Ewart and Dilworth Limited

Ferguson Lodge

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 well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Ferguson Lodge is a care home providing accommodation and personal care for up to 46 people. The service provides support to people with a dementia related condition, physical disability, sensory impairment or older person in 1 adapted building. At the time of our inspection there were 39 people using the service.

People's experience of using this service and what we found
A system to ensure regulatory requirements were met was not in place. We identified widespread shortfalls across the service including the assessment of risk, management of medicines, duty of candour, safeguarding, need for consent, staffing and governance.

A duty of candour policy statement was in place. However, this did not assure us the provider understood their responsibilities in relation to this regulation. Documentation to show how staff had worked in an open and transparent way and to evidence what actions had been taken in response to notifiable safety incidents were not in place.

Systems were in place to recruit staff safely. However, there were inconsistencies in the recruitment records viewed. We have made a recommendation about this. A range of risk assessments were in place. However, all the risks people were exposed to had not been fully assessed. Risk assessments to ensure the safety of the environment and equipment were not always in place. For example, a legionella risk assessment had not been completed in line with requirements. Medicines were not always managed safely.

Appropriate action had not always been taken to safeguard people from the risk of abuse and some incidents had not been reported to the local authority in line with their reporting thresholds. There were not enough staff to meet people's needs. We observed periods where people had to wait for staff support due to them being busy doing other tasks. One person told us they regularly had to wait for support due to staff being very busy. Staff displayed kind and caring attitudes towards people during their interactions and people spoke positively about staff.

People were not supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. For example, staff had not always assessed people's ability to consent to their care and treatment.

The provider had not ensured the 'Statement of Purpose' for the location had been notified to CQC and effective communication systems were not fully in place to share information between staff. We have made a recommendation about this.

There were gaps in the training delivered to staff which had been deemed mandatory by the provider. In

addition, not all staff had completed training in relation to supporting people who have a learning disability or autism which is a legal requirement.

People's nutrition and hydration needs were met. However, the meal time experience was not always person-centred for some people. We have made a recommendation about this. Systems were in place to work with health care professionals to ensure the physical health needs of people were met.

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

Rating at the last inspection
The last rating for this service was good (published 5 October 2018).

Why we inspected
The inspection was prompted in part by notification of an incident following which a person using the service sustained a serious injury. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk of accidents and incidents and the safety of equipment. This inspection examined those risks.

After our inspection visits we received further information informing us a second person using the service had sustained serious injuries. This incident is also subject to further investigation by CQC as to whether any regulatory action should be taken. Therefore, the inspection did not examine the circumstances of this incident either. However, a decision was taken for us to complete further inspection visits to check the safety of the service and equipment used.

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 COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection.

We have found evidence that the provider needs to make improvements. Please see the safe, effective and well led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

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

Enforcement and recommendations
We have identified breaches in relation to the statement of purpose, need for consent, safe care and treatment, safeguarding, good governance, staffing and duty of candour at this inspection. We have also made recommendations in relation to recruitment and person-centred care during meal times.

Please see the action we have told the provider to take at the end of this report.

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 continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Ferguson Lodge

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 Health and Social Care Act 2008.

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
This inspection was undertaken by 5 inspectors, an operations manager 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
Ferguson Lodge is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Ferguson Lodge is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed the information we held about the service, including the statutory notifications we had received from the provider. Statutory notifications are reports about changes, events or incidents the provider is legally obliged to send to us. We contacted the local authority commissioning and safeguarding teams, the local NHS infection prevention and control [IPC] team, fire service, Integrated Care Board and Healthwatch to request feedback. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 9 people who used the service and 5 relatives about their experience of the care provided. We spoke with 18 members of staff including the registered manager, deputy manager, duty manager, administrator, senior and care staff. In addition, we received feedback from one healthcare professional.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We reviewed a range of records, this included care and medicine records for 27 people. We looked at the recruitment records for 3 staff and a variety of records relating to the management of the service, including policies and procedures. Following the inspection site visits we requested additional information by email and continued to seek clarification from the provider to validate the evidence we found.

Requires Improvement

Is the service safe?

Our findings

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

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- Safeguarding systems were not effective in protecting people from the risk of abuse. Some people's movements were restricted by staff without the appropriate legal authority. For example, some people were sat in chairs with a side table placed in front of them and their walking aid moved out of their reach to prevent them from getting out of chairs.
- Staff had not always recognised when an incident required a safeguarding referral. For example, we read documentation which detailed a person received a burn to their scalp. The deputy manager confirmed this incident had not been reported to the safeguarding authority when it should have been.
- Some competency assessments had been completed with staff to assess their performance. However, we observed one occasion of staff not adhering to safe procedures. In addition, we received concerns about moving and handling practices. We passed these concerns to the relevant agencies.
- Following the inspection we made a number of referrals to the local authority safeguarding team to share our inspection findings.

The providers failure to ensure effective systems were in place to protect people from the risk of abuse was a breach of Regulation 13 (Safeguarding) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment

- There were not always enough staff to meet people's needs. Staff restricted some people in chairs if they were busy completing other tasks and were unable to provide support or observe people. One staff member told us, "We put tables in front of people and give them a drink before we go and do another task. We think of things to do so that we know people are going to be safe in their seats if we are away supporting other people."
- Staffing requirements were assessed using a dependency tool. However, the dependency tool used in the home assessed information differently to the electronic care system used. In addition, it was not clear if the information used to assess dependency was accurate due to the practice of staff restricting people in chairs.
- Several people required support from 2 staff when receiving personal care. There were delays in staff responding to people who required help due to their being insufficient staff to meet people's needs.

The providers failure to ensure there were sufficient numbers of staff to meet people's needs was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff interacted positively with people. Throughout the inspection we observed numerous positive

interactions where staff treated people with care and kindness.
● Systems were in place to ensure staff were recruited safely. Appropriate pre-employment checks such as checking references were completed. However, there were some employment gaps for candidates which had not been considered during the recruitment process.

We recommend the provider reviews their systems to ensure best practice guidance is always followed during the recruitment process.

Assessing risk, safety monitoring and management
● Environmental risks had not always been adequately assessed. For example, a risk assessment was not in place in relation to the management of legionella bacteria within the home. This is necessary to comply with safety regulations. The provider wrote to us following the inspection to advise they were in the process of organising the completion of a risk assessment.
● Evidence was not available to show regular checks were being completed for wheelchairs and bed rails to ensure they remained safe to use. Maintenance records specified wheelchair checks were supposed to take place on a weekly basis. There were large gaps in the records to evidence when these checks had taken place. For example, the checks for a number of people showed their wheelchair had been checked once within a 12 month period.
● Some checks had been completed to assess the safety of beds and bed rails. However, the deputy manager was unable to confirm what the providers expectation was for how often these checks were required. A schedule of regular documented checks were not in place. The registered manager/nominated individual told us beds were checked daily by care staff but there was no evidence to support this. One staff member said, "Maintenance staff carry out any equipment checks. We [care staff] would report things if we noticed it."
● Risks people were exposed to were not always adequately assessed. For example, some records were not detailed enough and contained information which was contradictory. The malnutrition universal screening tool [MUST] for 1 person had been incorrectly calculated which increased their risk of experiencing harm. In addition, risk assessments had not been updated where a maintenance issue had been identified with bed rails to reassess the risk people were exposed to while waiting on repairs.

The provider's failure to ensure risks were adequately monitored and assessed was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely
● Medicines were not always managed safely. Quantities of remaining medicines did not always match the records of doses administered. This meant we could not be assured medicines were always administered as prescribed.
● Medicine administration records [MAR] were not consistently completed. For example, handwritten entries did not always include the quantity received or carried forward. In addition, where codes were used to record a medicine had not been administered, the reason for this was not clearly documented.
● Guidance was not always in place to support the safe administration of topical medicines [creams and lotions applied to the skin]. Records were not clear to guide staff in how often creams should be applied and some records were missing. One person had medication applied to the skin as a patch. Records to demonstrate the patch was rotated in line with the manufacturer's guidance was not in place. This increased the risk of this person experiencing side effects.
● Protocols for medicines prescribed on a 'when required' basis or which had a variable dose were not always in place. The reason a 'when required' medicine was administered and the outcome of its effectiveness was not always recorded. This meant there was a risk people did not receive their medicines

consistently.

While we did not identify any impact to people the providers failure to ensure medicines were managed safely was a breach of Regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 supporting people living at the service to minimise the spread of infection.
● 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 responding effectively to risks and signs of infection.
● 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.

Visiting in care homes
● Procedures were in place to support visits in the home. People were supported to see their relatives to help promote their wellbeing.

Learning lessons when things go wrong
● Following the inspection, we wrote to the registered manager/nominated individual to request an action plan which addressed our inspection findings. The registered manager/nominated individual told us they were committed to taking the necessary action to deliver service improvements and learn lessons to ensure they were always providing a quality service which was safe.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection we rated this key question good. At this inspection the rating has changed to requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
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 MCA 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. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS).

We checked whether the service was working within the principles of the MCA, whether appropriate legal authorisations were in place when needed to deprive a person of their liberty, and whether any conditions relating to those authorisations were being met.

- People's ability to consent to their care and treatment was not always assessed. Where people lacked the capacity to make particular decisions for themselves best interest decisions had not always been completed.
- Staff had not always recognised instances where people were restricted. For example, best interests decisions had not been completed for people who could not consent to the use of bedrails or wheelchair lap belts but were restricted by these.
- We read documentation where staff recorded they had locked the bedroom doors of some people during the night to manage an incident. The registered manager/nominated individual told us staff had implemented emergency measures in response to this incident. However, capacity assessments had not been completed after this incident to assess if people had the capacity to understand how to open their bedroom door independently from the inside should the situation arise again.

The providers failure to ensure the principles of the MCA were followed was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Relevant applications had been made to the local authority for DoLS authorisations where people lacked capacity to consent to their care and treatment.

Staff support: induction, training, skills and experience
● Training assessed as mandatory by the provider had not been completed by all staff. This included the registered manager and management team. In addition, from 1 July 2022, all health and social care providers registered with CQC must ensure their staff receive training in learning disability and autism. The provider had not implemented the 'Oliver McGowan' mandatory training on learning disability and autism which is the government's preferred and recommended training for health and social care staff to undertake.

The failure to ensure an effective system was in place to ensure all staff were trained and suitably skilled to carry out their job role was a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Systems were in place to ensure staff received regular supervision with a member of the management team. The registered manager was not a visible presence in the home and therefore was not involved in the support systems in place for staff.

Staff working with other agencies to provide consistent, effective, timely care
● Records did not fully demonstrate an effective system was in place for the sharing of information between external agencies.

We recommend the provider reviews their communication systems to ensure records demonstrate there is effective information sharing between external agencies.

Supporting people to live healthier lives, access healthcare services and support; Supporting people to eat and drink enough to maintain a balanced diet
● Systems were in place to support people with their health needs. We received positive feedback from a visiting healthcare professional of their positive working relationship with staff and of things being in place to meet people's healthcare needs.
● Records did not always demonstrate people had been supported with their oral healthcare.
● People's nutritional and hydration needs were met. People told us food was appetising and that alternatives were available if they did not want to choice on the menu.
● The meal time experience was not always person-centred. People on the first floor ate their meals in the lounge. A member of staff told us they did not support people to go to the dining room for their meals due to the lift being unreliable. People eating in the lounge were given their main meal and pudding at the same time.

We recommend the provider reviews current best practice guidance in relation to person-centred care around mealtimes.

Following our inspection, the provider wrote to us and stated people were offered the opportunity to use the dining room at mealtimes. They also explained they regularly observed mealtimes and had not seen people being served their main meal and pudding together. In addition, a recent food questionnaire in August had not raised any concerns relating to the mealtime experience.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law; Adapting service, design, decoration to meet people's needs
● People's needs were assessed and a range of assessments were completed to meet people's needs.
● The home was appropriately adapted to meet people's needs. Signage was used to help orientate people

in the building.

- People could personalise their bedrooms with belongings of their choosing to reflect their preferences.

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 our last inspection we rated this key question good. At this inspection the rating has changed 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.

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

- The registered manager/nominated individual did not have effective oversight of the service. They did not work at the home on a full time basis and delegated managerial tasks to the deputy manager, duty manager and administrator. There was no evidence the registered manager/nominated individual completed audits of the service to monitor the work completed by staff or to monitor compliance with the regulations.
- Effective governance systems were not in place. A range of audits were completed. However, they were not effective in monitoring quality at the service. This was evidenced by the breaches of regulation we identified during our inspection.
- Some records were not held on site. This impacted on the ability of staff to monitor quality and safety. For example, on the first day of the inspection we requested maintenance records and environmental risk assessments for the home. There were delays in providing this information to us due to the registered manager/nominated individual's difficulty in locating the relevant records. In addition, some records were not available and could not be provided to us.

The providers failure to ensure an effective governance system was in place was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider had not ensured the 'Statement of Purpose' for the location had been submitted to CQC in line with legal requirements. A statement of purpose is a legally required document that includes a standard set of information about a service.

The failure to ensure the Statement of Purpose was notified to CQC was a breach of Regulation 12 (Statement of purpose) of the Care Quality Commission (Registration) Regulations 2009.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- An effective system for the sharing of information between staff was not fully in place. For example, records did not demonstrate how communication was shared between external care staff working into the home.
- Handover records were not always detailed and some staff would simply write "No concerns" when recording information to pass to their colleagues.

The providers failure to ensure effective communication systems were in place to share relevant information with staff was a breach of Regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Relatives told us staff communicated with them well and responded to any feedback they had. One relative said, "[Name of deputy manager] is very helpful to any queries I may have."
● Some links had been established with community organisations to promote equality and diversity within the home. This included a visit from a local school where the children had a mission to spread joy and happiness and a visit from a local community group who undertook cookery and craft sessions with people.

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
● A duty of candour policy statement was in place. However, this did not assure us the provider understood their responsibilities in relation to this regulation.
● Documentation to show how the provider was meeting its duty of candour responsibilities was not available. There had been 7 incidents during the last 12 months which met the criteria as being a notifiable safety incident under the duty of candour regulation. The deputy manager told us they had communicated with relevant people when incidents had occurred. All the necessary actions required to be compliant with the duty of candour regulation had not been completed.

The providers failure to ensure a system was in place to meet the requirements of the duty of candour was a breach of Regulation 20 (Duty of candour) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The deputy manager told us their policy and procedure in relation to duty of candour would be updated.

Working in partnership with others
● Staff had been liaising with the local authority and other agencies with regards to the concerns identified during our inspection. They had also worked with health and social care professionals with regards to people's care and support.

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 12 Registration Regulations 2009 (Schedule 3) Statement of purpose An effective system to ensure the Statement of Purpose was reviewed and updated was not in place. Regulation 12 (1)(2)(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Processes were not always followed correctly to ensure that people's rights were upheld and decisions were made in the best interests of people who lacked the mental capacity to make specific decisions themselves. Regulation 11 (1)(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment An effective system to assess, monitor and manage risk was not in place. Medicines were not managed safely. Regulation 12 (1)(2)(a)(b)(c)(d)(e)(g)(h).

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 An effective safeguarding system was not in place.

Regulation 13 (1)(2)(3).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance An effective system to monitor the quality and safety of the service was not in place. Regulation 17 (1)(2)(a)(b)(c)(d)(i)(ii)(e)(f).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 20 HSCA RA Regulations 2014 Duty of candour Records did not demonstrate how the provider was meeting their responsibilities under the duty of candour. Regulation 20 (1)(2)(3)(4).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing An effective system to ensure sufficient numbers of suitably skilled, competent and supported staff were deployed, was not fully in place. Regulation 18 (1)(2)(a).