Fernbrook Care Homes Limited

Fernbrook House

Inspection report

37-47 Fernbrook Avenue, Southend On Sea, SS1 2QW
Tel:01702 460364

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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?	Requires improvement

Overall summary

The inspection took place on the 14 and 15 December 2015.

Fernbrook house is registered to provide care and accommodation with nursing care for up to 30 older people who may have care needs associated with dementia. At time of the inspection there were 29 people living in the service.

The home had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Concerns we found during our inspection were mainly confined to people who received care on the first floor of the service.

People's needs were being met, however people's comments varied on whether the service had sufficient numbers of staff to cover both floors at all times of the day and night. There were concerns about the deployment of staff specifically on the first floor in terms of supporting people with higher care needs.

Opportunities for people to engage in social activities were variable, particularly for people who were immobile and/or remained in bed so improvements were required.

Summary of findings

Most people to have sufficient amounts to eat and drink to ensure that their dietary and nutrition needs were being met; however the dining experience was not always good for everyone.

There were systems in place to seek the views of people who used the service and their relatives on how the home can make improvements people and relatives did feel this was effective. Relatives and people who used the service knew how to make a complaint and were assured that all complaints would be dealt with and resolved in a timely manner. The service had a number of ways of gathering people's views about the quality of the service which included holding meetings with people, staff and relatives.

Arrangements were in place to ensure that staff had been recruited safely and received opportunities for training, we found all staff to have received regular supervision however the manager had not received formal supervision since commencing employment to provide them with ongoing support and opportunity to identify any areas of their practice that might require improvement.

Staff knew the needs of the people they supported. We found that people were always treated with respect and dignity and people received good care.

The registered manager had a very good knowledge of the recent changes to the law regarding Deprivation of Liberty Safeguards (DOLS) and was also aware of how and when to make a referral if required. People were safeguarded from harm. Staff had received training in Mental Capacity Act (MCA) 2005 and had knowledge of Deprivation of Liberty Safeguards (DoLS).

The service had a number of quality monitoring processes in place to ensure the service maintained its standards however they did not appear to have been effective.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

Views about staffing levels were mixed and some people, staff and relatives on the first floor felt that not enough trained and experienced staff were available. This was because of how staff were deployed to support people.

People who used the service felt safe. Staff knew what to do if they were concerned about people's safety and welfare.

We found people's medicines were managed and stored safely. Staff were recruited safely.

Is the service effective?

Requires improvement

The service was not consistently effective.

People's dining experience was not always positive. People did not always get the support they needed with meal provision. People did not appear to be given a choice of meals nor could we evidence people being supported in decision making.

Management team and staff had good knowledge of legislative frameworks i.e. Mental Capacity Act 2005 to ensure people's rights were protected.

Staff received an initial induction. On-going support was offered to staff who attended various training courses which enabled them to apply knowledge to support people effectively.

Access to healthcare professionals was available when required.

Is the service caring?

Requires improvement

The service was not consistently caring.

Staff treated people kindly and respected people's privacy.

We found staff not to always be knowledgeable of people's individual care.

Is the service responsive?

Requires improvement

The service was not responsive to people's needs.

People were not always engaged in meaningful activities and supported to pursue pastimes that interested them, particularly for people living with dementia.

Staff were not able to consistently be responsive to people's needs.

People's care records were not sufficiently detailed or accurate to their needs.

Effective arrangements were in place for the management of complaints.

Summary of findings

Is the service well-led?

The service was not consistently well-led.

The Registered Manager did not have enough time in the week to manage the service.

The service had a number of quality monitoring processes in place to ensure the service maintained its standards however they did not appear to have been effective.

There were systems in place to seek the views of people who used the service and their relatives on how the home can make improvements people and relatives did feel this was effective.

Requires improvement 

Fernbrook House

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 Registered Manager is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on the 14 and 15 December 2015 and was unannounced. The inspection was undertaken by two inspectors on the 14 December 2015 and one inspector on the 15 December 2015.

Before the inspection we reviewed the information we held about the service including previous reports and notifications. We also reviewed safeguarding alerts and information received from a local authority and other Commissioners. Notifications are important events that the service has to let the Care Quality Commission know about by law. We use this information to plan what areas we were going to focus on during our inspection.

Some people were unable to communicate with us verbally to tell us about the quality of the service provided and how they were cared for by staff. We therefore used observations, speaking with staff, relatives and reviewing care records to help us assess how people's care needs were being met.

We spent time observing care in the communal areas and 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 looked at the recruitment and support records for three members of staff. We reviewed other records such as medicines management, complaints and compliments information, quality monitoring and audit information and maintenance records relating to the premises.

Requires improvement

Is the service safe?

Our findings

At our last inspection in November 2014 we had concerns about the amount of staff available to meet people's needs however this was due to an unexpected staff shortage on the day of inspection. At this inspection we found that improvements needed to be made as people could be at risk due to inadequate staffing levels. There was not enough staff to keep people safe and meet their needs at all times.

People's views on staffing levels were mixed between the two floors. On the ground floor we found staff to be alert to any concerns or dangers resulting from people's choices, being distressed or anxious, however on the first floor despite staff being alert to people's needs, staff were rushed and task focussed. One person informed us, "I am no longer able to walk so I need support to get to the lounge; however I opt to stay in my room as I have to wait about an hour for staff to come and help me."

Staff's comments about staffing levels at the service were varied. Although some staff told us that staffing levels were acceptable and they could meet people's day to day needs, others informed us staffing levels were inadequate to meet people's needs and that this could be stressful especially when the home was at full capacity.

Our observations on the first day of the inspection over a 20 minute period in the morning showed that although there were three members of staff on duty, three people sitting in the upstairs lounge became anxious and distressed. During this observational period no staff came into the lounge to ascertain why people were distressed and this was due to the members of staff supporting other residents with their care needs elsewhere. One person shouted out throughout the day as though in pain. This appeared to agitate others sitting in the upstairs lounge after a period of time. Some people became increasingly more impatient holding their heads trying to shut the noise out, whilst others shouted back for them to "stop shouting." This was all fed back to the manager who informed us that this was not a regular occurrence, the person was monitored over a period of two hours and a referral was made to the Doctor. An additional member of staff was called in to support staff on the first floor.

On the second day of inspection we noted people in the first floor lounge were still anxious and repeated shouting at each other. One person was repeatedly asking if they could be taken shopping and another was shouting at other residents. The inspector intervened by asking the one of the people what they wanted to go and buy from the shops. The inspector alerted the manager to the person's request and they then arranged for one of the care staff to sit down with the person to write a shopping list. A member of staff sat down with the person and wrote a shopping list this helped the person to settle and focus on their shopping list. And for the person who was shouting at other residents, once the inspector had intervened and found out they liked Elvis, the manager brought them a picture of Elvis Presley and immediately the person mood changed. The person appeared happy and shared love for Elvis with the residents who were sitting next to them.

We found staffing levels to be insufficient on the first floor to meet people's needs safely. We also found call buzzers in both lounges not to be accessible to people meaning they had to call out if they needed assistance; this placed them at risk of their needs not being met and was not dignified for them. People on the first floor informed us they had to wait at least an hour for care staff to assist them. People using the service also added that the service seemed to be short on a regular basis despite them not knowing what the staffing levels were.

Our observations showed that the deployment of staff throughout our inspection was not always appropriate to meet people's needs especially on the first floor which housed people with complex care needs and required regular assistance with personal care and food and drink provision.

As part of the inspection we wrote to the provider after our visit raising our concerns around staffing levels in the home, the provider has since responded advising that staffing staff levels would be increased to ensure people's needs were being met adequately. Although this was encouraging we judged the service to be in breach of regulation due to the poor care outcomes people had experienced, staff's lack of knowledge of how to support people who became anxious and because this had already been highlighted as a concern during a previous inspection and not addressed sufficiently.

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

Requires improvement

Is the service safe?

Although staff understood their general duties in regards to keeping people safe, we were concerned that some people were experiencing poor emotional care outcomes and staff did not seem to know how to support these people to keep them safe and calm. In general staff were able to indicate how people may be at risk of harm or abuse and how they would go about protecting them and ensuring their safety. Staff knew about the provider's whistleblowing policy and procedures. Staff told us that they would escalate their concerns to the registered manager. If the concerns were about the registered manager staff stated they would contact the provider and/or other external agencies, such as Social Services.

We found the risk to some people was not always well managed, for example, during the inspection we observed staff attempting to mobilise one person with the use of a wheelchair with foot plates that were in a fixed knee high position. Although the person did not injure themselves on this occasion, when the person was mobilised with the wheelchair they appeared to be uncomfortable and facial expressions led us to believe the person was in pain. The person repeatedly moved themselves to the edge of the wheelchair seat trying to get off. Due to difficulties staff were facing with the equipment available it took four members of staff to transfer the person from one chair to the other. On reviewing the person's moving and handling assessments we found staff to be using the appropriate equipment. This was fed back to the manager who in turn decommissioned the use of the broken equipment and advised staff to use an alternative item of equipment. Despite this incident with the wheelchair we found risk assessments relating to the premises and equipment were completed, for example, risk assessments for people who had bed rails in place were completed detailing the potential risk of injury to the person.

The service ensured that it employed suitable staff because a clear recruitment process was followed. This made sure that staff were suitable to work with people in a care setting. Relevant checks had been carried out including obtaining at least two references, ensuring that the applicant provided proof of their identity and undertaking a criminal record check with the Disclosure and Barring Service (DBS).

We observed a staff member during their medication administration duties and they did so safely, ensuring that people received their prescribed medications as required and in a timely manner. Staff administered medicines to people in a way that showed respect for their individual needs, for example, they explained what was happening, sought people's consent to administer their medication and stayed with them while they took their medicines to ensure that it had been administered safely. Staff had received training in administering medicines and had their practice checked periodically. We reviewed medication administration records and found these to be in good order. Medication was stored and disposed safely.

Requires improvement

Is the service effective?

Our findings

People's dining experience was not always positive. During a 45 minute period in the downstairs lounge we observed one person struggling to eat their lunch due to limited dexterity in their hands and pain in their arm. The person had been left in a wheelchair and did not appear to be comfortable whilst eating and repeatedly asked to be taken back to the first floor lounge were they normally have dinner in their comfortable chair. During this time no staff came into the downstairs lounge to support this person with eating or cut up their food into bite sizes. When staff did arrive they asked if the person was finished and simply took the plate away before they had time to respond. The person repeated complained of pain in their arm, this was brought to the attention of the manager who then arranged for the person to be transferred to a more comfortable chair and was offered pain relief.

The service needed to improve the way mealtimes are organised and how choices are offered to people, including offering clear support and explanations to people which choices were being served. On the first floor lounge we observed people eating their lunch in the chairs they had been transferred into in the morning. We saw staff supporting people to eat in the lounge and one person in their bedroom. Staff were seated next to or in front of the person they were assisting and were heard to encourage an upright sitting position. Although staff were heard asking if the food was satisfactory and people were offered some encouragement to eat, there was no explanation nor description of what people were eating. We did not hear any choice of meal being offered, main or dessert and the only time people were given a choice of drinks was for tea or coffee outside of meal times. We observed one person pushed their dessert away saying, "It's disgusting." When we asked what it was, the person did not know and we could not tell either. Although the person was offered yoghurt as an alternative, the member of staff placed two yoghurts in front of the person only saying, "A strawberry one and an apricot one", then left the person to work out what had been said and which one was which. The person did not appear to have understood what had been said to them by the member of staff neither could they decide which yoghurt they were going to have. The person did eat one of the yoghurt, however very little support was offered in making a decision.

The nutritional needs of people had been identified and where they were considered to be at nutritional risk, we found that appropriate referrals to a healthcare professional such as GP, Speech and Language Therapist and/or dietician had been made.

Staff told us they received an effective induction over two weeks depending on their role and responsibilities. This included an induction of the premises and training in key areas appropriate to the needs of the people they supported. Staff told us, and the records confirmed that they had received recent training that included first aid, food safety, health and safety, infection control, dementia, mental health and equality and diversity. One staff member said, "The training is good we cover a range of interesting subjects that help me to do our work." Another said, "Most of the training is in-house such as moving and handling, first aid and fire. Some staff told us they had completed a national qualification this being National Vocational Qualification in Care. People were cared for by well trained staff. Staff we spoke to confirmed that they had completed an induction and that it had included opportunities where they shadowed a more experienced member of staff. This was so that they could learn how to support people effectively and understand the specific care needs of people living in the service. The staff training files we viewed showed that staff received training and reminders were set by the management team for when refresher training was required or due.

Staff felt supported by team meetings, formal and informal supervision and they had a structured opportunity to discuss their practice and development. One staff member informed, "The manager makes the team feel like a family, we can ask them anything and they will always support us and involve us in decision making." During the inspection the manager informed that they were currently in the process of reviewing and planning staff's annual appraisals.

During the inspection we saw some staff explaining and consulting with people to ensure effective communication. We also heard some people were asked for their views and permission before any activity took place and their views were respected. This showed us that staff understood the need for people to have choice and control in their daily lives as far as possible.

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

Requires improvement

Is the service effective?

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).

The registered manager had an understanding of the principles and practice of the Mental Capacity Act 2005 [MCA] and Deprivation of Liberty Safeguards [DoLS]. The registered manager informed us that they worked hard to ensure that people's needs and rights were respected. Appropriate applications had been made to the local authority for DoLS assessments. Where these had been agreed the provider had notified the Care Quality Commission. Staff had received training in MCA and DOLS and understood that they needed to respect people's decisions.

People's healthcare needs were monitored and supported through the involvement of a range of relevant professionals such as General Practitioner (GP) and diabetes nurse specialist. We found that people received appropriate healthcare support to meet their diverse needs. People and most relatives were happy with the level of healthcare support provided and told us that they were kept informed about people's health and wellbeing.

Improvements were required in the way the premises were maintained to meet people's individual needs by the adaptation, design and decoration of the service. We found the premises tired, worn and in need of redecoration and refurbishment throughout.

Requires improvement

Is the service caring?

Our findings

Although some people told us staff were kind and caring and relatives said, “Staff here are very nice, my relative has been to several other homes before this one and the care they receive here is very good” and, “When my relative first moved here twelve months ago we were told that they only had days to live however since coming here their health has improved immense”, we found that some staff were not knowledgeable of people’s individual care needs nor did they have knowledge of their histories and backgrounds. Staff did not always support people in a person centred way, their responses and interactions with people were often task led and routine based. For example, people, at times, had to wait long periods before being supported and people were not being engaged. And where staff did speak to people, although they did so in a calm, respectful manner, did not also allow them the time they needed to carry out any tasks.

For those people able to verbalise, we were told that staff treated them with dignity and respect. People’s privacy was respected and they were able to spend time in their rooms or in communal areas as they preferred. And although most staff’s practice demonstrated an understanding of the need to treat everyone with dignity and respect this was not always the case for those living with dementia who experienced poor care outcomes at times because staff did not attempt to engage with them to help them maintain their dignity.

Some people were asked for their views and were involved in their day to day care through being offered choice as far as possible in their daily lives. Some relatives we spoke with confirmed that they had been involved in care planning and felt their views were listened to. One relative told us, “The manager and care staff are always around if I have any questions.” We spoke to relatives who informed us that the service always sought advocacy support when needed to ensure that people had an independent voice, in addition we found information on advocacy support posted around the home. This meant that people and their relatives had access to the information should they require it. Advocacy services support and enable people to express their views and concerns and may provide independent advice and assistance.

We found people’s care plans that we viewed detailed each person’s preferences of care, including their past life history this ensured that staff were able to meet the needs of people effectively.

We noted that people were smartly dressed. Staff informed us that people’s well-being and dignity was very important to them and ensuring that people were well-presented was an important part of their caring role. People were able to maintain contact and continue to be supported by their friends and relatives. People’s relatives told us that they were able to visit the service at any time without restrictions.

Requires improvement

Is the service responsive?

Our findings

At our last inspection in November 2014 we had concerns about person centred care and people's involvement in their care delivery and activities. At this inspection we found that the improvements had not taken place and people were not being supported as individuals and their individual social interests and well-being was not very well catered for.

Throughout our inspection we found the lounge on the first floor was uninviting and held little to occupy a people. The lounge had an institutional feel, with the chairs set out along the three walls with the T.V. at one end of the room. We spent five hours collectively observing the care of seven people on the first floor who were sitting in the lounge. During this time a film played on the T.V which appeared to have a fault and repeated a particular section of the film again and again, however staff did not seem to notice. This went on for the whole of the first day and on our second day this was brought to attention of the manager and an alternative film was put on. We did not observe (see or hear) staff offer any form of activity or positive stimulation to any of the people sitting in the lounge. This meant people had no stimulation and minimal social interaction.

We spoke to people who used the service about activities. We were told that there were two activities co-ordinators, one who worked on a Friday and another throughout the week. One person informed us, "The co-ordinator from Monday to Thursday did not appear to know people's interests neither did they try and find out or know how to talk to people in the service." The same person went on to say, "The other co-ordinator only plays cards and dominos or does A B C, we aren't children." We noted they were able to engage people and saw people respond positively to them.

We spoke to one person responsible for providing activities on a Friday. They appeared knowledgeable about people's likes and abilities. We saw this person singing and encouraging people to join them in song, dance and movement throughout the morning. We were told that the activities co-ordinator that comes on a Friday is very good, one person said, "She's a showgirl and knows what we like."

A relative told us that their relative liked the Friday sing-a-long but there wasn't much else that went on. People who used the service told us that there wasn't enough to do; they said "We just sit here all day, day after day." People told us they had made Christmas cards with the Friday activities co-ordinator the last time they had visited and one person said, "We do get visitors which are nice but it can be a very long day with nothing to do."

Improvements were needed to ensure that all the people living at the service received support to engage in their favourite pastimes and live an active life. We found that people's care plans clearly identified their interests and likes in regards to social activities, however on looking at people's care plans and observations on the first floor it was not clear as to how people were being encouraged to meet this need.

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

The manager informed us that before each person came to the service they would assess their needs and ascertain how they would be best met. This was all documented in people's preadmission assessments. People's care plans clearly identified how people were to be supported to maintain their independence and how their needs would be best met in a safe manner. People's care plans covered nutritional, personal care, medication and how to manage and support people when they are anxious or distressed. The care plans we viewed had a person centred approach; each person's care plan clearly identified each individual's needs and how they would be best met.

People and their relatives told us that if they had any concerns then they would discuss these with the management team or staff on duty. People told us that they felt able to talk freely to staff about any concerns or complaints. There was a policy and procedure in place and people's concerns had been listened to and acted upon. Staff told us that they were aware of the complaints procedure and knew how to respond to people's concerns. A record was maintained of each complaint and included the details of the investigation and action taken.

Requires improvement

Is the service well-led?

Our findings

At our last inspection in November 2014 the service did not have a registered manager in post. At this inspection we found that the provider had employed a manager and they were registered with the Care Quality Commission.

During our inspection we observed that the service was not being effectively delivered by staff that were rushed and did not have time to meet people's needs, for example upstairs people were shouting and were clearly distressed but staff were unable to provide them with comfort or support as their duties were wholly task orientated. Upon investigating reasons for this we were informed by the registered Manager that they only worked one day a week supernumerary and therefore because of an unexpected death on the day and them being taken away from caring duties to deal with this staff were left short and without adequate support. This had a direct impact on people's wellbeing.

As part of the inspection we wrote to the provider after our visit asking for clarity in relation to the days allocated for manager to manage the service, the provider has since responded and advised that the manager's supernumerary days have been increased.

The registered manager and general manager acknowledged that the level of staffing in the home particularly on the first floor needed to improve to ensure that people's needs were being met. On the second day of our inspection the service was trialling a floating care worker to support staff on both floors this proved to work and allowed the manager time to focus on running the home and undertake managerial tasks.

It was also brought to our attention that the registered manager had not received any formal supervision since commencing their role as the registered manager. When we spoke to the general manager they confirmed that no formal supervision was recorded however they spoke to the registered manager on a daily basis and offered support where needed however they could not evidence this.

The registered manager told us that their aim was to support both people and their family to ensure they felt at home and happy living at the service. The registered manager informed us that they held meetings with relatives and people using the service as this gave the service an opportunity to identify areas of improvement and also gives relatives an opportunity to feedback to staff, be it good or bad. The registered manager was aware of the responsibilities of their role. They were constantly looking for ways to improve the service

Despite a number of effective monitoring systems in place it was evident that improvements needed to be made to improve the care and support people were receiving. Regular audits had taken place such as for health and safety, medication, falls and infection control. The registered manager carried out a monthly manager's audit where they checked care plans, activities, management and administration of the service. Actions arising from the audit were detailed in the report and included expected dates of completion and these were then checked at the next monthly audit. Notifications had been sent to CQC as required by the regulations.

Personal records were stored in a locked office when not in use. The registered manager had access to up-to-date guidance and information on the service's computer system which was password protected to help ensure that information was kept safe.

We found the registered manager to be open, transparent and highlighted their own errors and areas which needed to improve, to ensure the service was running smoothly and continually improving the care delivered to people. People felt that staff and the management team were approachable.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People using the service had limited access to meaningful activities.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements.**

This section is primarily information for the provider

Enforcement actions

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