Anchor Trust

Firth House

Inspection report

18 Firth Mews
Millgate
Selby
North Yorkshire
YO8 3FZ

Tel: 01757213546

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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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection took place on 26 July and 1 and 9 August 2018. The first day of this inspection was unannounced.

Firth House is a residential 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. Firth House can accommodate up to 41 people who may be living with dementia or a physical disability. At the time of our inspection, 37 people lived at the service.

The home is over two floors and separated into four smaller units each with their own distinct name. Each unit has a dining area with a small kitchenette for the use of people who live at the service and staff. There is a large lounge for everybody to use which opens out into the secure garden. Each person has their own room with en-suite facilities.

There was a registered manager in post. 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.

Although the service was staffed in accordance with the provider's dependency tool, there were insufficient staff to meet people's needs in a timely manner due, in part, to the layout of the building. We discussed our concerns about staffing with the registered manager and provider who took immediate actions by increasing the staffing levels.

On the first day of our inspection, risk assessments were not consistently in place for areas of identified risk. These were completed by the second day of our inspection. When risk assessments were completed, they were thorough and provided clear instruction for staff to follow to safely support people and reduce the potential risks.

A series of health and safety checks of the environment were completed, however some essential checks, including of bed rails, had not been completed in the two weeks prior to our inspection.

The temperature of the medicines storage was too high due to an ineffective air conditioning unit. The registered manager arranged for a contractor to assess the unit. Overall, medicines were managed safely and people received their medicines as required. Staff received medicines training and their competency was assessed annually.

The registered manager and provider completed a series of checks to monitor the quality and safety of the service provided to people. There remained some outstanding actions from these audits at the time of our

inspection and the checks had not highlighted some of the issues we found during our inspection. The registered manager and provider were responsive and immediately addressed the issues.

People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible. Mental capacity assessments and best interest decisions were completed when required and involved people's family members and professionals, when required. Staff sought people's consent before providing care.

People told us the food was of good quality and a variety of options available. People's weight and nutritional and fluid intake were monitored and the staff responded to any concerns.

People had access to healthcare professionals and staff sought their advice and input into people's care.

Staff received supervision and appraisals and told us they were well supported in their role. New staff completed an induction and had a probation period to ensure they had the necessary skills and knowledge for their new role. Staff undertook training the provider considered to be mandatory and completed refresher training to ensure their knowledge and practice was up to date.

People told us the staff were kind, caring and promoted their dignity. We observed warm interactions between staff and the people who used the service and people were comfortable with the staff. Staff took an interest in people's well-being and provided people with emotional support. People's families were warmly welcomed when they visited. Information about advocacy services was available.

People received person-centred care which was responsive to their needs. Care plans were not consistently in place for new residents however when care plans were completed these were person-centred and detailed. The support people received was also reviewed on a regular basis. There was a wide range of activities available both within and outside of the home and people were encouraged to remain physically active. A compliments and complaints policy was available and people told us they felt confident to raise any concerns they had. At the time of our inspection, no people required end of life care. People's wishes in relation to their end of life care was documented.

People's input was sought into the running of the service and the registered manager had maintained links with the community.

This is the first time the service has been rated Requires Improvement.

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?

Requires Improvement

The service was not consistently safe.

Staffing levels were insufficient to meet people's needs in a timely manner.

Risk assessments were not consistently in place for identified risks.

People received their medicines safely.

Staff understood how to protect people from abuse.

Is the service effective?

Good

The service was effective.

Staff received training and supervision to support them in their role.

People told us they enjoyed the food.

People had access to healthcare professionals.

Is the service caring?

Good

The service was caring.

Staff treated people with kindness and compassion.

People's dignity and privacy were promoted.

Relatives and visitors told us they felt welcomed to the home.

Is the service responsive?

Good

The service was responsive to people's needs.

People received person-centred care.

A wide variety of activities were available.

There was information about people's end of life wishes.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The issues we found during our inspection had not been highlighted through the quality assurance processes.

The registered manager was noted to be supportive.

Close links had been established with the local community.

Firth 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 comprehensive inspection took place on 26 July and 1 and 9 August 2018. The first day of the inspection was unannounced. The inspection team was made up of two inspectors for the first and third day and one inspector for the second day.

We used information the provider sent us in the Provider Information Return. This is information providers are required to send us at least once annually to give some key information about the service, what the service does well and any improvements they plan to make. This contributed to our understanding of the service.

Before our inspection we reviewed information we held about the service, which included information shared with the CQC and notifications sent to us since our last inspection. The provider is legally required to send notifications about events, incidents or changes that occur and which affect their service or the people who use it. We also contacted the local authority commissioning group and the local Healthwatch, a consumer group who aim to share the views and experiences of people using health and social care services in England. We used this information in planning our inspection.

During the inspection we spoke with five people who used the service and three relatives. We spoke with 11 members of staff. This included the registered manager, the district manager, the cook and care assistants. We also spoke with two visiting professionals.

We reviewed three staff files and looked at the overview of staff training, supervisions and appraisals. We looked at documentation for seven people who used the service, which included care plans, risk assessments and daily records. We viewed medicine administration records for six people. We also viewed a variety of documentation relating to the running of the service and the provider's policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Staffing levels were not sufficient to meet people's needs in a timely manner. The provider used a dependency tool to assess the minimum staffing levels required to safely meet people's needs, but the layout of the building was not considered as part of this.

On the first day of inspection, there was a team leader and five care workers supporting people. One care worker was based on each of the home's four units. The fifth care worker moved between the units providing additional support when needed. The team leader took responsibility for medicines and general oversight.

We observed short periods of time where there was no staff present on a unit as they were assisting people in their bedrooms or within a different part of the home. For one person, this meant they were alone in their room with their dinner, however they required support and supervision for all their meals due to a risk of choking. We immediately highlighted this to the staff members who were unsure about the level of support the person required. We checked their care plan which confirmed supervision was required for all meals. The staff member then took immediate action to ensure the person was safe.

Of the five people we spoke with who used the service, three described times when they felt rushed or had to wait for their support. A person who used the service said, "It upsets me having to wait. Yesterday I had an awful day, it was about 11am before they could get to me." They went on to say they thought the service was short staffed.

Some of the staff expressed concerns about staffing levels. They felt people were safe but told us they did not always have the time to spend with people. A member of staff said, "When you're the only person on the unit you don't have time to sit and talk to people." Other comments included, "Sometimes you don't have time. Medicine rounds feel rushed and mornings are harder" and "There is generally enough staff, but some days are hectic, particularly as the service has filled up." Call bells were answered by the staff in a timely fashion, however, particularly on a morning, we observed staff responding to continual call bells and needing to leave the activity they were engaged with.

We discussed staffing levels with the registered manager and provider. The registered manager advised no concerns had been raised by staff, residents or relatives in relation to staffing levels. However, the registered manager and provider listened to and acknowledged our concerns and took immediate actions to increase staffing levels. By the second day of our inspection, the registered manager had introduced an additional care worker and the rotas confirmed this. The provider also agreed to increase the team leader presence on a morning from one to two to assist with people's personal care and medicines administration. The provider also agreed to review the dependency tool they used to ensure this accurately determined safe staffing levels.

Whilst some risk assessments had been completed these were not consistently in place or updated when there had been a change in the person's needs. For example, one person was at risk of choking and a

choking risk assessment was not in place to guide staff on how to support the person to minimise the risk. Their Malnutrition Universal Screening Tool (MUST) had not been accurately completed to identify risks around weight loss and ensure appropriate follow-up actions were taken. We found other examples where risk assessments were not in place for people who had recently moved into the home. These were highlighted to the registered manager and by the second day of our inspection, risk assessments had been completed. The risk assessments in place were detailed and clearly directed staff on how to safely support people to reduce potential risks. Training in relation to the MUST risk assessment was also arranged for staff. Whilst the registered manager responded to our feedback this was reactive and not proactive risk management.

Medicines were securely stored, but, on the first day of inspection, the temperature in the medicines room was outside of the safe range, as it was too warm. An air conditioning unit was in place, but this had not been effective in cooling the room. We highlighted this to the registered manager who arranged for a contractor to assess the air conditioning unit.

Overall, medicines were managed safely. Staff completed medicines training and their competencies were assessed annually to ensure they had the necessary knowledge and skills. Records showed people received their prescribed medicines and creams. For 'as and when needed' medicines, there were detailed protocols in place to guide staff on what actions to take.

There were insufficient numbers of people who had received first aid training to ensure there was a competent person in the building on each shift. The registered manager took immediate action and arranged for members of staff to complete this training.

The home environment was clean, smelt fresh and was inviting. We found minor infection control issues within some of the bathrooms, which included engrained dirt and rust on the legs of shower chairs. Rust prevents the equipment from being adequately cleaned. We highlighted this to the registered manager who took immediate actions and replacements were ordered. Personal Protective Equipment (PPE) was available for staff to use to help prevent and control the spread of infection. A relative told us, "The home is always very clean and [the person's] room is always tidy."

Records relating to the checks of the building and equipment used were generally in place and ensured the safety of the people who lived at the service. Bed rail checks had not been completed for the last two weeks and, although visual checks were completed on the fire doors, these had not been tested. People who used the service had not been harmed as a result of these checks having not been completed. A new maintenance worker had been employed and the registered manager confirmed these checks would be completed as a priority.

People told us they felt safe. A person who used the service told us, "I feel really safe. If I move they know and they support me" whilst another person said, "I feel safe, I was always falling at home with no one there and had to wait. I don't fall here." A relative told us, "They (the person) are safe and I can sleep well at night."

Recruitment was managed safely and a newly appointed staff did not start until their DBS and two references had been received. DBS checks return information from the police national database and help employers make safer recruitment decisions.

Agency staff were used and profiles were in place which confirmed they had completed the necessary training to provide people with safe care. The use of agency staff was kept to a minimum and the same people were used to provide people with continuity.

Staff were skilled in understanding potential signs of abuse and knew who to speak with if they had any safeguarding concerns about people. Information was available to staff about the whistleblowing procedure however staff expressed their confidence that any issues would be dealt with by the management team.

Records of accidents and incidents were completed and detailed. The registered manager completed a monthly analysis to consider any patterns or trends around incidents, such as falls, any lessons learnt and actions as a result of this such as referrals to other agencies or a review of a person's medicines. Staff were confident in the actions they would take if somebody had an accident.

Good

Is the service effective?

Our findings

Assessments were completed with people before they moved into the home to understand their needs and the support required. This helped ensure the staff could meet people's needs.

On the first day of inspection, we found the documentation for new residents had not been fully completed. For example, one person had complex health conditions and there was no recorded information about this. We discussed this with the registered manager and care plans were in place on the second day of our inspection. The registered manager told us, moving forward, care plans would be completed within 48 hours of admission.

Positive feedback was given about people's experience of the assessment process when moving into the home. For example, a relative told us, "The manager came to the hospital to do the assessment and really made us feel part of the move."

People's communication needs were assessed and strategies to effectively communicate with them had been considered. For example, staff had used a translation device to communicate with a person for whom English was not their first language. Staff told us the person was delighted with this. Care plans also recorded whether people had any sight or hearing impairments to ensure information was delivered to them in the most accessible way.

The registered manager and staff understood the principles of the Mental Capacity Act (MCA) and promoted these through the way they supported people. MCA assessments and associated best interest decisions were completed when people lacked capacity in relation to elements of their care. Best interest decisions included people important to the person and professionals.

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). The registered manager understood DoLS and appropriately identified people who may potentially being deprived of their liberty and notified the local authority.

Staff sought people's consent before providing care and understood the importance of this. People's consent was also recorded on their care file.

Daily records were completed which documented the support provided to people and any other important information. Staff also attended a handover twice daily. This was an opportunity to share any appointments, to discuss the support provided or any concerns which needed to be addressed and followed up. These systems were effective in ensuring staff were informed about people's needs.

People told us the food was of a good quality and they enjoyed it. A relative said, "[The person] wouldn't eat at home and here they are clearing their plates." There was a variety of snacks and drinks available

throughout the day and there was also a sweet shop and a bar. A selection of meals was available according to people's personal taste, needs or cultural requirements.

Staff monitored people's weight and their food and fluid intake to ensure they were eating and drinking enough. When there were any concerns these were discussed with the relevant professionals and their advice followed.

Professional input was sought from a variety of professionals including speech and language therapists, GP's and district nurses to ensure people had the support they required. A visiting professional told us, "The home is generally very good. It's easy to find staff and they know the people well and we are well supported when we come in."

Supervision is a process, usually a meeting, by which an organisation provides guidance and support to their staff. Staff told us they felt supported in their role and they received annual appraisals and regular supervisions. Supervisions were used an opportunity to ask how the person was, any goals they had and their training needs.

New staff completed an induction period and had regular supervisions to discuss their progress, the training completed and whether they were enjoying the role.

Staff completed a variety of mandatory training which included equality and diversity, manual handling and safeguarding. A new member of staff commented, "The training has been the best that I've had." Refresher training was also completed for topics including medicines and moving and handling to ensure the staff had the necessary skills and knowledge in line with current best practice.

The home environment was comfortable and furnished to a high standard. People's rooms were personalised to their own tastes and were decorated with photographs and flowers and some people had brought their own furniture. This demonstrated people were included in decisions about their rooms and the service wanted to ensure they felt comfortable and at home.

People who may have been at risk of falling had sensors in their bedrooms to automatically alert when they may require assistance without restricting their movements. This meant staff could respond to risk without the person being under constant supervision.

Good

Is the service caring?

Our findings

People who used the service told us staff were very kind towards them. Comments included, "I am very well cared for", "The lasses are really nice. They tell you if you need anything to press the buzzer" and "They (the staff) will do anything. They look after you very well, can't fault the staff at all. They are all very good." A visiting professional told us, "There are really good relationships between staff and residents."

We heard staff speak with people in a polite and courteous manner. People were addressed in their chosen name, staff always said please and thank-you and excused themselves if they needed to provide assistance to another person. For example, a staff member was playing cards with somebody in their room when a buzzer went off. They apologised and explained they needed to go and make sure the person was okay but would be back.

Throughout the inspection we observed lots of very warm and meaningful interactions between staff and the people who used the service. Staff were patient with people and showed genuine concern for their well-being. For example, we heard a staff member reassure somebody who was finding it hard being in a different environment and said, "You can always cry on my shoulder and I'll cry on yours".

During each day of our inspection we heard staff and people who used the service laughing and talking together in a relaxed manner and people who used the service responded positively to staff. This showed us people had developed meaningful relationships with the staff who supported them.

Staff respected and promoted people's privacy and dignity. We saw them knock on people's doors and physically lower themselves to ensure they were speaking to the person at eye level. Staff told us how they closed curtains before providing personal care and covered people if they're having a wash.

Staff showed a good understanding of people's needs. They described the level of support a person required, whether there were any on-going concerns and, if there were concerns, what actions had been taken.

People were supported to express their views to enable them to make decisions. Staff continually presented people with choices about the food they wanted to eat, where they wanted to sit and activities they wanted to engage in. We heard a staff member explain to a newer member of staff how to present choices to a person to enable them to decide without overwhelming them with information.

Staff were mindful not to take people's independence away from them and actively encouraged them. We observe a staff member encourage a person to walk, telling them how well they were doing and guiding them around potential obstacles.

People's relatives told us they felt at ease and welcomed when they visited the home. Relatives were encouraged to use the facilities and staff talked with them in a relaxed manner. A relative told us, "Staff told us to treat it like your mum's home."

At the time of our inspection there were no people receiving the support of an advocate. The registered manager understood the role of advocacy services in supporting people to make important decisions about their life. Information about advocacy services was available to people.

Good

Is the service responsive?

Our findings

Care plans were not consistently in place for people who had recently moved into the home. We highlighted this to the registered manager and these were completed by the second day. Care plans described people's communication, moving and handling and emotional and psychological needs. Care plans were person-centred and described people's abilities alongside the support they required. For example, '[The person] can make their own choices with food' and 'is able to wash their own hands and face.'

Information about people's family, personal history and likes and dislikes were also documented. Care plans reminded staff of the importance of remembering the person's preferences and promoting their dignity during personal care. For example, one care plan stated, 'while doing personal care constantly talk to [the person] and give them reassurance. Ensure privacy and dignity is maintained.'

Reviews of people's care were completed monthly and people's families were invited to contribute to the reviews. However, we found changes to people's needs were not consistently recorded within the care plans. For example, one person's review noted a deterioration in their mood and this change was not reflected in their care plan. We discussed with the registered manager who agreed to update this information.

An activities coordinator was no longer employed at the home as staff were encouraged to support people on a one to one basis and to engage with organised activities. Each afternoon there was a variety of scheduled activities. This included performances by musicians, films and takeaways. On one of the days we visited people were decorating buns and we observed staff and people laughing and talking to one another throughout the entire activity. Trips were also arranged which included an outing on a boat and to a restaurant.

On a weekly basis an interactive music group was held at the service where parents brought in their babies and toddlers. People who used the service were invited to join in and the registered manager told us how much everybody enjoyed these sessions.

The registered manager had considered ways to keep people who used the service active. This included a visit from a fitness instructor who did resistance training with people. Foot cycle machines had been purchased, at people's request, and we saw people using these as they were sat in the armchairs. The registered manager was also in the process of arranging a swimming session for people who wanted to do this.

Different events and celebrations were held and family members were encouraged to attend. A summer fair was being arranged and there was a recent party to celebrate 50 years since the opening of the service. A memorial day was also held every year to remember those who had lived at the service and passed away.

The variety of activities arranged, within and outside of the home, demonstrated that the registered manager and staff team recognised the importance in people having regular stimulation and the

opportunity to continue experiencing new things.

At the time of our inspection there was nobody receiving end of life support. End of life care plans were in place and people's wishes and where they wanted to be cared for were documented. The registered manager told us this was people's home and they would support them for as long as they could.

A compliments and complaints policy was available. There had been one formal complaint received in the last twelve months and the registered manager had responded to this in line with the provider's policy. People who used the service and their relatives told us they felt confident to raise any issues with the management team. A relative stated, "[The registered manager] is lovely. I would have no problem in going to them."

Requires Improvement

Is the service well-led?

Our findings

We looked at the procedures in place for quality assurance and governance. These enable registered managers and providers to monitor the quality and safety of the service and to drive improvement.

The registered manager completed or delegated a wide range of audits which included safety of equipment and the environment, medicines, staff training and care plans.

The provider undertook regular visits to the service and demonstrated a commitment to quality assurance. Actions as a result of audits were recorded and their progress revisited. The registered manager told us they felt well supported by the provider. An internal compliance inspection was completed in February 2018. This had highlighted the need to ensure documentation was up-to-date and that MUST risk assessments had not been properly completed. Although the actions required had been recognised by the provider some actions remained outstanding at the time of our inspection. The checks had also not highlighted some of the issues we found during our inspection with staffing levels, storage of medicines and first aid training.

The registered manager and provider were responsive to the issues we raised. The risk assessments and care plans which were updated between the first and second day of our inspection were done thoroughly and with consideration. In addition to this, first aid training was arranged, staffing levels were increased and the necessary checks completed. We found nobody had been harmed as a result of the issues we found. However, there were areas that required improvement and these were acknowledged and actioned by the registered manager and provider.

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.

The registered manager was a visible presence within the home and we received positive feedback about them. Comments included, "[The registered manager] is passionate people are looked after well. They would listen and react" and "This is probably the best home I have worked in. [The registered manager] has been supportive and has helped me." A professional told us, "[The registered manager] has a positive attitude in what they do. Everything is about it being the residents home" and went on to say "I would feel confident for a relative of mine to move in. It's a really, really nice home."

The registered manager had appropriately notified the CQC of any incidents within the home which may have affected people who used the service.

People's views on the running of the service were sought in a variety of different ways and their feedback was used to develop the service. Residents and relative's meetings were held and satisfaction surveys were given to people. In the most recent survey, 100% of those who responded said they were happy living at Firth House.

A variety of staff meetings were held which included heads of departments, night staff and the full staff team. Records showed staff were invited to speak up about things they were concerned about. These meetings were also used as an opportunity to discuss any lessons learnt from recent accidents, incidents and safeguarding concerns with the aim of improving the support provided to people.

The registered manager developed and maintained close links with the community during the years they had worked at the home. For example, people studying at the local college spent time at the home as part of their course. Some students had been employed to work at the home as a result of this.