Leonard Cheshire Disability

Fryers House - Care Home with Nursing Physical Disabilities

Inspection report

Tel: 01794 526 200

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Ratings

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

Overall summary

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 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

The inspection was unannounced.

Fryers House provides nursing care and accommodation for up to 22 people with a physical disability. Many people living at Fryers House use a wheelchair, require support with personal care and help to eat and drink. Some people require family or an independent representative to advocate on their behalf. This may be due to their health condition or difficulty in communicating effectively.

Some staff did not have suitable skills to communicate with people effectively. Documentation from team

Summary of findings

meetings showed staff were asked to speak with people in English. Relatives consistently told us many staff were not able to speak English and people using the service could not always understand them.

Staff were not always knowledgeable about people's hobbies and interests and some people told us they did not feel listened to. Relatives told us people were encouraged to take part in activities they had no interest in. This was confirmed when we spoke with people and looked at the hobbies recorded in their care plans. One person said: “I wish they would listen to me”. Another person said: “I don’t like doing this (the activity), I used to do it when I was a child but not now”

Consent to receive care and treatment was not reviewed regularly and best interest decisions were not always documented. Staff were not always knowledgeable about how to assess people’s capacity to make specific decisions.

People were at risk of receiving inappropriate care and treatment as documentation was not always clear. The provider did not have effective arrangements in place to check all records associated with people’s care were correct. Some staff told us they did not know which records were accurate.

Staff were knowledgeable about protecting people from abuse and accurately described the services safeguarding procedures.

Staff received appropriate induction, learning and development. They were knowledgeable about deprivation of liberty safeguards (DoLS) and were able to describe what may constitute people's freedoms being unlawfully restricted. DoLS protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. At the time of our inspection no one was subject to DoLS.

People with complex needs were protected against risk of poor nutrition and dehydration. Records showed staff monitored people’s food and fluid intake and were knowledgeable about their allergies and food preferences. A relative said: "The food is nutritious and I would be happy to eat here".

People who had been identified as being at risk of skin damage had been appropriately assessed. Staff were knowledgeable about when people needed to be repositioned to reduce pressure on skin and accurately described the detail in people’s repositioning care plans.

Staff responded to concerns about people's wellbeing and made contact with healthcare professionals when necessary. Relatives told us staff engaged proactively with doctors and external healthcare professionals. Records showed people accessed GP appointments and were supported to visit hospital when needed.

Relatives told us they were regularly involved and encouraged to provide feedback about the management and culture of the service. Care review records confirmed this. One relative described the service as having a nice family atmosphere.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

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. Records relating to decisions made in people's best interests were not always documented or reviewed in line with the requirements of The Mental Capacity Act 2005 (MCA). Staff were not always knowledgeable about how to assess people's capacity to make decisions or give consent.

Staff were knowledgeable about what may constitute a deprivation of liberty (DoLS) and knew to contact the local authority should this be required. Staff were knowledgeable about the different signs of abuse and knew who to contact if they suspected abuse was taking place.

The provider had arrangements in place to regularly assess staffing levels.

Is the service effective?

Good

The service was effective. Staff had been appropriately trained to understand the support required to meet people's needs. They received a comprehensive induction into understanding their roles and responsibilities. Frequent supervision and appraisal was used to motivate and develop staff. Staff told us they felt well supported.

The provider had effective arrangements in place to support people who were at risk of dehydration and malnutrition. Relatives told us they had no concerns about the nutritional value of the food.

Referrals to healthcare organisations were made when required. Records showed staff responded effectively when helping people to access support from the GP and other professionals.

Is the service caring?

Requires Improvement

The service was not caring. Staff did not always interact with people effectively and people told us they did not always feel listened to.

Records documented people's interests and described activities they enjoyed participating in; however staff were not knowledgeable about their individual preferences and hobbies.

People were not treated with respect. Staff did not always engage with people in a person centred manner. Relatives told us staff treated people with dignity.

Is the service responsive?

Requires Improvement

The service was not responsive. People were at risk of receiving inappropriate care or treatment as the provider had conflicting documentation

Documentation showed complaints were listened to and investigated. Relatives consistently told us concerns were dealt with in a timely manner.

Summary of findings

Relatives told us people heath care needs were met. Documentation showed reviews of people's care took place frequently.	
Is the service well-led? The service was not well-led. The provider did not have effective arrangements in place to check documentation was consistently accurate. Staff, relatives and people had good opportunities to raise any concerns and to provide feedback. People told us the service had a positive and friendly culture.	**Requires Improvement** 

Fryers House - Care Home with Nursing Physical Disabilities

Detailed findings

Background to this inspection

Before we visited Fryers House we checked the notifications that we held about the service and the service provider. A notification is information about important events which the service is required to tell us about by law.

Before the inspection, the provider completed a 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 improvements they plan to make

Our inspection team consisted of one inspector and 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 also had the support of a specialist advisor who had experience in providing nursing care.

We observed how staff interacted with the people during meal times and during social activities. We reviewed eight people's care records including nutritional documents, repositioning records, behavioural support plans and incident records. We looked at the providers safeguarding documents, reviewed their improvement plans and checked records relating to the management of the service.

We spoke with 12 people and conducted a short observational framework inspections (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us. We spoke with the acting head of operations, three nurses, an activities coordinator, four support workers, four relatives, the acting care supervisor and two healthcare professionals. The registered manager was not available at the time of our inspection.

We previously inspected Fryers House on 9 July 2013 and found no concerns.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Requires Improvement

Is the service safe?

Our findings

People were not always respected or involved in discussions about their care as some staff could not communicate with them effectively. People told us they felt helpless and at risk when receiving personal care due to staff speaking with them in a language they could not understand. Notes from a team meeting dated 4 July 2014 stated: “Still people [staff] talking in their own language”. One relative said: “There is so many agency staff at weekends and people living here just don’t understand them”. Another relative said: “People living here can’t understand them because they can’t speak English”. One person said: “I can’t understand the staff sometimes because they don’t speak very well and I don’t like it”. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Staff were not always knowledgeable about the requirements of The Mental Capacity Act 2005 (MCA) and documentation did not always show people's decisions to receive care and treatment were respected and agreed in their best interest. The MCA contains five key principles that must be followed when assessing people’s capacity to make decisions. These principles were not always applied. A relative said: “My daughters wishes may need to be overruled in her best interests”. The person’s records showed the risks of particular decisions, benefits and alternative options had not been appropriately assessed, and that decisions had not been regularly reviewed. Support workers could not always tell us how they gained consent before providing care and could not describe how they used the MCA to ensure people’s decisions were respected and agreed. This is a breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff were knowledgeable about the different signs of abuse and knew who to contact if they suspected abuse. We observed two support workers talking to each other and sharing information about a recent safety concern. They followed the correct procedure and records showed relevant professionals were informed.

Risks to people’s safety were appropriately assessed, managed and reviewed. Care records contained up-to-date risk assessments and where risks had been identified, strategies were in place to reduce the possibility of harm. Staff accurately described the information contained in people’s risk assessments and informed us reviews were conducted every day during daily staff meetings. A care worker told us each person’s needs were spoken about during the daily meeting which we confirmed by observing the handover. A nurse told us the handover was important to ensure risks associated with people’s health were shared between staff.

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care homes. These safeguards protect the rights of people using services by ensuring that if there are any restrictions to their freedom and liberty, these have been authorised by the local authority as being required to protect the person from harm. The provider had taken appropriate steps to identify people who may require a DoLS assessment. The operations manager said: “We have contacted the local authority and referred many people to be assessed for DoLS”. Support workers told us they only deprived someone of their liberty if it had been authorised and in their best interest.

People were protected as far as possible from potential abuse as the service had a robust recruitment system to assess the suitability and character of staff before they commenced employment. Documentation included previous employment references and pre-employment checks. Records also showed staff were required to undergo a Disclosure and Barring Service (DBS) check. DBS enables employers to make safer recruitment decisions by identifying candidates who may be unsuitable to work with vulnerable adults. Documentation showed the provider had arrangements in place to identify and assess staffing levels. We observed sufficient numbers of staff were employed to care for people.

Good

Is the service effective?

Our findings

Relatives and healthcare professionals told us they were positive staff had received good training and were supported in their job role. One person said: “They [staff] know what they are doing; I have got no doubts about that”. Another person said: “I am happy with the care I get”

Relatives and healthcare workers told us people were cared for by staff that were knowledgeable about people's nutritional needs and were able to identify when people may require access to healthcare services. They told us they were confident staff were appropriately trained to support people effectively. One person said: "They help me when I eat because I really can’t do it on my own. They know what I can have and what I like". A relative told us: "I am sure people have enough food and drink, I visit a lot so I would know if there was a problem".

People who were at risk of dehydration or malnutrition had been identified and were encouraged and supported to eat and drink sufficient amounts. We observed some people drinking squash, tea and coffee whilst others were frequently offered various drinks. One relative said: "It has been a hot summer and I can say they make sure people are kept cool and given lots of drinks”. One person said: “Anytime I ask for a drink they give me one but they do come round and ask if I want one”. Records showed staff had recorded and monitored people's food and fluid intake to ensure they did not become malnourished or dehydrated. One support worker said: “This is to check they are drinking enough”.

We looked at 12 people’s nutritional care plans and asked four members of staff to tell us about their dietary requirements. Each of the staff had good knowledge of people’s nutritional needs and were able to describe the different types of diet people had. One member of staff said: “The people you have asked me about, two are diabetic, five are fed via a PEG, two are puree diet and the rest are normal diet”. Percutaneous endoscopic gastrostomy (PEG) is a procedure which provides a means of feeding. Another member of staff said: “Some people have a risk of choking so we have to make sure their food is the right consistency for them”. Each of the dietary care plans we looked at accurately reflected what staff told us.

These plans outlined the likes, dislikes and preferences of each person and the staff were aware of each individual’s preference. We observed people received the correct consistency of food

Staff received effective induction, supervision and training. They told us the common induction standards (CIS) they completed at the start of their job, and the on-going learning and development supported them to obtain the necessary skills to meet people’s needs. CIS are the standards employees working in adult social care need to meet before they can safely work unsupervised. Staff had regular supervision and appraisal (Supervision and appraisal are processes which offer support, assurances and learning to help staff development). Senior staff had conducted competency checks with support staff to ensure they were appropriately skilled to meet people’s need, such as administering medicines and manual handling practices. One support worker said: “We completed training in first aid, epilepsy, moving and handling and loads of other courses”. Another support worker told us they had received training in how to support people with a learning disability. Staff supervision records showed discussions were held in respect of their induction and personal development.

People who were at risk of developing skin damage were supported effectively. Records showed nursing staff had received training in how to identify skin breakdown, provide treatment and document their findings. A nurse told us the service held a file containing pictures of people’s wounds which were used to review the healing process. Care plans detailed the support and treatment people needed to maintain their skin integrity. Repositioning records showed the frequency of which people were supported to move position to relieve pressure on the skin. A support worker told us people were repositioned to avoid further damage to their skin. They said: “We move people from their side to their back and we also make sure people don’t stay in their wheelchairs for a long time because they can also get sore skin”.

People told us they were supported to attend hospital appointments and visits to the GP. One relative said: “I come to visit a lot and I can see people are looked after here, the staff do respond to any concerns and they will call the doctor or the hospital if they need to”. The manager told us nursing and support staff were required to document any form of communication they had

Good

Is the service effective?

concerning people's health. One nurse said: "We have a lot of paperwork to do and we record everything. Each time we speak to the doctor or any visits to the hospital or dentist we record it in their file". This was confirmed when we looked at people's records.

Requires Improvement

Is the service caring?

Our findings

There was a lack of consistency in how support workers and nursing staff listened and respected people. Some people told us they did not feel staff were knowledgeable about their personal histories, experiences, likes and dislikes. Relatives felt staff did not always take the time to speak with people.

Care notes about people's personal histories and preferences were documented but were not always known by staff. For example, we observed a volunteer stripping lavender flowers in front of people so that they could make lavender bags. In a later discussion with one of the participants they told us they did not want to do the activity. Four members of staff were not able to describe three people's personal histories, hobbies or interests.

Relatives told us they felt more time should be spent supporting people emotionally and trying to engage them in conversations. One relative said: "Sometimes I don't think people are always listened to or given the chance to talk about things they want to talk about". Another relative explained their family member had limited verbal communication skills due to their brain injury. They said: "My relative will say "no" to everything no matter what question you ask, however if you take the time to try and speak to [relative] they will say more". We observed the relative ask their family member a series of questions and the person replied with "no" but when asked "if there was one thing that could change what would be?" They replied with: "I would like them (staff) to listen to me". We observed the interaction between three different members of staff and three people for a period of 15 minutes. During these observations one support worker made no effort to communicate with the person they were supporting and was using their mobile phone for a period of eight minutes. Other observations included two staff members talking to each other for a period of four minutes whilst standing directly in front of one person. This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Relatives told us their family members were supported with dignity. One relative told us they were a frequent visitor to the service and always found people were well dressed and personal hygiene maintained. We observed people's doors were closed when personal care was being provided. Staff treated people with dignity when assisting them to eat by ensuring any excess food that may have fallen was quickly removed.

People were encouraged to maintain their family relationships. Relatives told us they were able to visit their family members without restriction. We observed lots of people being visited by their family and documentation showed visits took place regularly. One relative said: "I can come whenever I want, I visit a lot and the staff are always helpful". Relatives also told us they were able to speak with staff and tell them how they felt about their family members care. One relative explained the family member had limited mobility and was not able to communicate effectively. They said: "We sometimes have meetings to make sure everything is going as well as it should be. The staff seem pretty well trained and from what I have seen they understand how to help people with disabilities".

Requires Improvement

Is the service responsive?

Our findings

People were at risk of receiving inappropriate care or treatment as the provider had conflicting documentation. One support worker said: "People living here have been asked if they want to be resuscitated. If they can't answer then we speak to the family. There is paperwork in their files if we need to refer to it". Documents relating to one person stated "Do Not Attempt Resuscitation" (DNAR). However their care plan stated: "I can express my wishes and I wish to be resuscitated". The support worker explained they did not know which one was accurate as the care plan was not dated. Another support worker said: "I really don't know which is right; there is so much paperwork in people's files I get confused". This requires improvement.

People received medical treatment in response to accidents and investigations were conducted appropriately. For example, an incident record showed how staff responded effectively after one person had a fall. Their care plans and risk assessments had been reviewed and updated to reflect their change in care needs. Relatives told us the staff were responsive to incidents, one relative said: "There have been times when the staff have been concerned about my family member's health and the staff have called me. They called me after my family member had a fall and they spoke to me about who they were going to try to make sure it didn't happen again".

People's individual needs were regularly reviewed and plans provided accurate information for staff to follow. Records showed people's changing needs were promptly identified and kept under review. For example, one document showed how one person's care plan was reviewed and updated after a recent change in their medication. Staff told us they reviewed care plans on a regular basis and people, relatives and healthcare professionals told us they had opportunities to express their views about the person's care and support. Records viewed confirmed this.

People and relatives knew how to raise concerns and complaints were listened to and investigated. For example, during our inspection we observed a relative complaining to three members of staff about a particular issue. We later spoke with the relative who told us they were satisfied with the outcome and that the staff had taken their comments on board. Relatives told us they would contact the manager if they wanted to make a compliant. One relative said: "If they done nothing about it I would go to social services or CQC". The provider had a complaints policy and procedure. The procedure provided information as to how complaints would be dealt with and what people could do if they were not satisfied with the response. Staff told us they would try and rectify any issue at the time it was raised otherwise they would refer the complaint to the manager. One person said: "I have never had any reason to complain because I am happy with what the staff do but if you walk along the corridor you can see a list of phone numbers you can call if you're not happy".

People who were not able to express their views effectively were supported by a family member to speak on their behalf. Care review records showed relatives and advocates had been involved in in reviewing people's needs and were encouraged to make suggestions about how to improve people's experiences. A relative told us they had good opportunities to raise concerns and talk about their family members care during reviews with staff or by speaking with them during visits.

Requires Improvement

Is the service well-led?

Our findings

People and relatives told us they felt the service was well-led. One person said they were happy with the management arrangements and told us they knew who was in charge. Another person said: "Some of the staff do different jobs but I know who to go to if I need to speak to a manager". A relative told us they felt the service had good senior staff in place to help create a well-led service. They also said: "If I have any issues I know who to go to and they sort it out".

People were at risk of receiving inappropriate care and support as the provider did not have effective systems in place to check some people's documentation was accurate. The acting head of operations told us the registered manager and other senior staff were responsible for checking records were accurate. They told us the registered manager's role was to conduct regular quality assurance audits, record their findings and put plans in place to ensure anything requiring improvement was updated. Audits showed the provider had reviewed storage of medicines, checked medication administration records had been completed correctly and the disposal of medicines. Other audits included health and safety checks relating to the suitability of the premises, control of substances hazardous to health and (COSHH), and legionella and fire safety. However quality assurance records did not show people's decisions to be resuscitated had been checked or legislation such as the MCA had been fully implemented in people's care. The acting head of operations told us they were in the process of reviewing their auditing systems. They said: "We are aware some of our systems need to improve so we will make sure we review everything and get it right". This requires improvement.

Relatives and healthcare professionals told us the service had some good senior members of staff employed and said the leadership of the management was good. One relative told us the presence of a registered manager had not always been consistent due to their personal circumstances but advised us it did not have a negative impact on people. They said: "There are some very good staff here and they do a wonderful job. If I have ever had any worries or concerns they have always given me reassurance and have come up with the goods".

Staff told us the service had an open and relatives told us they felt comfortable to raise concerns, ask questions and become involved in people's care. Staff told us they felt able to raise concerns. The service had a whistle-blowing policy which provided details of external organisations where staff could raise concerns if they felt unable to raise them internally. Staff were aware of different organisations they could contact to raise concerns, for example, care staff told us they could approach the local authority or the Care Quality Commission.

Staff told us they felt well supported and motivated by their line manager and said they could access advice when they needed it. The acting care supervisor told us they could access support from the acting head of operations if required. Staff said they were encouraged to raise any concerns about people's care needs and were regularly asked at team meetings to discuss people they supported. One member of staff said: "We have team meetings where we talk about anything we need to. This includes the support we have to do our job and talking about things like health appointments for people that live here". Records of team meeting showed they took place frequently and topics discussed included health and safety, people's care needs, accidents and incidents.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Nursing care Personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services **People were not always treated with consideration and respect.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Nursing care Personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment **People were at risk of receiving inappropriate care as the registered manager did not always act in accordance with the requirements of the Mental Capacity Act 2005.**

This section is primarily information for the provider

Enforcement actions

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