South Yorkshire Care Limited

Mary Fisher House

Inspection report

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Ratings

Overall rating for this service	Good
Is the service safe?	**Requires improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

This inspection took place on 21 July 2015 and was unannounced.

At our last inspection on 10 September 2014 the provider was meeting the regulations that were assessed.

Mary Fisher House provides personal care and accommodation for up to 24 older people. The service is a converted house with a purpose built extension. Accommodation is provided over three floors by a passenger lift and chair lifts four further steps on the first floor. All bedrooms are single occupancy and have ensuite facilities. There is limited parking in the grounds but plenty of roadside parking nearby. The home is within walking distances of Harrogate town centre and local amenities. On the day of the inspection there were 21 people living at the service.

There was 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.

Summary of findings

Staff knew the correct procedures to follow if they considered someone was at risk of harm or abuse. They received appropriate safeguarding training and there were policies and procedures to support them in their role.

Risk assessments were completed so that risks to people could be minimised whilst still supporting people to remain independent. The service had systems in place for recording and analysing incidents and accidents so that action could be taken to reduce risk to people's safety.

Staff recruitment practices helped ensure that people were protected from unsafe care. There were enough qualified and skilled staff at the service and staff received ongoing training and management support. Staff had a range of training specific to the needs of people they supported.

The home had safe systems in place to ensure people received their medication as prescribed; this included regular auditing by the home and the dispensing pharmacist. Staff were assessed for competency prior to administering medication and this was reassessed regularly.

The home was clean, however, we felt infection control could be compromised as some areas of the home required refurbishment in order they could be cleaned effectively. For example some of the ensuite toilet floors were badly stained.

People were offered choices and staff knew how to communicate effectively with people according to their needs. People were relaxed and comfortable in the company of staff.

Staff were patient, attentive and caring; they took time to listen and to respond in a way that the person they engaged with understood. They respected people's privacy and upheld their dignity when providing care and support.

There had been a recent decline in the number of activities on offer because of a staff vacancy and people commented negatively about this. However, prior to the vacancy people commented positively on activities and we were assured the newly appointed activities organiser was starting at the home the following week.

People's rights were protected because the provider acted in accordance with the Mental Capacity Act 2005. This is legislation that protects people who are not able to consent to care and support, and ensures people are not unlawfully restricted of their freedom or liberty. The manager and staff understood the requirements and took appropriate action where a person may be deprived of their liberty.

People's needs were regularly assessed, monitored and reviewed to make sure the care met people's individual needs. Care plans we looked at were person centred, descriptive, and contained specific information about how staff should support people.

People knew how to make a complaint if they were unhappy and all the people we spoke with told us that they felt that they could talk with any of the staff if they had a concern or were worried about anything.

Staff spoke positively about the registered manager. They told us she was supportive and encouraged an open and inclusive atmosphere. The staff we spoke with were aware of their roles and responsibilities and they told us that the registered manager was a positive role model in providing a high standard of care.

The provider completed a range of audits in order to monitor and improve service delivery. Where improvements were needed or lessons learnt, action was taken.

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 safe

The service was safe. People were safe. Staff had been trained to recognise and respond to abuse and they followed appropriate procedures.

Care and support was planned and delivered in a way that reduced risks to people's safety and welfare. Staff knew how to minimise risks whilst supporting people to live their life as independently as possible.

Appropriate checks were completed as part of staff recruitment this helped reduce the risk of employing unsuitable people. There was enough staff to provide the support people needed.

People's medicines were managed safely and they received them as prescribed.

Some areas of the home required refurbishment to ensure effective cleaning and reduce the risk of spread of infection.

Is the service effective?

Good

The service was effective

Staff had the skills and expertise to support people because they received on-going training and effective management supervision.

People received the assistance they needed with eating and drinking and the support they needed to maintain good health and wellbeing. External professionals were involved in people's care so that each person's health and social care needs were monitored and met.

People's rights were protected because staff were aware of their responsibilities under the Mental Capacity Act 2005. Staff obtained people's consent before they delivered care and support and knew what action to take if someone was being deprived of their liberty.

Is the service caring?

Good

The service was caring.

People were comfortable and relaxed in the company of the staff supporting them.

The relationships between staff and the people they cared for were friendly and positive. Staff spoke about people in a respectful way and supported their privacy and dignity.

Summary of findings

Staff knew people well because they understood their different needs and the ways individuals communicated.

Is the service responsive?

Good

The service was responsive.

People using the service had personalised care plans and their needs were regularly reviewed to make sure they received the right care and support.

Staff responded when people's needs changed, which ensured their individual needs were met. Relevant professionals were involved where needed.

People had previously been involved in activities they liked, both in the home and in the community. However, a new activities organiser was due to start at the home. Visitors were made welcome to the home and people were supported to maintain relationships with their friends and relatives.

Is the service well-led?

Good

The service was well-led.

There was a registered manager and people spoke positively about them and how the service was run.

Staff worked well as a team and told us they felt able to raise concerns in the knowledge they would be addressed.

People who used the service and their relatives were encouraged to express their views about the standards of care. Various quality assurance systems were used to keep checks on standards and develop the service. This enabled the provider to monitor the quality of the service closely, and make improvements when needed.

Mary Fisher 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 provider 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.

Prior to our inspection we reviewed the information we held about the service. This included any safeguarding alerts and outcomes, complaints, previous inspection reports and notifications that the provider had sent to CQC. Notifications are information about important events which the service is required to tell us about by law. The registered manager had also completed a Provider Information Return (PIR).The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

This inspection took place on 21 July 2015 and was unannounced.

The inspection was carried out by one inspector, a pharmacist inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

We spoke with eight people who used the service, 2 relatives, a visiting professional, the registered manager, operations manager and five members of staff during the course of our visit.

We looked at four people's care records to see how their care was assessed and planned. We reviewed how medicines were managed and the records relating to this. We checked three staff recruitment files and the records kept for staff allocation, training and supervision. We looked around the premises and at records for the management of the service including quality assurance audits, action plans and health and safety records.

We contacted the local authority commissioners and Healthwatch to ask for their views and to ask if they had any concerns about the home. From the feedback we received no one had any concerns.

Requires improvement

Is the service safe?

Our findings

We spoke to people who used the service who told us they felt safe. One person expressed concern about the lift being out of action for two days. They said they had to use the stairs with help from staff which they found difficult.

The service had policies and procedures with regard to safeguarding adults and whistleblowing. When we spoke with staff about their responsibilities for keeping people safe they referred to safeguarding polices and confirmed they had received training about safeguarding adults. They were able to explain the process to follow should they have concerns around actual or potential abuse. Information the CQC had received demonstrated the registered manager was committed to working in partnership with the local authority safeguarding teams. The service had made and responded to safeguarding alerts appropriately.

We saw in resident meeting minutes that a regular agenda item referred to being and feeling safe. The registered manager had discussed safeguarding and abuse with people who used the service. People who used the service had formed a resident group and they group had devised dementia friendly posters to help people identify who to speak to if they felt unsafe or had been hurt. We saw these posters in prominent places around the home.

We looked at the recruitment records for three staff and found they had all completed an application form, which included details of former employment with dates. This meant the provider was able to follow up any gaps in employment. All of them had attended an interview and two references and DBS (previously criminal records bureau) checks had been obtained prior to the member of staff starting work. This process helped reduce the risk of unsuitable staff being employed. The manager told us people who lived at the home were included in interviewing potential staff which demonstrated the service promoted people in the running of the home.

We spoke with the registered manager about how they determined staffing levels and deployed staff. They told us the provider determined staffing levels; however the registered manager had been given discretion to increase staffing where people's dependency levels increased or for example providing additional support for people approaching the end of their life.

We reviewed staffing rotas and saw during the day there was a senior carer and two carers on duty. They were supported by ancillary staff such as kitchen and housekeeping staff and the administrator. The registered manager worked six days a week and alternated working on either Saturday or Sunday. The registered manager said they included themselves on the rota and worked a late shift in order that they could work alongside staff and provide personal care to those people who lived at the service. Overnight there was a senior carer and carer on duty.

We observed the daily handover from night staff to day staff. The leader of the shift passed on relevant information about people's needs and planned event/appointments for the day. Staff were also allocated areas within the home to work and allocated break times in order to ensure there was sufficient staff available. This helped make sure that people's needs were met. During our visit we noted that although staff were busy they had time to spend with people and that call bells were responded to swiftly.

We looked at how risks were assessed and managed. We saw completed risk assessments for example for weight loss, pressure sores, moving and handling and mobility. These were completed fully and identified hazards that people might face. There was guidance about what action staff needed to take in order to reduce or eliminate the risk of harm. This helped ensure people were supported to take risks as part of their daily lifestyle with the minimum restrictions. For example one person enjoyed walking around the home which included going up and down the stairs, This increased the risk of falls for this person however, for this person the risk was minimal and preventing the person from taking this route would cause undue distress.

There were risk assessments in place relating to the safety of the environment and equipment used in the home. For example hoisting equipment and the vertical passenger lift. We saw records confirming equipment was serviced and maintained regularly. The service had in place emergency contingency plans, for example the registered manager shared with us the risk assessment put into place for the recent heatwave. This included increasing checks on people, increasing and encouraging fluids and discouraging people from sitting outside when the sun was

Requires improvement

Is the service safe?

at its hottest. The use of sunhats and sun cream was encouraged. There was a fire risk assessment in place for the service and personal emergency evacuation plans (PEEPs) for individuals.

We walked around the building and saw grab rails and handrails to support people and chairs located in such a way that people could move around independently with places to stop and rest. Communal areas and corridors were homely and free from trip hazards.

The home was clean and people made positive comments about the cleanliness of the home for example; "The cleaning is OK", "everything is nice and clean", "I cannot grumble at the cleaners".

However, we noted that some of the bathroom and en suite floors were badly stained particularly around the base of toilets. This could compromise the effectiveness of cleaning and increase the risk of the spread of infection. Similarly the flooring in the dining room was scuffed and worn in places and although it appeared clean the worn nature of the surface could also increase the risk of the spread of infection.

We saw staff had access to personal protective equipment such as aprons and gloves. We observed staff using good hand washing practice. There were systems in place to monitor and audit the cleanliness and infection control measures in place.

We looked at the medicines, medication administration records (MARs) and other records for 12 people living in the home. We spoke with the manager and the senior care worker responsible for handling medicines on the day of our visit about the safe management of medicines, including creams and nutritional supplements within the home.

Medicines were locked away securely to ensure that they were not misused. Daily temperature checks were carried out in all medicine storage areas to ensure the medicines did not spoil or become unfit for use. Stock was managed effectively to prevent overstocks, whilst at the same time protecting people from the risk of running out of their medicines. Medication records were clear, complete and accurate and it was easy to determine that people had been given their medicines correctly by checking the current stock against those records. On occasions where medicines had not been given, care workers had clearly recorded the reason why.

We saw that trained, senior care workers supported people living in the home to take their medicines in ways that maintained people's individual needs and preferences as much as possible. The manager told us that she planned to update the care plans of people prescribed medicines that only needed to be taken 'when required' to include more detailed personalised information. This would enable newly trained care workers, who may be less familiar with the people living in the home, to administer each person's medicines consistently and correctly.

Regular audits (checks) were carried out to determine how well the service managed medicines. We discussed how these audits had been developed and improved in order to make the auditing process more robust and effective. We saw evidence that where concerns or discrepancies had been highlighted, the senior care workers and manager had taken appropriate action straightaway in order to address those concerns and further improve the way medicines were managed within the home.

We recommend action should be taken to improve areas of the home identified as a risk to infection control.

Good

Is the service effective?

Our findings

People we spoke with were complimentary about the staff. Comments made included "The staff are very good", "The staff are all lovely, I can't grumble about them", "The staff are all perfect". When asked about the number of staff, people generally thought there were enough although one person did tell us "This place wants more staff definitely". The Relatives we spoke to thought there were enough staff on duty to meet their relative's needs.

We discussed with the registered manager the training arrangements for staff. They told us newly appointed staff completed the care certificate which included mandatory health and safety training such as moving and handling, first aid and safeguarding adults. We spoke to a member of staff who had recently completed the certificate and they told us they found it beneficial to their work. They said they had gained new knowledge but had also confirmed and reinforced existing knowledge. Staff were encouraged to complete National Vocational Training (NVQ) and also completed specialist training such as end of life care, dementia awareness and Mental Capacity Act (MCA)2005 training. The registered manager showed us a training matrix which recorded the training staff had completed and a system which alerted them when staff were due for updates. Staff we spoke with told us there were good opportunities to attend training and it was relevant to their role. They confirmed that they had completed appropriate training courses for lifting and handling, fire precautions and dementia training. None of them thought there were any additional training courses they could/would like to go on to help them meet people's needs more effectively at present.

Staff told us they received regular supervision which encouraged them to consider their care practice and identify areas for development. Staff told us they found supervision sessions useful and supportive. Staff also completed an annual appraisal. This meant that staff were well supported and any training or performance issues were identified.

We reviewed four people's care plans and saw a pre admission assessment which detailed personal information about the person's needs. The care plans contained information about people's choices and preferences, for example one person preferred one pillow on their bed and liked the bedside lamp to be left on during the night.

We looked at whether the service was applying the Deprivation of Liberty Safeguards (DoLS) appropriately. These safeguards protect the rights of adults using services by ensuring that if there are restrictions on their freedom and liberty, these are assessed by trained professionals to determine whether the restriction is appropriate and needed. The registered manager told us they had a good working relationship with the local authority DoLs team and Community Mental Health Team. They told us at the time of the inspection they had made one application for a DoLs authorisation and were awaiting an outcome. We saw evidence of best interest decisions made for people as part of the care planning process.

When we spoke with staff they demonstrated a good understanding of the principles of the MCA with particular regard to day to day care practice ensuring people's liberty was not unduly restricted.

We spoke with people about the quality of meals available in the home. Most people we spoke with were happy with the standard of food. Comments made included "We get well fed", "I think the food is very good", "The food on the whole is OK. There has been a slight drop in standards but on the whole it's not bad", "The food – I've no complaints". One person told us "The food – sometimes it's lovely, sometimes it's off, depends on the chef".

We observed the breakfast and lunchtime experience in the home. We saw that people were given time to enjoy their meal and it was a social and relaxed occasion. There was a choice available to people and people told us that staff asked them what they would like to eat prior to the meal. We saw people using adapted cutlery and plate guards in order that they could be independent when eating their meals.

Whilst we were at the home we noted that people had access to juice and water and that people were offered tea and coffee at regular intervals and we heard staff encouraging people to drink sufficient fluids.

During this inspection the care records we looked at included those of people who had nutritional risks associated with their health and well-being. Nutritional risk assessments had been completed which directed staff on

Good

Is the service effective?

what action to take; for example one person preferred to walk around the home for most of the day so staff prepared finger foods which could be eaten whilst the person was walking. We saw care plans included how often people needed to be weighed, whether food or fluid charts needed to be completed and any recommendations from the speech and language assessment if this had been completed. We saw plans had been reviewed regularly and amended as required.

Staff reported good working relationships with local health professionals. People's care plans included information about people's access to chiropody, hearing specialists and opticians.

The local area operated a system where each service was linked to a specific general practitioner surgery, (although people living at the home had the choice to remain with the doctor they were registered with prior to admission). They held a surgery in the home every week and responded to emergency visits if required. People told us the access they had to their doctor was good. One person said "There are no problems seeing the doctor. If I want to see the doctor staff make an arrangement for her to visit me here."

The home was an adapted property with a purpose built extension. Some parts of the home were less accessible than others. The manager explained consideration was given to this during the preadmission assessment to ensure people's mobility meant they were able to access their bedrooms. We noted handrails to assist people to walk independently and appropriately fitted grab rails in toilet and bathrooms. There was ramped access to the garden areas which had seating areas for people to rest and enjoy the garden. The service was not a specialist service for people living with dementia and as such the environment was not entirely adapted to be dementia friendly. However, we did see specific signage to assist people in orientating themselves around the home and dementia friendly colour contrasting had been taken into account when decorating the service.

Good

Is the service caring?

Our findings

People who used the service told us they were happy with the standard of care and support they received and all the staff were kind. Comments included "The staff are all lovely". One person living at the service told us they felt they were being treated with respect and dignity. We were told by a staff member there was one person in the home with no relatives and therefore they tried to make up for that by acting as a surrogate relative, trying to find time to have occasional chats with the person concerned.

We spent time in the lounge areas of the home. Staff approached people in a sensitive way and engaged people in conversation which was meaningful and relevant to them. For example we heard staff referring to family and known interests. We saw that staff acted in a kind and respectful way and people looked well cared for and appeared at ease with staff. The home had a relaxed and comfortable atmosphere. We saw that staff crouched down to talk to people at eye level and they spoke at a pace that was comfortable for the person.

We saw that staff treated people with respect. We also observed care been taken to ensure peoples dignity was maintained for example covering people's knees with a blanket. We saw staff knocked on bedroom doors and awaited for a response before they entered. Discussions with staff showed a genuine interest and very caring attitude towards the people they supported. The registered manager told us they had 'dignity champions' whose role it was to promote practice which maintained people's dignity. The home had made a dignity pledge and people were asked as part of satisfaction surveys whether they felt the dignity pledge had been met. We also saw reference to discussions in resident meeting minutes that issues around privacy and dignity were discussed. This indicated a commitment to ensuring and promoting dignity.

Our observations indicated that people who used the service were able to spend their day as they wished. On a number of occasions we saw that staff explained to people what was about to happen and checked that people were in agreement with this. For example assisting people to move to the dining room when it was lunchtime. We saw people's bedrooms were personalised with their own furniture and possessions or family photographs.

People and their relatives who we spoke with said they were not familiar with their care plan. The relatives we spoke with did express satisfaction that their relative was being adequately cared for and was happy and content in the home.

Staff told us they had received training with regard to providing end of life care. Staff told us they received excellent support from district nurses and of the importance in providing good end of life care saying that it was a 'privilege.'

We were told people had access to an external advocacy service if required and details were included in the service's welcome pack .The registered manager told us they promoted an open door policy for people who live at the service and their relatives. During the day we saw visitors coming and going; they were offered a warm welcome by staff. We spoke to two visitors who said they were very happy with the care their relatives received.

Good

Is the service responsive?

Our findings

The manager explained that they completed pre admission assessments of people's needs. They said they involved other people in the process such as relatives and health and social care professionals, to ensure as much information was gathered as possible in order to determine whether they would be able to meet those needs.

We looked at four care plans and saw that they contained an assessment completed on admission which detailed people's needs and further care plans covering areas such as personal care, mobility, nutrition, daily and social preferences and health conditions. We saw that people had corresponding risk assessments in place. People's plans gave specific, clear information about how the person needed to be supported. For example one person's care plan stated they did not sleep very well and enjoyed a slice of toast and a cup of tea during the night.

We could see that people's care had been reviewed and their plans amended. For instance we saw that one person had lost weight and had been referred to the dietician and now required their food and fluid intake to be monitored. We saw the corresponding records for this. This meant that the person's changing needs had been being monitored.

We observed the handover meeting at the change of shift and heard verbal reports of each person. Changes to people's needs were made known so staff were able to provide appropriate care. Our discussions with staff indicated that they knew people well and this reduced the risk of providing inappropriate care.

This is where the activities co-ordinator stuff belongs and from the first sentence below it seems that you have previously cut it from here

Prior to them leaving people were involved in a wide variety of communal and community activities as well as individual one to one sessions. We saw how these had been recorded and evaluated. The registered manager told us they had appointed a new activities organiser who was due to start the following week. People living at the home were clearly missing the activities organiser and as a consequence we received some negative comments which included "Activities – nil!", "one of the girls takes me for walks, something to break the monotony"; "there are no activities at all at present".

Information about how to make a complaint was available. People we spoke with knew how they could make a complaint if they were unhappy and said that they had confidence that any complaints would be responded to. There were no recorded complaints since the previous inspection. The registered manager said she felt this was because she had an 'open door' policy and encouraged any concerns to be addressed quickly and efficiently. The residents group had devised an easy to understand complaints procedure which we saw available around the home and on the main notice board.

The provider completed an annual survey of people who used the service, their relatives, staff and other professionals to gather feedback on all aspects of the service provided including care, privacy, staffing, activities, food, quality of life, laundry and the environment. Results were published and with appropriate action plans put in place in response. We saw the results of the most recent and noted a request for more fresh fruit which saw evident at meal times and for snacks.

Good

Is the service well-led?

Our findings

People who lived at the home and their relatives told us they knew who the manager was and saw her regularly around the home; they confirmed she was approachable and responded to concerns and queries.

The staff we spoke with were all complementary about the registered manager. They used comments such as “She’s brilliant, good for me and the residents. I have no concerns”.

They said they were supportive and clear about their expectations in delivering high quality care.

Staff we spoke with said they enjoyed working in the home and one commented “we are like a family”. Staff meetings had been held at regular intervals, which had given staff the opportunity to

share their views and to receive information about the service. Staff told us that they felt

able to voice their opinions, share their views and felt there was a two way communication

process with managers and we saw this reflected in the meeting minutes we looked at. They said the registered manager offered an open door and was fair and honest with them.

There was a clear management structure at the service. The staff we spoke with were aware of the roles of the management team and they told us that the registered manager had a regular presence in the service. They told us the registered manager spent time in the home talking with and working alongside staff.

During our inspection we spoke with the manager about people who used the service. They were able to answer all of our questions about the care provided to people showing that they had a good overview of what was happening with staff and people who used the service. They said they utilized the internet to keep up to date with NICE guidance and up to date current good practice. They told us they were proactive in developing good working relationships with partner agencies in health and social care. The feedback we received from these agencies supported these statements.

The registered manager was knowledgeable and experienced. From evidence gathered through this inspection we could see they placed a lot of emphasis on people receiving high quality care. They told us they aimed to invest in the staff team to deliver this and hoped staff felt valued and supported.

The manager spoke enthusiastically about developing care and support for people living at the service and ensuring the care people received was personalised. They told us they placed great value on learning by ‘live’ experience and relating this to how it would feel for people living in the home. They gave an example of placing a meal in front of staff stating ‘here’s your dinner’ with no opportunity for staff to state whether they liked or had chosen the food. This was followed up with a reflective discussion about how the experience had felt for staff and improving how staff supported people, communicated with people and offered choice around meal times.

The manager explained there were a range of quality assurance systems in place to help monitor the quality of the service the home offered. This included formal auditing, meeting with the provider and talking to people and their relatives. Audits included from regular daily, weekly, monthly and annual checks for health and safety matters such as passenger lifts, fire fighting and detection equipment. There were also care plan and medicines audits which helped determine where the service could improve and develop.

Monthly audits and monitoring undertaken by regional managers helped managers and staff to learn from events such as accidents and incidents, complaints, concerns and whistleblowing. The results of audits helped reduce the risks to people and helped the service to continuously improve.

There were procedures in place for reporting any adverse events to the Care Quality Commission (CQC) and other organisations such as the local authority safeguarding team, police, deprivation of liberty team, and the health protection agency. Our records showed that the provider had appropriately submitted notifications to CQC about incidents that affected people who used services.