Francis House Limited

Francis House

Inspection report

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Tel: 01246470690

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

Francis House is a 'care home.' People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Personal care is provided in one adapted building for up to eight older people with mental health needs.

At our last inspection we rated the service as Good. At this inspection we found the evidence continued to support the rating of Good. There was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns. This inspection report is written in a shorter format because our overall rating of the service has not changed since our last inspection in October 2015. There were seven people accommodated.

People continued to receive safe care in a clean, well maintained and adapted environment, which they were comfortable and happy with. People and staff were informed and confident to raise any safety concerns relating to people's care, if they needed to. People felt safe at the service and staff knew how to keep them safe from any abuse or harm associated with their assessed health, environment or care equipment needs.

Staffing measures, emergency contingency planning and related safety procedures, helped to ensure people's safety at the service. Management action was agreed, to review staff lone working and deployment arrangements at night, to further ensure people's safety.

Risks to people's safety associated with their health conditions, medicines, environment and any care equipment, were assessed before people received care and regularly reviewed in consultation with them. People's medicines were safely managed.

Staff were trained, knew how and provided people's care in a way that ensured their choice, involvement and least restrictive care. People's consent or appropriate authorisation was obtained for their care, to ensure their rights and best interests.

Safety incidents were monitored, analysed and used to inform any care improvements needed. Care and service improvements, including any lessons learned from this; were shared with staff and followed to reduce any further risks to people's safety.

People continued to receive effective care. Staff helped people to maintain and improve their health and nutrition. People were supported to access external health professionals when they needed to and staff followed their related instructions for people's care when required.

People's health and personal care plans were devised in consultation with them and regularly reviewed. Staff consulted with people to optimise their inclusion, understanding and ownership of their agreed care;

and to ensure effective information sharing with external care providers when required. People were provided with care and service information in a format they could understand.

People continued to receive individualised care from staff, who were kind, caring and fostered good relationships with them and their families. Staff understood and followed people's preferred daily living routines, lifestyle and care preferences. This was done in an individualised way that helped to ensure people's choice and independence.

Staff knew how to communicate with people in the way they preferred and understood. People were informed to help them understand their rights, what they could expect from their care and how to access relevant advocacy, if they needed someone to speak up on their behalf. People's views were regularly sought about their care and they were informed, confident and knew how to make a complaint if they needed to.

The service continued to be well led. The provider operated effective systems to ensure the quality and safety of people's care, ongoing service improvement and partnership working to enhance people's care experience.

Staff understood their roles and responsibilities for people's care. People's care was effectively informed, lawful and well led. The provider met their legal obligations, to share relevant information with us about people's care, and to inform others with an interest about our judgements.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains Good.	**Good**
Is the service effective? The service remains Good	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Francis 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.

This was a comprehensive, unannounced inspection, which took place on 24 May 2018. The inspection team consisted of one inspector.

Before our inspection the provider sent us their completed Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We spoke with local authority health and social care commissioners and looked at all the key information we held about the service. This included written notifications about changes, events or incidents that providers must tell us about.

We spoke with three people who lived at the service, a relative and a visiting social care professional; and we observed staff interaction with people. We spoke with three care staff, including an activities co-ordinator. We also spoke with the registered manager and the provider's operations manager. We looked at three people's care records and other records relating to how the service was managed. This included medicines records, meeting minutes and checks of the quality and safety of people's care. We did this to gain people's views about their care and to check that standards of care were being met.

Good

Is the service safe?

Our findings

People continued to receive safe care. People felt safe at the service and they knew how and were confident to raise any related concerns if they needed to. One person said, "I am happy here; I do feel safe." Another said, "Yes, it's very good; safe, reliable care staff." People living at the service and staff working there were informed how to recognise and report the abuse of any person receiving care if they needed to.

The provider's staffing arrangements helped to ensure people's safety at the service. The provider followed nationally recognised guidance to check staff were safe to provide people's care at the service before they commenced their employment. Regular account was taken of people's individual care and support needs and used to inform staff deployment arrangements to ensure sufficient provision.

Emergency contingency planning arrangements and related procedures for staff to follow, helped to ensure people's safety at the service. For example, in the event of a fire alarm, power failure or to follow the Herbert protocol. The Herbert Protocol is a national scheme introduced by the Derbyshire police authority and other health and social care agencies, which encourages care professional, staff or people's family carers, to compile useful information which could be used in the event of a vulnerable person going missing. Assurance was provided by the registered manager, in relation to the provider's emergency contingency plans concerned with lone staff working policy; to ensure people's safety at night, in the event of a staff member's serious ill health emergency.

Risks to people's safety from their health condition, environment or any care equipment used, were assessed before people received care; recorded and regularly reviewed. Staff understood and followed the related care actions required, to help reduce any identified risks to people's safety. A revised approach to undertake and record individual risk assessments was recently introduced, along with staff guidance to ensure accurate completion. This followed nationally recognised guidance concerned with people's individual mental and physical health needs. For example, any risk of harm to self or others; or risks from falls, stroke or malnutrition. A summary of people's care information relating to their individual safety and medicines needs was provided, to go with the person if they needed to transfer to another care provider. This, along with relevant staff training measures helped to ensure people's choice, involvement and least restrictive care.

People's medicines were safely managed and subject to regular risk assessment, review and ongoing management checks. Before our inspection, the registered manager told us about a medicines safety incident, when it happened at the service. Whilst no harm resulted to any person receiving care, their subsequent management review of the incident, found improvements were needed to help prevent any future re-occurrence. This included revised safety procedures; staff measures, re-training and supervision, along with a revised ongoing management checks to make sure this was followed. Staff responsible for people's medicines understood and followed this, which showed lessons were learned and improvements made when things went wrong.

People felt the home was kept clean and well maintained, which we also found. Staff were trained and

equipped to ensure they followed safe practice for infection prevention, control and cleanliness at the service. For example, staff wore personal protective clothing, such as gloves and aprons, when they provided people's personal care, handled waste materials or dirty laundry. This helped to protect people from the risk of a health acquired infection from cross contamination.

The registered manager provided information, which showed the provider's corrective action, to address fire safety advice from the local fire authority, following their recent visit to the service. A recent letter to the provider from the local environmental health authority, showed they found safe food hygiene and handling arrangements at the premises. This helped to ensure people's safety at the service.

Good

Is the service effective?

Our findings

People continued to receive effective care and were happy with this. Staff supported people to maintain or improve their health and nutrition; and to access relevant external health professionals when they needed to. This included for specialist and routine health screening when needed. One person said, "Oh yes, I see the doctor when I need to and I get my feet and eyes checked too." Another person said, "I see health staff when I need to – they are very good here like that."

Staff knew people's dietary needs and preferences and they followed instructions from relevant health professionals concerned with people's nutrition, where required. For example, to ensure people received the correct type of food for their health requirements and foods they enjoyed.

Staff understood people's mental and physical health conditions and followed their related personal care needs, which were shown in their care plan records. This was done in consultation with people, in a way that helped to promote their involvement and independence. For example, one person told us how staff helped them to regain some of their independent living skills, through repetitive, stepped tasks. This was done in consultation with them and a relevant external health professional; to support the person's rehabilitation and goal for independent living. Staff we spoke with were very aware of the importance of working with the person at their own pace and supporting them to help increase their confidence.

Staff understood and followed the providers stated aims for people's care, to promote people's inclusion, choice and ownership. During our inspection we saw staff spent planned one to one time with two people, to review and agree their care plans with them.

People were informed and supported to understand and manage their own health conditions in a way that was meaningful to them. For example, one person living with a learning disability was provided with care information in an 'easy read' format, to help them understand what they needed to do to help manage their diabetes condition. People were provided with care information in an alternative format they could understand when needed. Such as large print or simple language with a combination of pictures or symbols. Each person had a 'Care Passport,' agreed with them. This is important, key care information that goes with the person if they need to transfer to another care provider. It also included, what was important to people for their individual care, such as their care preferences, likes, dislikes and communication needs. This helped to ensure people received consistent and effective care, in the way they preferred.

Staff said they received the training and support they needed to provide people's care. They were also provided with any specific written guidance about people's individual health conditions when needed, which they understood. For example, any known heart condition or acute infection risk. This included, what this meant for each person's care at the service, including symptoms to observe for and any ongoing health treatment and monitoring needs. This meant people received care from staff who were informed, trained and supported to perform their role and responsibilities.

Staff understood and followed the Mental Capacity Act 2005 (MCA) when required for people's care. The 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 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 who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Consent to care was sought in line with the MCA. Staff understood how to support people to make decisions, or respond when people were unable to make specific decisions. The provider had submitted a formal application to the local authority responsible for DoLS authorisations, when required for one person's care. People's care records showed assessments of their capacity and best interest decisions were specified when required. This helped to ensure people received care that was lawful and in their best interests.

The environment was adapted to meet people's safety, independence and orientation needs. People were able to move around the home safely and independently, with sufficient space for any equipment they needed to use, such as walking aids. People said they were comfortable and satisfied with their environment and their own rooms, which they were able to personalise as they wished.

Good

Is the service caring?

Our findings

People said they had good relationships with staff, who they described as kind and caring. One person said, "Staff are lovely; I don't know what I would have done without them." Another said, "They know who I am and who's talking." We saw this was so throughout our inspection and found that staff treated people with patience, respect and regularly showed compassion and good humour. We also saw that staff promoted and understood the provider's stated care aims, which included to ensure people's dignity, privacy, rights, choice and independence. One person said, "I have friends here; staff are kind; If I feel sad or worried, I can talk to any of them; they're all lovely and very kind; they treat me with respect – I feel very lucky to be here."

We saw that staff consulted with people about their plans for the day and supported their daily living choices, routines and care preferences. For example, some people went out food shopping with a staff member and then on for lunch together. Other's chose to do individual activities, such as in their own room, out in the garden, or out with a family member. Another person told us they often preferred their own company, but said that staff supported them to go out to do things they enjoyed and to pursue their hobbies and interests, when they wished. We saw staff had helped to provide one person with an adapted walking trolley, following their recent physical ill health. The person said this enabled them to continue to be able to carry their meals on a tray to their own room, when they preferred to eat there, which they were please about.

People's agreed care and preferred daily living routines were detailed in their written care plans for staff to follow. Staff understood and followed what was important to people for their care and personal relationships. People were supported to maintain their contacts with family and friends as they chose. Two relatives came into the home to see people during our inspection. One said, "I come regularly; they always make me feel welcome and give us privacy."

Staff used a range of accessible ways to communicate with people. People or their representatives were provided with relevant care and service information, which could be provided in alternative formats; to help people to understand their rights and what they could expect from the service. This included the provider's stated aims and values for people's care. Staff training measures and regular management checks of people's care helped to ensure staff consistently followed this.

Access could be arranged for the provision of audio information. For example, to support any person living with a sight impairment. One person living with this had chosen to receive verbal information and explanations, as they preferred to use spoken word directly with staff. People were informed about their rights relating to their care, lives and daily living arrangements. This included how to access independent professional or lay advocacy services, if people needed someone to speak up on their behalf. This helped to ensure people's autonomy, rights, equal participation in and understanding of their care.

Good

Is the service responsive?

Our findings

People continued to receive individualised care, which met with their wishes, preferred daily living routines and lifestyle choices. This information was recorded in people's written care plans, to help inform their related care, daily living arrangements and life aspirations. One person said, "Staff know what I like and what I don't; they know when I'm not [feeling] good; they help." We saw that staff followed the person's wishes, to support their interests and family contacts. Another person told us, "I think staff understand me; they give me time when I need to be on my own; they are not intrusive; but they do encourage me not to be too isolated, which can be a problem." A care staff member said, "This is people's home; we are here for them; to give them the individual support they need; it's important for us to understand that."

During our inspection we saw that staff responded in an individualised and timely manner, to provide people with the assistance and support they needed. This included supporting and motivating people to accomplish their routine daily living tasks. Or, supporting people to rest and spend time in the way they preferred. This was done in a way that promoted people's independence and personal accomplishment and met their individually assessed care needs. People were supported to regularly engage in social, recreational, spiritual and occupational activities of their choice. People were also supported to vote in local and general elections as they chose.

Staff understood what was important to people for their care and knew how to communicate with people in a way they understood. Staff told us about two people who could sometimes become anxious or confused because of their mental health condition. During our inspection, we saw staff took time with both people to provide them with the emotional support they needed and at their own pace. This showed a sensitive, informed and measured approach to people's care.

The provider complied with the Accessible Information Standard (AIS). The AIS was introduced to make sure people with a disability or sensory impairment are given information in a way they can understand. People were provided with service and care information in a format they were able to understand; such as easy read language or large print.

People were regularly supported to engage in home and community life, as they chose. Regular individual and community meetings were held with people to consult with them about their care, home life and daily living arrangements. Staff understood and followed people's preferred daily living routines, wishes, life and health aspirations. These were agreed with people and shown in their written care plans. For example, staff were supporting one person who wished to move out of the area, to be near to their family. Staff had worked in consultation with the person, the receiving care provider of their choice and relevant health and social care professionals. This enabled the person to make to right decision about their future care.

People and their relatives were informed and confident to raise any concerns or make a complaint about their care if they needed to. People's and relatives' views about the quality of care provided were regularly sought by a range of methods. This information was used to inform and make care changes or improvements when required.

We have not reported on end of life care for people at the service as there was no one receiving this at the time of our inspection.

Good

Is the service well-led?

Our findings

The service continued to be well led. There was registered manager for the service. 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.'

People, relatives and staff were happy with the management and running of the service and found the registered manager to be visible, open, helpful and approachable. One person said, "The manager talks with me to see how things are going." Another said, "I know who the manager is – she's there; she's very good."

Staff were kept informed and understood their role and responsibilities for people's. Staff followed the provider's stated care aims and relevant communication and reporting procedures concerned with people's care. A range of comprehensive operational care policies and related safety procedures were provided to inform and support people's care and related staff practice. The provider sought regular opportunities to review and improve the service against nationally recognised guidance. Staff were updated regarding recent policy changes in relation medicines safety, incident reporting, information handling, confidentiality, record keeping and data protection. Subsequent management checks showed this was understood and being followed by staff. A review of the safety arrangements for staff lone working at night was assured by the registered manager at this inspection.

The registered manager and an external manager for the provider, regularly checked the quality and safety of people's care at the service. For example, checks of people's health status, medicines and safety needs. Accidents, incidents and complaints were also regularly monitored and analysed, to identify any trends or patterns that may inform any care improvements required. When any resulting changes or improvements were needed for people's care, staff confirmed this was communicated to them in a timely manner by management. Staff performance management and development measures were also consistently operated;

The provider regularly engaged with people and relatives to obtain feedback about their care experience and to keep them informed about the service. Records showed their overall satisfaction with care and service provision. This helped to ensure the quality and safety of people's care and related staff practice.

The service worked closely with and liaised with relevant external agencies and health professionals concerned with people's care at the service. For example, to support people's mental and physical health improvement or rehabilitation. This helped to ensure people received care that was effective, lawful and met with nationally informed care standards.

With the exception of a delay; the provider usually sent us notifications about important events when they happened at the service. This was subsequently sent to us by the registered manager and showed that other relevant parties, including care commissioners had been notified at the time. It is a legal requirement that a

provider's latest CQC inspection report is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had conspicuously displayed this in the home and on their website.