

Eldercare (Halifax) Limited

Fernside Hall Care Home

Inspection report

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West Yorkshire
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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 of Fernside Hall took place on 6 September 2016 and the visit was unannounced. Fernside Hall is registered to provide residential care for up to 24 older people. The accommodation is arranged over three floors and there is a passenger lift available. There are two lounges and a dining room on the ground floor and a kitchen/sitting area on the first floor. There are 20 single bedrooms, 18 of which have en-suite toilet facilities and two double bedrooms with en-suite facilities. At the time of our inspection there were 17 people using the service.

Our last inspection of Fernside Hall took place on 9 November 2015 and found breaches of regulations in regard to reporting of notifiable incidents, care records, reporting, analysis and actions following accidents and incidents, dignity and respect, audit and governance, recruitment, induction and training. We told the provider they needed to take action and we received an action plan. At this inspection we found improvements had been made with regard to these areas although the service needed to maintain and continue these improvements over a sustained period of time.

The manager of Fernside Hall at the time of the previous inspection had left the service. The manager at the time of our visit had been in employment at the service for approximately six months and had applied for registration with the Care Quality Commission. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us they felt safe at the service and no-one we spoke with had concerns. Staff we spoke with understood how to keep people safe and what to do in an emergency situation. The service had safeguarding procedures and individual risk assessments were in place to keep people safe.

People we spoke with told us they liked living at Fernside Hall and were happy with the service. They told us staff were kind and caring and treated them with respect and good humour. A relative we spoke with confirmed this. We observed some compassionate and caring exchanges between staff and people living at the service and staff we spoke with knew people well.

We saw consent was requested wherever possible and people's individual preferences were taken into account.

Medicines were administered and generally managed safely although the service was in the process of altering the storage of medicines to ensure these were stored at the correct temperature.

Accidents and incidents were generally well recorded and appropriate procedures followed although the manager recognised this had not happened with one identified recent incident.

Staff were safely recruited to ensure they were of suitable character to work with vulnerable people. Staff received a range of training which was generally up to date and had opportunity to attend other service specific courses and professional development training. The manager was recommencing a programme of staff supervision and appraisals and was aware this was an area for improvement.

Overall, there were sufficient numbers of staff deployed although the service needed to review the numbers of staff deployed at peak times to ensure levels consistently allowed for safe care and support.

Care records were person centred and newer care records contained good, detailed information. Work was in progress to ensure all care records were of a good standard.

A range of activities was on offer, according to people's preferences and choices. People were consulted about what activities were of interest to them and the home employed an activities co-ordinator.

The home was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS) and acting within the legal framework of the Mental Capacity Act (MCA).

A range of audits and checks were undertaken by the service to monitor, identify issues and take action to resolve them. The service received regular visits from the provider to provide support and guidance.

People who used the service, relatives, staff and healthcare professionals praised the new manager and said they generally found them approachable and could see improvements had taken place.

We saw evidence people's views were sought to making positive changes in the service.

A complaints policy was in place although the service had not received any recent formal complaints.

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 was not always safe.

Medicines were managed and administered safely. However, the service had identified temperatures in the current storage areas for medicines was too high and was making alternative arrangements.

Staffing levels were generally appropriate although needed reviewing at peak times. Safe recruitment processes were in place.

Accidents and incident reporting had improved although further improvements were needed.

People and their relatives told us they felt safe in the service.

Requires Improvement ●

Is the service effective?

The service was effective.

The provider was working within the legal requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards, (DoLS).

People's consent was sought wherever possible.

Staff training was up to date or booked and a training matrix was in place.

People enjoyed the food provided and were offered a choice of menu.

People had access to a variety of health care professionals.

Good ●

Is the service caring?

The service was caring.

People were treated with kindness and compassion and privacy and dignity was respected.

Good ●

Staff had a good knowledge of people's likes, dislikes and care needs.

People and relatives told us they were involved in the planning of their care although this was not formally documented.

Is the service responsive?

Good ●

The service was responsive.

A wide range of activities were available, with individual and group work undertaken.

Care records were person centred and contained detailed information about people's care needs, likes and dislikes.

Care records were up to date and relevant to people's changing needs.

A complaints policy was in place although the service had not received any recent formal complaints.

Is the service well-led?

Requires Improvement ●

The service was well led, although improvements needed to be consistent and sustained before rating the domain higher than 'requires improvement'.

Systems were in place to manage, monitor and improve the quality of the service.

People were consulted about aspects of the service through questionnaires and resident meetings.

Comprehensive staff meetings took place regularly.

Fernside Hall Care Home

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.

The inspection took place on 6 September 2016 and was unannounced.

The inspection team comprised two adult social care inspectors.

Prior to the inspection, we gathered and reviewed information about the service. This included notifications received from the service and information received from the local authority contracts and safeguarding teams. The provider had also completed a Provider Information Return (PIR) before the inspection. 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. We reviewed this information prior to the inspection.

During the inspection, we spoke with three people living at the service, one family member, three staff members, the activities co-ordinator, the manager and the area manager.

We observed care, support and interactions during the inspection, medicines administration and management, reviewed four care records, some in detail and others to check specific information, four staff files, training information and other information relating to the management of the service. We looked around the building and saw people's bedrooms, bathrooms and communal areas.

Is the service safe?

Our findings

People told us they felt safe at the service. A relative we spoke with said, "All [person's name] needs are met and I know [person's] safe," and, "I can go on holiday without worrying."

Staff were able to clearly outline the steps they would take if they felt they witnessed abuse and we found these were in line with expected practice. We asked staff to tell us about their understanding of the safeguarding process. Staff gave us appropriate responses and told us they would report any incident to the registered provider and they knew how to escalate concerns if necessary. Staff we spoke with were able to describe how they ensured the welfare of vulnerable people was protected through the organisation's whistle blowing and safeguarding procedures. We saw safeguarding was an agenda item discussed at staff meetings.

Accidents and incidents were generally reported appropriately, analysed and risk assessments completed where appropriate. However, we saw an example where the provider's own procedure had not been followed appropriately, where a person living at the service had fallen and sustained an injury to the head. The provider forms in the file indicated hourly observations should be carried out following a fall and none were documented on the form. We also saw in the care records the emergency services were not called until the next day. We discussed this with the manager who agreed the person should have been taken to hospital immediately and told us they had spoken to the staff members on duty at the time about the time lapse and lack of observational recording.

We saw records to confirm that regular checks of the fire alarm were carried out to ensure that it was in safe working order. We confirmed that checks of the building and equipment were carried out to ensure people's health and safety was protected. We saw documentation and certificates to show that relevant checks had been carried out on the gas boiler, fire extinguishers and portable appliance testing (PAT) was up to date. This showed the registered provider had taken appropriate steps to protect people who used the service against the risks of unsafe or unsuitable premises. The service made use of a lift over the three floors and the basement. We saw the lift had been serviced.

We looked around the home and found it clean and generally well maintained. Some parts of the building had been refurbished although the décor in other areas looked rather dark and in need of refreshment. We saw the carpets were worn in some places and the area manager and manager told us new carpets had been ordered to mitigate trip hazards constituted by some ill-fitting carpets. They also explained redecorating plans were in place to brighten the environment and people had been involved in choosing the colour scheme for the paintwork. We saw this had been highlighted in the service action plan. People told us they chose their rooms and were able to bring their personal possessions with them. One person told us, "I have a great room; they help me sort problems in it."

We found there were appropriate arrangements in place for obtaining medicines, checking these on receipt into the home and storing them. We looked through the medication administration records (MARs) and it was clear all medicines had been administered and recorded correctly. A MAR is a document showing the

medicines a person has been prescribed and recording when they have been administered.

Adequate stocks of medicines were securely maintained to allow continuity of treatment. We checked the MAR's together with receipt records and these showed us that people received their medicines correctly. Medication profiles for each person were available which informed staff about each person's protocols for their regular and 'as required' medicine. All staff who administered medicines had been trained and completed regular competency checks to ensure they were able to safely handle medicines.

We observed the senior member of staff supported people with taking their medicines in a respectful and caring way, keeping the person informed and without being rushed. The senior member of staff followed good practice guidance and was able to give an account of people's medicines and why each had been prescribed.

We identified that medicines were stored in various areas which could rise above the safe temperature for storage of medicines guidance as stated by the pharmaceutical companies. However the management team had already identified this problem, noted this on the service action plan and were moving the storage of medicines to a more appropriate central location.

We looked to see how staff were recruited. At the previous inspection we were concerned the service was not conducting comprehensive background checks on people before they started working. At this inspection we looked at four staff records and found all staff had been interviewed, had two positive references checked, their ID checked and a Disclosure and Barring Service (DBS) check completed. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with vulnerable adults.

Staffing levels appeared adequate at most times, with three or four care staff on duty during the daytime. We found information about people's needs had been used to determine the appropriate staffing levels to meet people's needs. Through our observations, discussions with people and staff members and review of the rotas, we found there were generally enough staff to meet the needs of the people who used the service. We saw people were attended to when they asked for help. Additional support staff were on duty during the day such as catering, domestic and maintenance staff. An activity coordinator also worked most days at the home. However, we saw there were busier times of the day when staff did not have a constant presence in the communal areas of the service. For instance, there was a lack of visible staff presence when the senior care staff member was administering medicines and the other care staff were deployed assisting people out of bed, as well as assisting with breakfast. Staff told us two people who lived at the service required two care staff to assist with hoisting. This meant people were not always supported when they required a prompt or guidance. For example, we observed during the morning two people in the living room struggling to eat their breakfast and although they were making some progress, they were spilling a lot of food. This was when care staff were deployed elsewhere and were not a constant presence in the room. Other times of the day were quieter for staff. We mentioned this to the manager and they said they would review the staff distribution level.

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In the case of a residential home a Deprivation of Liberty Safeguards (DoLS) must be in place. We found the service was working within the principles of the MCA and the registered manager had an understanding of how these principals applied to their role and the care the service provided.

The Care Quality Commission is required by law to monitor the use of Deprivation of Liberty Safeguards (DoLS). DoLS are applied for when people who use the service lack capacity and the care they require to keep them safe amounts to continuous supervision and control. Three DoLS authorisation were in place and we saw that these were in line with the assessment of people's needs.

We reviewed the care records for people who lacked capacity and found they contained assessments of the person's capacity to make decisions. There were records to confirm that discussions about decisions had taken place with the person's family, external health and social work professionals and senior members of staff. This showed any decisions made on the person's behalf were done after consideration of what would be in their best interests. Best interest decisions were recorded in relation to care and support and finance amongst others. We saw evidence regarding people's consent being sought through care records, resident questionnaires and meetings and through observations made on the day. For instance, we saw people had signed to give consent for various things such as the taking of photographs, administering of medicines, sharing their care plan information with other appropriate people, and going on outings and trips.

All the staff we spoke with told us that they were supported in accessing a variety of training and learning opportunities. They were able to list training they had received over the last year such as moving and handling, infection control, meeting people's nutritional needs and safeguarding. Staff told us they felt able to approach the manager if they felt they had additional training needs and were confident the manager would facilitate this additional training. For instance, one member of staff told us they had requested training on 'palliative care' and the manager had agreed to this. We looked at the training matrix and saw the majority of staff had completed all their mandatory training. We concluded from our review of staff records and discussions that staff were suitably qualified and experienced to fulfil the requirements of their posts. For instance, a senior member of staff we spoke with told us they and two other staff were being put forward for commencing NVQ5 training, which is a management level training programme. They told us this was being supported as part of their professional development. The service organised training through their head office who informed the manager when people were due to attend a course.

Staff we spoke with during the inspection told us they had not received regular supervision and annual appraisal but the new manager was starting to complete these again. Supervision is a process, usually a meeting, by which an organisation provide guidance and support to staff. The manager told us most staff had only received supervision once this year because they had identified the lack of supervision and started the process again. We saw records to confirm that recent supervisions had taken place.

We saw tools were in place to monitor if people's weight was within a healthy range and these were being accurately completed. We saw records to confirm people had regular health checks and were accompanied by staff to hospital appointments. We saw evidence of visits from a range of health care professionals including GPs, district nurses, chiropodists and dietician. This meant people who used the service were supported to obtain the appropriate health and social care that they needed.

We observed people generally received appropriate assistance to eat and were treated with gentleness, respect and were given opportunity to eat at their own pace. However, we observed during the busier times of the day staff support was more infrequent, for instance at breakfast-time when staff were also deployed assisting people out of bed. People were offered choices in the meal and staff knew people's personal likes and dislikes. Menus were seasonal with input from the people who used the service and people's dietary information was displayed in the kitchen area to ensure the chef understood people's dietary needs. The cook discussed the menus with people and explained other options were available. We found staff checked people's weight and when it was noted that someone was losing weight the staff provided fortified drinks and encouraged the person take additional nutrition as well as referring them to the local dietician. We saw where people had been assessed as needing a soft diet with input from the dietician this was provided accordingly.

People told us they enjoyed the food. One person said, "Food like in a five star hotel." However, we saw the menu board in the dining room showed the menu for the previous Saturday so had not been changed for several days. We pointed this out to a member of staff. However, the menu was not altered accordingly.

Is the service caring?

Our findings

During our observations, we saw kind and caring interactions between staff and people who used the service. People were relaxed and smiling when staff approached and we saw people enjoying a chat or a joke with each other and staff. Comments from people living at the service included, "I'm satisfied. I haven't anything to complain about. I have no trouble with them (staff). It's very good", "Love it here", "It's always a friendly place to be", "They (staff) try to pull my leg but it's all good fun" and, "Really happy here".

A relative of a person living at the service told us they thought all the staff were approachable and said, "Staff really know [person's name] well," and, "Staff are great."

A care worker told us, "It's a good home; it's more homely. It's a nice friendly atmosphere", "We (staff) all do what we can for them (people who use the service)," and, "I think the residents are happy. We have a laugh and a joke with them. You see them all the time so you can just brighten up someone's day."

We saw staff approached different people who used the service in the manner they liked to be addressed. For instance, we saw one person enjoying a laugh and a joke with the staff, whereas another preferred a more formal approach. We saw this information was documented in the people's care files, and staff gave us examples of how they approached people in different ways. Staff were able to tell us about people, their likes, dislikes and care needs which demonstrated they had a good knowledge of the people they were supporting.

Staff told us and we observed how they upheld people's privacy and dignity, for instance by knocking on people's bedroom doors before entering and ensuring toilet and bathroom doors were closed when supporting personal care.

The manager told us people and their relatives were involved in the planning of their care and this was confirmed by the relative we spoke with who said, "I get asked my opinion if there is a decision to be made." However, this was not documented on the care plan review form we saw in the care files we looked at and people's signatures had not been documented on the form, or on the 'Care Plan arrangements' synopsis form, even though there was a space for this. We discussed the lack of documented evidence of people's involvement in care planning with the manager who told us this was something they had overlooked but would start to implement. They agreed this would provide further evidence of people's involvement in the planning of their care.

We saw people's end of life wishes had been recorded in the care files we reviewed and people's cultural and religious beliefs were adhered to.

We saw the service had policies and procedures regarding equality and diversity. However, although people's diversity was explored in terms of culture and religion we found there was no record of consideration of people's sexuality being explored or staff training in this area. The lack of exploration of all aspects of people's diversity risked this important aspect of meeting people's rights to have all important

relationships respected being potentially overlooked.

Is the service responsive?

Our findings

Since the last inspection we saw the service had made improvements to the care records and it was apparent a lot of work had been put into making these more person centred. We found the majority of these to be person specific and easy to navigate, with sections pertinent to aspects such as skin assessment and risk, fire risk management, falls, food, nutrition and mealtimes, family contact and social company, falls, sleep and rest, communication and respect and activities. We saw information contained in the individual sections was written from the point of view of the person living at the service, including person specific information such as, 'I need the home to be free of hazards due to my poor eyesight. I can tend to shuffle instead of taking steps', 'I prefer a shower to a bath' and, 'Please ensure I am treated with dignity and respect at all times.' We saw good information was recorded about the level of support required, such as, 'I can dress myself if you pass me my clothes one by one.' Staff were able to confirm this information when we spoke with them.

We saw care records were up to date, and reviewed regularly. Care plans had been updated when care needs had altered. For instance, when a person had been assessed as being at greater risk of falls a detailed falls risk assessment had been put into place.

Where relevant, risk assessments associated with the plan of care had been completed and the appropriate section was cross referenced in the care record. This meant risk assessments associated with care plans could be easily found within the care record. However, in one of the new care files we reviewed, we saw some risk assessments were not in the section stated. We pointed this out to the manager who agreed this had been overlooked and would amend accordingly.

People's personal preferences were respected and evidenced through observations during the inspection which corresponded with detailed information in the care files. For instance, we read in one person's care records they preferred to drink coffee rather than tea and we saw this was given during the day.

Since the last inspection, the service had employed an activities co-ordinator a wide variety of activities were on offer. We saw activities were well thought out and reflective of people's wishes and the activities co-ordinator was motivated and enthusiastic about their role. During our inspection we observed the activities co-ordinator working with people individually and in groups, depending on their wishes. We saw baking done individually and in pairs, a music quiz and discussion taking place during the morning of the inspection. The area manager commented about the activities co-ordinator, "[Name] is so patient." The activities co-ordinator told us they were keen to offer smaller off-shoots of activities since not everyone wanted to participate in group activities and we observed this during our visit. They told us, "It can be very rewarding; very demanding, but very rewarding. Knowing people are working together and working things out is wonderful." For instance, they gave us an example of two people living at the service adapting and then engaging in a particular game to suit them. One of the people involved had previously not been interested in being involved in activities. They also told us they had found another person enjoyed carpet skittles whereas they had appeared disinterested in activities previously. They told us, "You've got to go with what they want to do and do what they're interested in." The activities co-ordinator kept an activities folder

in which they commented on what activities individuals told them they enjoyed, as well as participation in particular activities. They told us this, and activity meetings helped form future plans. We saw activities included crazy golf, beach ball, art, table games, bingo, apple tasting from the tree in the garden and discussion and reminiscence about this, magnetic darts and a floor crossword. A four week rolling activity plan was being implemented, dependant on people's choice and preferences.

We observed the service responded appropriately to equipment failure. For instance, we saw the fire alarm repeatedly engaging over the lunchtime period. We saw staff checked where the fault was, ensured people were not unsettled and took action to remedy the issue, calling out the service engineer. We saw the service employed the use of assistive technology such as chair and bed sensors where required, with risk assessments for these in people's care records.

The service had a complaints policy and information about making a complaint was displayed in the home. We reviewed the complaints file and saw no formal complaints had been made over the last year. We asked if the service kept a record of compliments, which they currently did not. However, we saw two cards displayed expressing thanks for the care provided, one of which said, "To all the staff at Fernside Hall Residential Home. You are simply the best."

Is the service well-led?

Our findings

At the last inspection we rated this domain as inadequate. We found there were not effective systems in place to manage, monitor and improve the quality of the service provided, statutory notifications were not being submitted and good governance was not in place.

At this inspection we found the provider had taken appropriate action and was now meeting legal requirements. Following our last inspection the area manager had produced an action plan to address the concerns we found and at this inspection we found these concerns had largely been addressed. However, while improvements had been made, we needed to see a longer period of sustained and consistent good practice before rating the domain higher than 'requires improvement'.

Since our last inspection, the previous manager had left the service and a new manager had been employed for approximately six months. The new manager had applied for registration with the Care Quality Commission and reviews of our records confirmed they were going through the registration process. People we spoke with spoke highly of the service, the staff and the manager. They told us that they thought the home was well run and met people's needs. People told us that they were very happy at the home.

Staff we spoke with told us they felt settled at the home although there had been a lot of management changes over the last twelve months. The majority of staff we spoke with felt positive about the service and the support from the new manager and although there was still an element of 'settling in' at the home, the culture appeared to be positive. A staff member told us, "I'm happy here. I think morale is good."

We saw the management team had introduced an 'employee of the month' as well as a bonus scheme for staff when recruited and upon successful completion of their probation. This showed us the provider was keen to retain staff and encourage best practice.

Staff and relatives we spoke with told us they respected the new manager and felt they could and would approach them with concerns. A relative of someone living at the home told us, "I'm a lot happier now with the new manager." One staff member said, "I feel supported by [manager]." They told us they felt the manager had consulted them more than previous managers on areas such as their personal development and commented the manager was open to new ideas that would benefit people living at the service, saying, "I can bounce ideas off [manager]." However, another staff member felt they would like to be listened to more, although they said they appreciated the manager was still settling in.

During our inspection, we observed the manager had a visible presence in the home, assisting with care delivery where required, such as at meal times. We saw the manager chatting with staff and people living at the home and leading by example. A staff member told us, "[Manager] has helped on shifts, is visible, and chats with residents."

We saw improvements had been made in the quality assurance and audit processes. We found the area manager and manager understood the principles of good quality assurance and used these principles to

critically review the service. We found the provider and staff actively monitored the service and used the information they gathered to make improvements. For example, they had identified the issue of medicines being stored in too warm an environment through the audit process and were moving the medicines storage to keep them all together and in a cooler area.

The manager and area manager undertook regular reviews of care records and medicines and kept a log of where actions were required and when these had been completed. Further checks of the environment, mattresses, weight loss, wheelchairs, bed rails and infection control audits had taken place.

We saw evidence the provider was giving good support to the service and regularly visited to provide support and guidance, as well as to check the service was running smoothly. The manager told us they received good support and said, "[Area manager's name] is really good; only a telephone call away." The manager told us they attended meetings with managers from other services to share best practice and discuss areas for improvement.

The manager sent a weekly report to the provider and action points were added to the annual action plan for the service. We saw the current action plan was on-going and comprehensive, highlighting issues found in the previous Care Quality Commission inspection and subsequent provider visits, and included target date for completion, comments and actual completion dates. From this information and our observations, we concluded the manager and provider were working well together to improve the service.

We saw that the registered provider and staff held regular discussions with people who used the service, relatives and staff, which provided a forum for people to share their views. The service had recently sent out a quality questionnaire to relatives and people living at the home about their opinion of the service, including an 'easy read' version for those who would respond better to this format. We saw responses were generally positive, although all the returned questionnaires were from relatives rather than people living at the service. Residents meetings had been held and records confirmed that a wide range of topics were discussed at these, such as food at the home, proposed activities as well as choosing colour schemes for the service redecoration.

We saw monthly staff meetings had been scheduled for the year for both day and night staff. We reviewed minutes of the last meeting and saw these were comprehensive, covering a wide range of service topics such as safeguarding, CQC, incidents and accidents, training, supervisions and appraisals, environment, activities, newsletter, service updates, resident's information and care records. We saw from the minutes and staff told us these meetings were a good opportunity to discuss any issues or concerns and ideas for improvement.

Statutory notifications had been submitted to the Care Quality Commission as appropriate.