Willerfoss Homes Limited

Merrywick Hall

Inspection report

41 New Road
Hedon
Hull
Humberside
HU12 8EW

Tel: 01482899477

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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

Merrywick Hall is a care home for up to 28 people with a learning disability or with autistic spectrum disorder. There are two floors and bedrooms are located on both floors. People who live on the first floor need to be able to use the stairs as there is no passenger lift. There is a bungalow in the grounds that is part of the same registration. On the day of the inspection there were 27 people living at the home.

At the last inspection in April 2015, the service was rated as Good. At this inspection we found that the service remained Good.

People told us they felt safe living at the home. There were sufficient numbers of staff employed to make sure people received the support they needed, and those staff had been safely recruited.

Staff had received appropriate training to give them the knowledge and skills they required to carry out their roles. This included training on the administration of medicines and on how to protect people from the risk of harm.

People were supported to have maximum choice and control over their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

Staff were kind, caring and considerate. They respected people's privacy and dignity and encouraged them to be as independent as possible.

Care planning described the person and the level of support they required. Care plans were reviewed regularly to ensure they remained an accurate record of the person and their day to day needs.

People were given the opportunity to feedback their views of the service provided. People told us they were aware of how to express concerns or make complaints.

The manager was the registered manager for the home's 'sister' service. However, they were not yet registered to manage Merrywick Hall.

The manager was gradually introducing new care planning documentation, quality assurance systems and other improved practices to provide consistency between the two services.

The manager carried out audits to ensure people were receiving the care and support that they required, and to monitor that staff were following the policies, procedures and systems in place.

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 was well-led but the manager was not registered. The manager submitted notifications to CQC as required and people told us the manager was approachable and professional. Quality audits were carried out to monitor that people had received a safe and effective service. People were given the opportunity to give feedback on the quality of the service provided.	**Requires Improvement**

Merrywick Hall

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 checked 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 inspection that took place on 25 May 2017 and was unannounced. That means the registered provider did not know we would be inspecting. The inspection was carried out by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before this inspection we reviewed the information we held about the home, such as information we had received from the local authority and notifications we had received from the registered provider. Notifications are documents that the registered provider submits to the Care Quality Commission (CQC) to inform us of important events that happen in the service. We received feedback from one of the health care professionals we contacted. The registered provider was asked to submit a provider information return (PIR) before this inspection. The PIR is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The PIR was submitted within the required timescale.

On the day of the inspection we spoke with thirteen people who lived at the home, a visitor, three members of staff, the manager and the registered provider. We looked around communal areas of the home and some bedrooms, with people's permission. We also spent time looking at records, which included the care records for three people who lived at the home, the recruitment records for two members of staff and other records relating to the management of the home, such as quality assurance, staff training, health and safety and medication. On 26 May 2017 we spoke with a further three members of staff over the telephone.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. One person said, "I am safe here – I share a bedroom with my friend." A relative told us, "[Name] is very well looked after here and very safe". Staff described to us how they kept people safe. One member of staff said, "We keep an eye out for any type of abuse. We also carry out health and safety checks" and "We observe people who have epilepsy closely. We check for hazards such as open drawers."

Care needs assessments had been carried out, and when risks had been identified, action was taken to minimise potential risks without undue restrictions being placed on people. We saw risk assessments in respect of epilepsy, bed sensors, weight gain, unpredictable behaviours, road safety and accessing the community. Risk assessments were reviewed each month to ensure they remained relevant.

Staff had received training on safeguarding adults from abuse. They were able to describe different types of abuse they might become aware of and the action they would take to protect people from harm. Staff told us they would not hesitate to use the home's whistle blowing policy. People had personal descriptions in their care plans that would assist the emergency services to find them if they were missing from the home.

On the day of the inspection we observed there were sufficient numbers of staff on duty. Staff were visible in communal areas of the home and people received attention promptly. Standard staffing levels during the day were a senior care worker and four care workers who started and finished work at various times of the day. In addition to this, two people received one to one support, one person for 14 hours and one person for two hours a week. There were three night staff on duty, including a senior care worker. One of these members of staff was allocated to work in the bungalow. Rotas evidenced that these staffing levels were consistently maintained. There was a domestic assistant, a cook and an administrator on duty over five days a week. The manager was in the process of recruiting an additional cook so that there would be a cook on duty over seven days a week. This meant care staff were able to concentrate on supporting the people who lived at the home.

We checked the recruitment records for two members of staff. These records evidenced that references and a Disclosure and Barring Service (DBS) check were in place prior to people commencing work. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults to help employers make safer recruitment decisions. This meant that only people considered safe to work with people who may be vulnerable had been employed at Merrywick Hall.

People's care plans included details of each medicine they were prescribed, the condition the medicine had been prescribed for and any potential side effects. We saw that medicines were stored safely, obtained in a timely way so that the person did not run out of them, administered on time, recorded correctly and disposed of appropriately; this included the management of controlled drugs.

Accidents and incidents were recorded, analysed and audited to identify any patterns that might be emerging or improvements that needed to be made. Individual accident / incident records were held in

people's care plans.

There was an emergency plan that provided advice for staff on how to deal with fire and the registered manager had identified that other emergency situations needed to be included in the plan. Each person had a risk assessment / evacuation plan in place and there were plans for this information to be transferred on to personal emergency evacuation plans.

We reviewed service certificates and these evidenced that equipment and systems had been appropriately maintained. This included the fire alarm, fire safety equipment, mobility and bath hoists, the electrical installation, the call system, portable electrical appliances and gas safety. Weekly and monthly checks carried out by the home's maintenance person were clearly recorded, such as tests of the fire alarm and bed rails.

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 Mental Capacity Act 2005 (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We saw records of the DoLS applications that had been submitted to the local authority for authorisation.

We saw evidence that MCA and DoLS had been discussed in recent group supervision meetings, and staff demonstrated a good understanding about people's rights and the importance of obtaining people's consent to their care. One person's care plan recorded, "[Name] has consented verbally to some areas of their care plan and other areas have been devised in their best interest due to lacking capacity or understanding or retaining the information given." Staff told us, "We ask before we do anything" and "We always ask people what they want to do, and who they would like to go with them, as they all have their favourites."

It was clearly recorded when decisions had been made in the person's best interest when they did not have the capacity to make the decision themselves. For example, there had been a best interest meeting to discuss one person's dental treatment. Staff described to us how they helped people to make day to day decisions, such as which meal to choose, what clothes to wear and what activities to take part in. One member of staff commented, "We don't make any assumptions."

Staff confirmed that they completed a thorough induction programme that included shadowing experienced care staff before they were included on the staff rota. Staff who were new to the caring profession were also required to complete the Care Certificate; this ensured that new staff received a standardised induction in line with national standards.

Training records showed staff had completed training on the topics considered essential by the home, including safeguarding adults from abuse, MCA and DoLS, fire safety, equality / diversity / inclusion, first aid and moving and handling. Records showed that staff had completed some additional training such as dementia and autism awareness. Staff who had responsibility for the administration of medicines had also completed training on that topic. Induction and refresher training had been combined in April 2017 and staff had attended training on first aid, epilepsy, moving and handling, food hygiene and infection control.

Records showed that staff had an opportunity to meet with a manager to discuss any concerns and their development needs in annual appraisals, one to one supervisions with a manager and group supervisions. Staff told us they felt well supported, although one member of staff told us they would like more regular supervision meetings.

People were supported by GPs, community nurses and other health and social care professionals and these professionals were recorded on a 'circle of support' document in the person's care plan. Any advice sought from health care professionals had been incorporated into care plans, and risk assessments demonstrated

actions plans and interventions for staff to follow in managing individuals varying health needs. People had patient passports in place. These are documents people can take to hospital appointments and admissions to inform hospital staff of their specific support needs. Some people also had epilepsy management plans in place that advised staff at which stage medicine should be administered and when the emergency services should be contacted.

People's special dietary requirements and their likes and dislikes were recorded in their care plan and we saw people had appropriate nutritional assessments and risk assessments in place. Food and fluid intake was recorded when this had been identified as an area of concern. There was a menu on display that recorded two choices of main meal at lunch time and tea time. People said they enjoyed the meals at the home and told us about their favourite foods.

The home had no passenger lift and people who had rooms on the first floor were able to use the stairs without assistance. We observed that people who could mobilise independently walked around all areas of the home without restriction and had no problem with finding their way around.

There was a major refurbishment programme being carried out at the home and the area of the home affected was partitioned off and not accessible to people who lived at the home. There were also barriers in the garden to prevent people from entering the area where building materials were stored. During the refurbishment programme, there was no dining room available for people who lived at the home. However, there was a small living / dining room on the first floor that some people had started to use, some people had been invited to have lunch at the bungalow and other people chose to have their lunch in the main lounge. The building work did not appear to have an adverse effect on the people who lived at the home; they all appeared to be interested in the extension and the improvements that were being made to the rest of the property, including five en-suite bedrooms, a library, a cinema room and internet connections.

Good

Is the service caring?

Our findings

People told us they were happy living at the home. One person commented, "I like living here. I've been here since it opened." We observed that interaction between people who lived at the home and staff was positive, and demonstrated that people felt comfortable around staff. Staff communicated well and supported people's preferences.

People had been allocated a key worker. A key worker is a member of staff who takes a particular interest in a person and spends quality time with them. One person told us, "I've got a key worker and a care plan. I talk to my key worker about it." The registered manager told us they had pictures of all care staff and asked residents who they would prefer so they could choose their own key worker. We saw evidence in care plans that key workers reviewed care plans each month.

People at the service valued their independence and we saw that staff respected this. One person told us, "I like to do things on my own in my room. I feel I can here – the staff look after me and keep me safe." On the day of our inspection some people were out at day care facilities and one person was out at work. Staff told us, "A couple of people walk to the local shops and know the shop keepers and locals in the area."

The people who lived in the bungalow were an integral part of the main house but lived more independently. The home had plans in place to build a log cabin in the grounds. This was going to be used to help people develop independent living skills, and provide additional activities for people who did not attend a day centre or take part in the local community.

Information was available at the home about advocacy services, and one person had their own independent advocate to represent them. Advocacy services provide independent support and encouragement that is impartial and therefore seeks the person's best interests in advising or representing them. One person had received support from an Independent Mental Capacity Advocate (IMCA) prior to their care plan review. IMCAs provide support for people who lack the capacity to make their own decisions and have no-one else to represent them.

Care plans recorded whether a person preferred a particular member of staff, or a male or female member of staff, to support them with personal care. Staff told us they knocked on people's doors before entering, they ensured doors and curtains were closed and that they covered people to protect their modesty. One person told us, "Staff help me with a wash and a shower. They keep me covered and they always ask me before they do things." A health care professional told us that they had observed people were always treated with dignity and respect. This showed us that people's privacy and dignity was considered.

Staff signed a confidentiality statement when they were new in post. We saw that written and electronic information about people who lived at the home and staff was stored securely. This helped to protected people's confidentiality.

Staff received training in equality and diversity and there was an appropriate policy in place for them to

follow.

Good

Is the service responsive?

Our findings

People's needs had been assessed when they first moved into the home and the information had been used to develop an individual plan of care. We saw that care plans contained information about the person in a 'one page profile'. This included a brief life history as well as 'What people admire about me', 'What makes me happy' and 'How best to support me'. A new care plan summary had been developed which made it easier for staff to keep up to date with people's current care needs; information had been divided into 'red, amber and green' sections to signify the importance of the information. The care plan summaries were kept in people's bedrooms so they were easily accessible to staff.

We discussed with the manager that there were a small number of anomalies in care records, such as inconsistencies in food and fluid intake records, and they agreed to address this with staff.

Care plans were reviewed each month by staff and more formal reviews were held with commissioners and relatives. This provided an agreed and up to date record of each person's care needs. Daily handover meetings ensured staff were provided with up to date information. At recent meetings staff had been reminded of the importance of thorough recording on handover sheets, and that they should be used to monitor falls and seizures for several days after the event. The communication book was completed as part of the handover process and there was evidence that staff were encouraged by management to listen to each other's ideas.

It was clear that staff understood people's individual support needs. One member of staff said, "People can't always put across how they are feeling. It's about knowing the person and how they communicate." When a person displayed behaviour that could put themselves or others at risk of harm, staff had been advised how to manage this behaviour to reduce the risks. A staff member said, "To avoid the triggers, we ensure all staff know if [Name of person] asks for a shower to respond immediately, and with the person they want to assist them." We observed that staff were skilled at de-escalating any situations that arose.

People were supported to keep in touch with family and friends and with the local community. One person told us, "[My relative] visits on a Wednesday and phones on a Sunday. I post letters. I got a letter from the Post Office to say they were pleased that I posted letters using the community post box."

There was an activities champion working two days a week who was a qualified 'learning disability' tutor. They were responsible for arranging activities and trips out, as well as signposting people in the right direction for independent living and delivering adult education within the service. Activities were also carried out by care staff as part of their day to day duties. Staff told us that they felt there were enough activities to keep people occupied. They told us about visits to the shops, people attending day centres, people taking carrots to feed the horses and trips to the beach. On the day of our three people went on the bus to a nearby seaside town with two members of staff and several people sat outside together enjoying the sunshine. One person told us, "I love sports. I have lots of sporting DVD's and videos and the sports channel on my Freeview" and another said, "I've been out to the local for my lunch – a beef gravy sandwich and a pint. I bought some new clothes too."

People told us they knew who to speak to if they had any concerns. One member of staff told us they would support people to make a complaint if they were reluctant to do so. They said, "I would document everything, speak to the individual and then speak to a manager. If I wasn't happy with the response, I would seek advice from CQC." Records showed that no formal complaints had been received since 2015.

People had an opportunity to express their views on the care and support provided at monthly 'resident' meetings. The minutes were in pictorial format and showed that menus and activities were discussed, and that people were asked if they were happy with their care. People also received a satisfaction survey; one person told us, "I've filled in a survey about what I like about living here."

Requires Improvement

Is the service well-led?

Our findings

There was a manager in post who was not registered with the Care Quality Commission (CQC). 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 manager was the registered manager for the organisation's 'sister' service and but was not yet registered as the manager for Merrywick Hall.

We asked for a variety of records and documents during our inspection, including people's care plans and other documents relating to people's care and support. We found that these were well kept, easily accessible and stored securely. In addition to this, the current ratings for the service awarded by CQC were clearly displayed in the home, as required by regulation.

Staff told us they were happy with how the home was managed. Comments included, "Managers are professional" and "I can't fault it. Everyone is there for me. Seniors are very competent." One member of staff told us they had suggested a few things to the manager including issues about care plans, and commented, "My comments were taken on board. [Name of manager] is now doing new ones." A health care professional told us, "I have always found [Name of manager] to be open and honest with the residents best interests being central. They will contact me with any concerns regarding the two residents who I support. Since becoming manager [Name] has addressed some issues in relation to care plan reviews and working practice to ensure the safety of the residents."

The manager told us they were always looking for ways to improve. They had produced an action plan to address areas that had been identified as requiring improvement, including care plans (they had already re-written some care plans), nutrition and diet, the environment (there was an extensive refurbishment programme taking place), medicines (a new medicines storage area was planned as part of the new refurbishment), health and safety and quality assurance. One area recorded in the action plan was for people who lived at the home to be involved in preparing their own snacks. We saw this happening on the day of the inspection. Another was for the chef to make more home-made foods, and we sampled some home baking on the day of the inspection.

The manager carried out quality audits to monitor that systems at the home were working effectively and that people received appropriate care. These included audits on care plans, health and safety, infection control, policies and procedures, housekeeping, accidents / incidents, safeguarding and medication. Some audits included questions for staff about the policy and procedures in place to test out their knowledge. We noted that the need for additional staff training had been identified during the medicines audit and had been booked for 18 April 2017.

Staff described the culture of the home as "Friendly, loving and caring", "Second to none. Very open" and "It's a good place to work – relaxed. Residents get on with staff. I'm pleased I work here."

Staff meetings and 'group supervisions' were held. Minutes of these meetings recorded topics discussed included the Care Certificate (all staff were given a booklet containing the standards), recording of creams, district nursing plans, infection control including use of personal protective equipment, support with personal care, positional changes, room checks and expectations of management. At the meeting in January 2017 gift vouchers were presented to staff who had achieved 100% attendance throughout 2016.