EMH Care and Support Limited

Fisher Close

Inspection report

1-3 Fisher Close
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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?	Requires Improvement

Summary of findings

Overall summary

Fisher Close is a care home that provides nursing support for up to 15 adults with learning and physical disabilities. Accommodation is provided within three separate purpose built bungalows which were adapted for equipment that people may need to support them. At the time of inspection 13 people were living there.

At the last inspection, the service was rated Good. At this inspection we found the service remained Good.

At the last inspection we found that there were not always enough staff to meet people's needs and at this inspection we saw that this had improved. There were enough staff and people were supported to be independent and to engage in activities at home and in the community.
Quality audits were completed in the home and were effective in highlighting any actions which needed addressing. The provider's systems for reviewing the quality of the home and ensuring the registered manager understood what improvements were required were not always effectively implemented.

Risk management remained safe and this included ensuring that people received their medicines as prescribed. People continued to be protected from abuse and lessons were learnt when things went wrong. Infection control was managed to protect people.

Staff were still equipped to do their jobs well through training and support. People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible. People continued to have enough to eat and drink and their healthcare needs were met in partnership with other organisations. The building was designed and adapted to meet people's needs.

The service remained caring and staff demonstrated kind, patient interaction with people which upheld their dignity and privacy. Relationships with families and important people were encouraged by staff.

The service remained responsive because staff understood people's needs well. Care plans were up to date and people's support requirements were regularly reviewed and amended. There were no complaints but there was a complaints procedure in place and information about how to complain was on display.

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 has improved to 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 has deteriorated to require improvement.	**Requires Improvement**

Fisher Close

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 5 January 2018 and was unannounced. It was completed by one inspector.
We produced an inspection plan to assist us to conduct the inspection visit with all the information we held about this service. We checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service. We used this to formulate our inspection plan. We also used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.
We used a range of different methods to help us understand people's experiences. Most of the people who lived at the home could not give us extensive verbal feedback and so we observed the interaction between people and the staff who supported them in communal areas throughout the inspection visit. We were able to talk with one person with the assistance of a member of staff who worked closely with them and could help us to understand their communication.
We spoke with the registered manager, a learning and development trainer, one nurse, and three care staff. We reviewed care plans for three people to check that they were accurate and up to date. We also looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement. This included audits, Medicines administration records, training matrix and staff rotas. We also reviewed two recruitment files.

Good

Is the service safe?

Our findings

At our last inspection there were not always enough staff to ensure that people's needs were met safely. At this inspection we found that improvements had been made. One member of staff we spoke with said, "We are usually fully staffed now. We have used some agency staff recently to cover sickness but they have worked here regularly". The registered manager told us, "We have no staffing vacancies anymore. I focussed on recruitment when I came into post". We saw that people had support throughout the day and that staff had time to spend with them individually. Records that we reviewed confirmed that staffing levels were planned in advance around people's needs and took into account their activities and interests. We saw that the provider followed recruitment procedures. One member of staff told us, "I had references taken and police checks done before I started working here".

People were protected from abuse by staff who understood how to identify signs and report in line with procedures. One member of staff said, "If I was worried about anyone I would report it to the nurse or manager straight away. I also know that the safeguarding number is on the wall in the office". We reviewed safeguarding with the registered manager and saw that safeguarding notifications had been raised when required and investigations had been completed in a timely manner.

Lessons were learnt when things went wrong and actions taken to reduce the risk of repetition. We spoke with the registered manager about a recent incident and they told us about the actions they had taken. They said, "We have contacted all of the relevant authorities and started an internal investigation. We also reviewed our procedures immediately and I am conducting supervisions with staff so that everyone is aware of the new safety measures". We saw that there were also records and analysis of accidents and any other incidents. This demonstrated to us that there were measures in place to review and learn from errors.

Risk was assessed and actions were taken to reduce the risk. We saw that people were supported to move safely and when we reviewed records we found that this was in line with the risk assessments. These risk assessments were written to ensure that staff understood what the person could do independently and safely first; and then what support they might need. In the PIR the provider told us, 'We adopt a positive risk taking approach which encourages people in taking part in activities rather than restricting people'. The registered manager stated, "It is our priority to enable people to assist people to be as independent as they can be". Other risks to people's health and wellbeing were also considered; for example, there were plans in place to assist staff to support people to calm during episodes of distress. Records that we reviewed showed that risk assessments were regularly reviewed.

Medicines were managed to ensure that people received them as prescribed. We saw that there were arrangements in place for people to take them to meet their needs; for example, some people took theirs' in liquid form. The registered manager told us, "Nurses administer the majority of the medicines but we do train some staff in administering emergency medicines as well in case the need arises when they are out with people; for example if the person has a prolonged epileptic seizure". There was guidance in place for staff to follow when people needed to take medicines which were prescribed 'as required'. Medicines were stored, recorded and monitored to reduce the risks associated with them.

The home was clean and hygienic which reduced the risk of infection. We saw that staff wore protective equipment when needed and one member of staff said, "We have white aprons and gloves to use when we support people and blue ones for the kitchen so we don't get confused". There was a member of staff employed to clean in one of the bungalows. Another member of staff said, "They are usually in the bungalow two days per week and the rest of the week the care staff do it". The registered manager said, "There is flexibility. For example if someone is unwell and we are concerned about spreading infection then the domestic staff will go to that bungalow and ensure it is cleaned thoroughly. We also have procedures where people and staff do not go into the different bungalows so that we can control the infection and prevent cross contamination". The registered manager maintained infection control audits and implemented any required action points.

Good

Is the service effective?

Our findings

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). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. We saw that staff supported people to make some decisions; for example one person was supported to use technology to communicate their wishes with staff and the manager. Other people lacked capacity to make their own decisions. Staff told us how they consulted with families and other professionals to ensure that their best interests were considered. Records that we reviewed confirmed this. DoLS authorisations were applied for when people did have restrictions in place that they couldn't consent to.

People's needs were assessed and support was given in line with evidence- based guidance. For example, we saw information from professionals and organisations about supporting one person's skin when they lay down. There was written and photographic guidance for staff to ensure they supported the person in line with the guidance.

The building and the environment was adapted to meet people's needs. For example, one bathroom had ceiling tracking for a hoist and an adapted bath. People had beds suitable for them; for example, some people slept near the floor because of the risk of falls on an adapted bed and other people had beds which were adapted so that the mattress moved to protect their skin.

People were supported to have enough to eat and drink and meals were adapted for specialist diets when needed. Some people were able to make a choice. One member of staff we spoke with said, "When people can't verbally tell us what food they like we judge how much they enjoyed a meal and if they ate it all. We use that as an indication of their choices". We saw that records of food and fluid were maintained if necessary.

People had regular access to healthcare professionals and staff were vigilant to changes in people's health. One member of staff told us, "We are in regular contact with health professionals. For example, one person hasn't looked well recently but they would resist a medical examination. We are working through meetings with the GP in their best interest to decide how to approach it". Records that we reviewed showed that people had regular health checks and that referrals were made to other professionals when needed. This demonstrated to us that the provider had effective relationships with other organisations.

Staff were skilled and knowledgeable and understood how to support people. One member of staff told us about their induction. They said, "I have done lots of training since I started here and although I have worked with people who were living with dementia before I hadn't done much training and so I really enjoyed that. I also had the chance to do shadow shifts in the house before being on the rota. This helped me to understand people's communication". Another member of staff said, "We have lots of good training and I am booked on refreshers soon". A third member of staff explained how they were supported to

maintain their professional nursing qualification. The registered manager told us, "Training and supporting staff has been a priority for me. When I started working here a lot of staff were not up to date with their training and so we have worked heard on making sure they have caught up". We saw records which demonstrated that training was planned in advance per individual member of staff.

Good

Is the service caring?

Our findings

People had caring, kind supportive relationships with the staff who supported them. One person told us, "They are very good". We observed that staff spent time with people assisting them to do things which they enjoyed. For example, they spoke with one person about the doll they had that they dressed and looked after and they helped the person to care for it. Other people were supported by staff through eye contact and smiles which they responded to. Staff understood people's different communication styles and adapted theirs when they spoke with them. For example, they understood some eye contact and vocalisation meant the one person was thirsty. When one person was distressed staff spoke with them and used signs to talk to them and this calmed them down.

Some people had communications systems in place to assist them to make choices about their care. One person had a picture board which explained to them what activities were planned and they could choose to put different activities on it. One member of staff said, "They are happier when they know what is planned for the evening when they come back from their days activities". Another person had computers and technology to assist them. The member of staff who was working with them explained that the person planned their time and informed staff what they wanted to do by e-mail. They also had equipment which had been adapted to enable them to move independently. The member of staff said, "It is great because they can decide where we are going when we are out and about. They can make their choices by moving". This showed us that people's communication needs were considered when planning their care and support.

Dignity and privacy were upheld for people to ensure that their rights were respected. We saw that if people needed personal assistance this was completed in private spaces. Staff were also vigilant to people's appearances and ensured that they supported them to change if their clothes became soiled.

People were supported to be as independent as possible. When some people were able to choose to move independently around their homes we saw that staff provided the agreed support to enable them to do this safely. One member of staff told us, "We stay with them when they move independently because of the risk of harm". We saw that the member of staff patiently walked with the person whenever they chose to move and that this kept them calm.

Some people had close family contact and staff told us how this was supported. This included some people going for regular visits to the family home and other people's families visiting regularly. The registered manager said, "We support everyone to maintain contact even if it is more distant; for example, through sending birthday cards and at Christmas". This meant people were supported to develop and maintain relationships.

Good

Is the service responsive?

Our findings

People were supported by staff who knew them well and understood their preferences. We saw that these were recorded in people's care plans which were regularly reviewed. They included one page profiles with people's photographs and communication plans which detailed important objects, use of touch, gesture and facial expressions. In the PIR the provider told us, 'All people have a named nurse who is responsible for evaluating care plans monthly and updating plans as needed'. Review meetings took place and included important people; for example, a family member or a health professional. Staff told us that they had time to read care plans and that they also kept daily records so that any changes in people's health or wellbeing were documented.

There were plans in place which documented how people wanted to be supported at the end of their life. For example, for one person it detailed where they wanted to be and how to manage their pain. The registered manager said, "We have some training planned with the hospice so that staff can develop skills in advance care planning and also in supporting people by being able to look for signs of deterioration". This demonstrated to us that there were systems in place to support people at the end of their life when it was needed.

Activities were available throughout the day in the home and some people also attended external centres. There was usually transport available to assist people to go out. We saw that some people used the transport to attend day services. One member of staff said, "Unfortunately one bus is broken today which does have an impact because some people like to go out every day even if it is just to have a drive around". One person had allocated hours with a specific member of staff to go out on a regular basis. The member of staff supported the person to give us feedback. Together they said, "[Name] researches on the computer where they would like to go and then let me know. We have been to lots of interesting places and have also visited important places from [name's] childhood and met up with family friends".

There was communication about complaints at the entrance and a procedure in place. One person told us with support that if they had any concerns they emailed the manager who would speak with staff but they had not needed to make a formal complaint. No formal complaints had been received but we saw that there were systems in place to manage them including a member of staff from a central team who was assigned to manage them. The registered manager said, "This means there is someone independent from the service reviewing them".

Requires Improvement

Is the service well-led?

Our findings

Quality audits were completed by the registered manager to measure the success of the service and to continue to develop it; for example for medicines management, the environment and people's finances. However in the PIR the provider told us, 'The service manager visits the home regularly and completes checks on the quality of the service using the quality audits and an action plan is developed for the registered manager to facilitate'. We saw that the last audit completed by the service manager was six months previously and they had only reviewed medicines. The registered manager did not have an action plan on the day of inspection. Some development plans had not been reviewed or actions taken. For example, we reviewed the latest fire risk assessment which had been completed in March 2015 and we saw that there were recommendations which had not been addressed. It was recommended that the fire panel should be re-sited from the cupboard to the main entrance and this had a completion date of March 2016. The registered manager told us that they had raised that this recently and that it was now being reviewed; although they did not know when it would be completed. Ten days after the inspection visit the provider sent us an action plan for the service; however, the registered manager was not aware of this on the day of inspection. This demonstrated to us that they systems for the provider to have an oversight of the quality of the service were not always effective.

In the PIR the provider told us, 'Quality satisfaction questionnaires for both service users and stakeholders are completed'. When we asked to review these the registered manager told us that the questionnaires for stakeholders were in development and had not been sent out. They also said that the questionnaires for the people who lived at the service were not suitable for them and they were considering different ways of gaining this feedback. Therefore, the systems that the provider stated they used to gain feedback on the quality of the service were not effectively implemented.

There was a registered manager in place. We saw that people knew the registered manager and interacted with them when they spoke with them. 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.

Staff felt that they were well supported and able to develop in their role. One member of staff told us, "We do get support from the manager and have regular supervisions". There were regular opportunities for them to share their ideas and any concerns; for example, through team meetings.

The manager ensured that we received notifications about important events so that we could check that appropriate action had been taken. We saw that the previous rating was displayed in the home and on the provider's website in line with our requirements.