Svivekcaregroup Limited

Mary Fisher House

Inspection report

66-68 Cold Bath Road
Harrogate
HG2 0HW

Tel: 01423503913

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Inadequate**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Mary Fisher House is a residential care home providing personal and nursing care for up to 24 people. At the time of our inspection there were 20 people living at the service. Mary Fisher House provides support to people aged over 65, some of whom live with dementia.

Accommodation is provided in one building across four floors which people could access through use of stairlifts and a passenger lift. Each bedroom had an ensuite toilet and sink and there were two shared bathrooms. People had access to some communal spaces including a living room and dining room.

People's experience of using this service and what we found
Parts of the premises had not been well maintained and were unsafe. There were fire doors, with large gaps underneath, which had been awaiting replacement since the previous inspection in April 2021. There had been longstanding issues with the hot water supply, which the provider had started to address. We observed damaged radiator covers, exposed light fittings and exposed woodwork which could cause harm to people. Parts of the building were not clean, including some bedrooms which smelt strongly of urine, and the kitchen, which had evidence of rodent droppings.

Staff infection prevention and control practices were not robust or in line with government guidance. Personal protective equipment (PPE) was not always disposed of safely, staff were observed to move their masks below their nose and mouth and were not always bare below the elbow.

Risk management processes were not well established or reliable in ensuring that risks to people were assessed and actions taken to mitigate these. When accidents and incidents occurred, these were not always recorded or followed-up.

Medicines practices were unsafe. There were occasions whereby people who used the service had received their medicines late or had not been given them, as there were none left. Sufficient and timely actions were not taken to address this. A medicines policy was in place, but staff practice was not always in line with this. Staff who administered medicines had not always been trained.

There were insufficient staffing levels to safely support people. People told us there wasn't always enough staff to meet their needs in a timely manner including with medicines support and to provide meals. There had recently been a high turnover of staff and, at the time of our inspection, there was a strong reliance on agency staff. Agency staff had not completed an induction to ensure they could safely work in the service and understood people's needs.

People were not supported to have maximum choice and control of their lives and were not always supported in the least restrictive way possible and in their best interests. People's consent had not always been sought and mental capacity assessments had not been consistently completed when there were

concerns about a person's understanding.

Staff had not consistently received training in important areas such as safeguarding and moving and handling. Staff who worked in the kitchen, preparing food, did not have always have training to ensure they understood the requirements of this role. We received generally poor feedback about the standard of food. When new staff started, they did not always complete a robust induction or have regular supervisions.

Elements of staff practice did not promote people's dignity, including not disposing of continence aids appropriately. Staff were observed to be polite in their interactions with people and worked hard to try and meet people's needs.

Pre-admission assessments and care plans were not always in place for people who lived at the service. This meant there was limited information to guide staff about people's needs and how to support them. Due to the low staffing levels, staff did not have the time to meaningfully engage with people and most interactions were task-based, focused on assisting with personal care, eating etc. During our inspection we observed no activities with people with people appearing to spend much of their time sitting or watching television quietly.

A series of checks were completed by the registered persons. However, these had failed to highlight and address the issues noted on this inspection, which meant people were at risk of harm.

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

Rating at last inspection and update
The last rating for this service was requires improvement (published 16 June 2021) and there were 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 we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted in part due to concerns received about staffing levels, medicines practices, personal care provided to people and management of the premises. A decision was made for us to inspect and examine those risks.

You can see what action we have asked the provider to take at the end of this full report. Following our inspection, the provider started to work with local authority agencies to begin making the necessary improvements and to mitigate the most serious risks.

Enforcement and Recommendations
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 monitor the service and will take further action if needed.

We have identified breaches in relation to consent to care, safe care and treatment, premises and equipment, staffing and good 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.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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 effective?

Inadequate

The service was not effective.

Details are in our effective findings below.

Is the service caring?

Requires Improvement

The service was not always caring.

Details are in our caring findings below.

Is the service responsive?

Inadequate

The service was not responsive.

Details are in our responsive findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Mary Fisher 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 Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This included checking the provider was meeting COVID-19 vaccination requirements. 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 two inspectors.

Service and service type
Mary Fisher House is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement dependent on their registration with us. Mary Fisher House is a care home without nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

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
This inspection was unannounced.

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 and professionals who worked with the service. The provider was not asked to complete a provider information return prior to this inspection. 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.

During the inspection
We spoke with seven people who used the service and two visitors to the service about their experience of the support provided. We also spoke with a healthcare professional. We spoke with eight members of staff. This included a senior carer, care assistant, registered manager, deputy manager, activities worker, housekeeper and agency worker. We also spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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 wide range of records. This included four people's care records and multiple medication records. We looked at three staff files in relation to recruitment, induction and supervision. A variety of records relating to the monitoring and management of the service, including policies and procedures, were reviewed.

After the inspection
We continued to seek clarification from the provider and registered manager to validate evidence found. We received further evidence by email which we reviewed including risk assessments, policies and procedures, agency profiles and rotas.

Inadequate

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 inadequate. The rating for this key question has remained inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

At our last inspection the provider had failed to robustly assess and mitigate potential risks relating to the health, safety and welfare of people. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Accidents and incidents were not always properly recorded or followed up with the relevant professionals or organisations. For example, people had sustained falls and records to explain how and when this happened were not in place. Actions had not been taken in response to these incidents. This did not demonstrate that appropriate actions had been taken to mitigate risk for people or learning from these events.
● Risk assessments were not consistently in place for identified risks to people. This included risk assessments for specific health conditions such as Parkinson's Disease or for people who were at risk of self-neglect.
● Not everybody had access to a call bell which meant they might not be able to alert staff for help in urgent situation. Risk assessments were not always in place to confirm how people would seek assistance, without access to a call bell.

A failure to ensure care and treatment was provided in a safe way was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
At our last inspection the provider had failed to ensure staff had the correct training and skills for their roles. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● There were insufficient staff to meet people's needs. The provider used a dependency tool to help them identify safe staffing levels to meet people's needs. However, there were several occasions where staffing levels were lower than the required numbers. This meant people's needs could not be met in a timely

manner. A staff member told us, "I feel residents are not being looked after."
● People who used the service noted a high level of agency use, low staff numbers and a changing staff team. A person who used the service told us, "They have problems with staff and are always short-staffed. They have trouble keeping staff." Other people described the impact this had such as being unable to establish a rapport and having extended periods of time where they didn't see any staff. We observed staff were not consistently familiar with people's needs.
● Staff had limited time to spend with people and engage with them outside of planned tasks such as personal care or eating and drinking.

A failure to ensure a sufficient number of staff were deployed was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Using medicines safely

At our last inspection the provider had failed to ensure safe medicines practices. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

● Medicines practices were not safe. Some people had run out of their essential medication and actions had not been taken to address this.
● There were missed doses of medication and time sensitive medication which had not been given at the correct times.
● Staff who administered medicines had not always completed training. Other staff's competency to administer medicines had not always been assessed.
● Risk assessments had not been completed for paraffin-based creams. These creams can increase the risk of people been harmed as a result of fire.

A failure to safely manage medicines is 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

At our last inspection the provider had failed to adequately protect people from the risk of infection transmission. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

We were not assured that safety was promoted through the hygiene practices at the service as some parts of the service were unclean, with some bedrooms smelling strongly of urine. Cleaning schedules did not include deep cleans and there was no record of cleaning for frequently touched surfaces. Whilst most staff did wear PPE correctly, we observed instances whereby staff practice was not in line with government guidance. This included masks been lowered underneath a person's nose and mouth and not been bare below the elbow. PPE was also not disposed of safely.

We found no evidence people had been harmed as a result of this. However, a failure to assess the risk of, and prevent the control of infection is a breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- We were assured the provider was accessing testing for people using the service and staff.
- We were assured that the provider's infection prevention and control policy was up to date.
- We were somewhat assured the provider was preventing visitors from catching and spreading infections.

Visiting in care homes
Visits were being facilitated in line with government guidance and visitors were welcomed to the home. Visitors were screened for symptoms of COVID-19 and had access to PPE.

At our last inspection the provider had failed to recruit staff safely. This was a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

- The provider carried out appropriate recruitment checks to ensure only suitable persons were employed at the service.

Systems and processes to safeguard people from the risk of abuse
- Some staff had not completed safeguarding training, which meant we could not be assured they would identify and report different types of abuse. The provider agreed to address staff training requirements.
- The provider had an up-to-date safeguarding policy in place.

Inadequate

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 requires improvement. The rating for this key question has deteriorated to inadequate. This meant there were widespread and significant shortfalls in people's care, support and outcomes.

Staff support: induction, training, skills and experience

At our last inspection the provider had failed to ensure staff had the correct training and skills for their role. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 18.

● Some of the staff had not received training essential to their role. Of the staff team who were actively involved in supporting people, we noted four who had not completed safeguarding, moving and handling or nutrition and fluid awareness training. There was limited evidence to demonstrate how the registered manager and provider were assured of their skills and knowledge to safely care for people.
● Staff who were new to the service had not consistently undertaken an induction related to their role to ensure they understood, their roles and responsibilities, people's needs and the health and safety requirements of the service. The provider did not have a process for safely inducting agency staff.
● There were some risks related to the staff team which had not been adequately assessed with consideration to how this could affect people who used the service.

A failure to ensure staff had received appropriate training and support for their role was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The provider began taking action to address the staff training following our inspection

Adapting service, design, decoration to meet people's needs
● The premises were not well maintained. There had been ongoing issues with the hot water and recent problems with the heating in the building. We observed rodent droppings in the kitchen and asked the provider to request a further visit from pest control. We also contacted the local food safety team about our concerns.
● Parts of the building needed redecoration. For example, there were fire doors which hadn't been replaced, damaged flooring in bathrooms, exposed woodwork and carpets which were heavily stained.
● Limited consideration had been given to adapting the environment to the needs of people living with dementia, such as using contrasting colour schemes or additional signage.

We found no evidence that people had been harmed however the premises and equipment were not clean, or properly maintained. This placed people at risk of harm. This was a breach of regulation 15 (Premises and equipment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

● Mental capacity assessments and best interest decisions had not always been completed when there were concerns about people's understanding.
● A record of people's consent to care and support was not consistently in place. There was limited information to demonstrate how people had been included in decisions about their daily lives.

A failure to ensure MCA's and associated best interest decisions had been completed was a breach of Regulation 11 (Need for consent) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Independent advocates had supported people when required.

Supporting people to eat and drink enough to maintain a balanced diet
● Staff who worked in the kitchen had not always had training to ensure they understood the relevant food safety requirements. The provider was in the process of appointing a chef.
● People's feedback about the standard of food was generally negative. A person who used the service described the food as, "Poor and tasteless."
● Staff followed people's individual dietary preferences, such as following a vegetarian diet, and nutritional requirements.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
● People's needs had not always been holistically assessed before moving into the service. This meant staff may not have been fully aware of their needs, preferences and personal history in order to provide person-centred care.
● Support was not designed or delivered in line with current best practice.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● Some of the people who used the service told us they had not been able to see a chiropodist. We discussed this with the registered manager who advised of the difficulties in sourcing one. There was limited

evidence to demonstrate this has been robustly pursued to ensure people's healthcare needs could be met.

● As the staff team weren't consistently aware of what people's needs were, this could have affected their ability to spot signs of deterioration and make onward referrals to other professionals or organisations. Staff had however sought the input of medical professionals when they felt people were unwell, including GP's and district nurses.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection of this domain for this service since it registered. This key question has been rated requires improvement. This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence

- Issues with the training and induction of staff along with management oversight meant improvements were needed to ensure people felt well cared for and received a good standard of care.
- Elements of staff practice did not promote people's dignity. We observed used continence pads left on people's floor, underwear placed on the back of doors and rooms which smelt strongly of urine. Actions had not been taken to promptly address issues which could have compromised people's dignity.
- Records did not consistently demonstrate that people had been well supported to maintain their personal hygiene and appearance. For example, some people went extended periods of time without being offered support to wash. We observed most people were clean and appropriately dressed.
- Information about people's skills and abilities had not been consistently assessed in order for staff to promote their independence and build upon their skills.
- Engagement between staff and people who used the service was task-orientated, due to the staffing pressures. Staff had little time to proactively support people who were experiencing emotional distress. We observed people went extended periods of time with limited staff interaction.
- We did, however, also observe staff speaking to people with kindness and patience. Staff knocked on people's doors before entering their rooms and took some effort to protect their modesty. Staff worked hard to try and meet people's needs.
- Some staff had completed equality and diversity training to raise awareness and aid understanding about meeting people's individualistic needs.

Supporting people to express their views and be involved in making decisions about their care

- Information about people's views were not consistently recorded. Risk assessments and care plans did not demonstrate how people had been included in discussions about their care.
- There was limited information about people's preferences in how they wanted to be cared for and factors that were important to them in their daily lives.
- Some people were, however, able to share their views with us and did so confidently and freely.

Inadequate

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection of this domain for this service since it registered. This key question has been rated inadequate. This meant services were not planned or delivered in ways that met people's needs.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; Supporting people to develop and maintain relationships to avoid social isolation; support to follow interests and to take part in activities that are socially and culturally relevant to them

- We reviewed documentation for four people who used the service and of these, only one had care plans in place which described their needs and how to provide support. For the other three people there were no care plans in place. Staff were not therefore provided with sufficient information to care for people well, and efforts were not made to personalise their care.
- Information was not recorded on people's files about their interests, hobbies and activities they enjoyed.

Complete and contemporaneous records were not in place for each person who used the service. This was a breach of Regulation 17 (Good Governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- There was no timetable of activities and staff did not initiate activities with people. We observed people watching television, but there was little other opportunity for stimulation for people. An activities worker had been employed but they were mainly working in the kitchen due to the recent issues with employing a cook.
- A visitor to the service did explain how the staff had supported somebody to keep being able to go out into the community, which was important to them.
- People were supported to continue having visitors and maintaining contact with their relatives.

Meeting people's communication needs
Since 2016 all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard. The Accessible Information Standard tells organisations what they have to do to help ensure people with a disability or sensory loss, and in some circumstances, their carers, get information in a way they can understand it. It also says that people should get the support they need in relation to communication.

- There was no information recorded about people's communication needs to demonstrate compliance with AIS.

Improving care quality in response to complaints or concerns

- The provider had a complaint policy in place. Complaints had been responded to appropriately.
- Some compliments had also been received. For example, "Everyone has been brilliant and made their last few years a positive experience." Another person stated, 'We would like to write and give thanks for the care

and attention my relative receives whilst staying."

End of life care and support

● The service had supported people at the end of their lives, however staff had not received training in this area.

● Information was not recorded on people's care plans about their end of life wishes and 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 requires improvement. 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; Continuous learning and improving care

At our last inspection the provider had failed to ensure practices and processes were completed in line with regulatory requirements. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17

● Audits and checks completed by the management team and provider had failed to highlight and address the issues raised during this inspection. Some of the concerns raised affected the quality and safety of the service provided to people, exposing them to significant risk of harm.
● As the systems and processes had been ineffective this meant the management team were not aware of all the areas for improvement. The checks completed did not highlight areas for learning or development of staff practice.
● There was not always a timely response to known issues, including fire door safety, rodent infestation and medicines management.

A failure to ensure practices and processes were completed in line with legal requirements is a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● A person-centred culture was not promoted in the service. Staff had limited time to spend with people to understand their abilities and empower them in their lives.
● People's outcomes for their care and lives were not known or, therefore, worked towards.
● The provider advised, following the inspection, there would be further conversation with people who used the service to understand and address their concerns.

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; Engaging and involving people using the service, the

public and staff, fully considering their equality characteristics

● The provider and registered manager were not always aware of incidents that had happened in the service to ensure these could be shared and responded to fully.

● Staff gave us mixed feedback about whether they felt supported and able to share their concerns. The provider was keen to ensure that moving forwards there was an 'open door policy' for staff to share their views.

● The provider understood the requirements related to duty of candour and listened to and responded to concerns shared during the inspection.

Working in partnership with others

● Following the inspection, the provider began taking actions to address areas of high risk with the input of local social care and health agencies. The provider worked proactively with them and was keen to utilise their knowledge.