● Where actions had been identified when things had gone wrong, these were not always completed. For example, learning from one incident stated additional training in emergency first aid would be provided for all staff by 3 December 2020. The training matrix showed this had not happened.

Systems were not in place to ensure learning from events when things went wrong or that action was taken to improve safety. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● Safeguarding procedures were not followed consistently. The provider did not always report safeguarding incidents to the local safeguarding authority and CQC. For example, incidents between people who used the service. This meant other agencies did not have oversight of what was happening.
● The service did not always protect people from potential abuse and neglect. Investigations were not always carried out when people were harmed. For example, if people had unexplained injuries.

The provider failed to ensure people were protected from the risk of abuse. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Most people and relatives we spoke with raised no concerns about staffing levels. However, one person commented that staff were sometimes 'rushed off their feet' and another person said shift changes and moving staff from the extra care housing scheme to the care home meant they were sometimes short-staffed.

● Staff told us they were often short staffed which they said impacted on the care they were able to provide. Staff described being 'rushed' and 'really full on'. They said sometimes agency staff were brought in but not always.
● The provider had no formal system in place to calculate safe staffing levels. The registered manager told us the current staffing levels were two senior care workers and nine care staff on duty throughout the day. Duty rotas showed these levels were not maintained.

We recommend the provider reviews staffing levels to ensure there are always sufficient, competent staff on duty to meet people's changing needs.

● Recruitment processes were safe with all required checks completed before new staff started employment.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.

● We were assured that the provider was meeting shielding and social distancing rules.

● We were assured that the provider was admitting people safely to the service.

● We were assured that the provider was using PPE effectively and safely.

● We were assured that the provider was accessing testing for people using the service and staff.

● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.

● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.

● We were assured that the provider's infection prevention and control policy was up to date.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At the last inspection we found the quality assurance systems in place were not sufficiently robust. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations. Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Continuous learning and improving care

- Significant shortfalls were identified at this inspection. There were continued breaches in relation to medicines and risk management; issues identified were similar to those raised at the last inspection. We also had significant concerns around safeguarding. None of these issues had been identified or addressed through the provider's own governance systems.
- There was a lack of effective management and leadership. Staff described managers as friendly and approachable however, they said issues raised were not always acted upon. For example, meeting minutes showed concerns had been raised about staffing levels and handovers in November 2020, yet no action had been taken and these remained an issue at this inspection.
- The registered manager was not always fully aware of what was happening in the service. For example, they said there were 27 people receiving personal care in the extra care housing scheme, yet handover records listed 33 people.
- The management team did not know how many accidents and incidents had occurred because the monthly analysis did not capture all events. The analysis for December 2020 showed a total of 5 incidents in the service yet our review found 23 incidents. This included multiple falls and incidents between people using the service.
- Quality audits were not effective in identifying issues and securing improvements. For example, medicine audits were limited in scope with the same issues recurring. Care plan audits identified shortfalls yet there was nothing to show what action had been taken to address these.
- Care records for people using the service were not always accurate or up to date. Although information about people's daily routines was very personalised; risk assessments and care plans were not always accurate or updated when needs changed.
- Provider oversight and monitoring was ineffective in identifying and managing organisational risk. The provider held weekly business review meetings with the service. The meetings were limited in scope with same areas discussed each time. The meetings had not identified any of the issues we found at this inspection.

We found systems to assess, monitor and improve the service were not sufficiently robust. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the inspection the provider submitted an action plan detailing improvements they would be making to the service.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● The provider had submitted notifications about some significant events to CQC. However, reporting of incidents and risks was unreliable and inconsistent. The provider did not always notify CQC of deaths, allegations of abuse and incidents of serious injury, which meant they did not fulfil their legal responsibility.

Failure to submit required notifications meant CQC were not made aware of some notifiable events so were unable to carry out their monitoring role. This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Registration) Regulations 2014.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People and relatives we spoke with gave positive feedback about the care they received and praised the staff. Staff were described as 'marvellous', 'very kind', 'pretty good, brilliant' and 'absolutely first class'. One relative said their family member was really happy and had flourished in the service. They stated. "If there was a score out of ten, I'd give them twenty".

● People and relatives confirmed staff had supported them to keep in touch with one another through video and phone calls while visiting was suspended. All felt they had been kept informed of what was happening in the service throughout the COVID-19 pandemic.

● Staff said they enjoyed working at the service and got on well with the management team. All felt they could raise any issues but some said these were not always acted on.

● Records showed the service liaised with a range of health and social care professionals in meeting people's needs.