

Methodist Homes Waterside House

Inspection report

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Ratings

Overall rating for this service

Requires Improvement



Is the service safe?

Requires Improvement



Is the service effective?

Requires Improvement



Is the service caring?

Requires Improvement



Is the service responsive?

Good



Is the service well-led?

Good



Overall summary

The visit took place on 30 December 2014 and was unannounced. We last inspected the service on 8 August 2013. At our previous inspection the provider was not meeting the law in relation to consent to care and treatment, staffing and records. Following our August 2013 inspection the provider sent us an action plan to tell us the improvements they were going to make. During this inspection we looked to see if these improvements had been made. We found that improvements had been made in respect of the issues previously identified.

Waterside House is registered to provide accommodation and support for 60 people. At the time of our inspection there were 39 people living at the service for long and short stays. The service contained four units, although only three of these units were in use at the time of our inspection.

There was a registered manager in post at the home. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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 we spoke with were complimentary about the service and its staff, describing them as kind and caring.

The service was clean and well- presented. People were happy with the level of cleanliness maintained by staff. However, we found that staff did not consistently wear personal protective equipment when handling food.

We found that medicine records were not always completed, which meant it could not be demonstrated that people had received this medicine as prescribed. Medicines were otherwise stored and used as per the prescriber's or manufacturer's directions.

Staff knew how to identify and report abuse. Staff were recruited in a safe way, which meant they were of appropriate character to care for people. There were enough skilled staff to support people safely.

Records showed that people were assessed to establish their ability to make decisions for themselves, where necessary. However, decisions that had been made in people best interests, where they were not able to make the decision for themselves, were not recorded.

We found that people were supported to eat and drink. We saw that robust records of people's intake of food and drink were not always maintained to demonstrate this had been provided consistently.

We saw some staff using techniques which ensured people understood and could effectively communicate choices they wished to make. These included the use of visual aids. However, some staff did not use these techniques, although they would have aided communication with the people they were speaking with.

People's health was supported with appointments with external healthcare professionals. These included appointments to promote people's health in the context of conditions they had, such as diabetes.

People's care records were personalised. Care records were regularly reviewed to ensure they were up to date. This meant that staff had access to the latest guidance on how to support people.

Most staff supported people's dignity, privacy and independence and encouraged people to complete tasks safely for themselves. However, we saw some examples of staff failing to support people's dignity by ensuring information about their needs was kept private.

Staff demonstrated that they knew people's preferences and what was important to them. We saw staff supporting people to participate in activities they enjoyed. Staff communicated with people's relatives to ensure they were kept up to date with developments and that issues were discussed as appropriate.

Care planning took into consideration people's spiritual needs and important relationships. We saw people being supported in a way which took into account their cultural preferences and diversity.

Although no-one we spoke with told us they had raised a complaint; the provider demonstrated that they dealt with complaints in line with the advertised complaints procedure.

The provider undertook audits concerning the quality and standards of care at the service in order to improve the service provided. A new registered manager and deputy manager had been recruited since our last inspection. While some improvements were on-going, staff were positive about the changes the new management team were implementing in improving people's experience of the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe.

Staff demonstrated an understanding of abuse and the need to report it, in order to keep people safe.

Risks to people were appropriately assessed and managed. There were enough staff to support people safely.

We found gaps one medicines record, which meant we could not be sure the person had received the medicines they required.

Staff did not consistently use personal protective equipment to prevent the risk of cross infection to people while handling food.

Requires Improvement



Is the service effective?

The service was not consistently effective.

People received mental capacity assessments to establish their capacity to make decisions. However, decisions made in people's best interests were not always recorded.

Some people's 'do not resuscitate' orders were not appropriately assessed or reviewed.

There were gaps in some people's records which meant we could not be sure people had been supported in the way they needed.

Staff supported people in a skilled way and were supported in their duties by the management team.

Requires Improvement



Is the service caring?

The service was not always caring.

Most staff demonstrated that they supported people's dignity, privacy and independence. However, we saw examples where people's dignity was at risk of being compromised by staff.

Most staff used effective ways of communicating with people in order to offer and understand people's choices. However, these methods were not consistently used where required.

Staff maintained regular and appropriate contact with people's relatives. We saw examples of compassionate interactions between staff and people.

Requires Improvement



Is the service responsive?

The service was responsive.

Good



Summary of findings

People had their needs assessed and staff knew how to support people in the best way.

People's preferences, diversity and spiritual needs had been considered as part of their care planning.

The provider responded to complaints raised by people using an established complaints process.

Is the service well-led?

The service was well led.

Staff were supported by the management team to carry out their roles. Issues of staff performance were addressed.

The provider analysed incidents and accidents to identify learning from these.

Action was taken where the provider's audits identified short falls.

Good



Waterside 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, and to provide a rating for the home under the Care Act 2014.

The visit was undertaken by two 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 service. The visit was unannounced.

As part of our inspection process we asked the provider to complete a Provider Information Return (PIR). The PIR is information produced by the provider to show how they

are meeting standards of care. We contacted three external health and care organisations to consult with them about their knowledge of the service provided to people living at the home.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

We spoke with eight people who lived at the home, across the three units which were in use. We also spoke with one of the provider's senior managers, the deputy manager and six care staff.

We looked at seven people's care records to see if their records were accurate and up to date. We looked at records relating to the management of the home, including quality audits.

Is the service safe?

Our findings

During our inspection of 8 August 2013 we had found that there were insufficient numbers of staff to care for people safely. During this inspection we found improvements in staff responding to people's needs. For example, we observed that call bells were answered promptly. People and staff we spoke with told us there were usually enough staff available to assist people safely. However, there were occasions on which people would have benefited from the support of more staff. For example, on Heather wing two domestic staff remained in the lounge in case people required assistance, as care staff were deployed elsewhere. Domestic staff were monitoring people so that care staff could be alerted, if required.

Some staff also told us that the activities coordinator had to assist in delivering personal care rather than focussing on activities, to ensure people received timely assistance. This was, for example, because care staff were occupied assisting people in their rooms. We looked at the staff rosters for the preceding two weeks. We also spoke with the deputy manager and a senior manager about how staff numbers were calculated. We saw that there was an increase in staff numbers, compared to people living at the service, since our last inspection due to the reduction in the numbers of people living at the service. The deputy manager told us that there had been recent challenges in covering an episode of staff sickness. This was confirmed by the staff rosters we looked at. This meant that the provider had considered increased staffing levels in the light of people's needs.

We looked at the recruitment practices of the provider. We looked at two staff files. We found that appropriate checks were carried out to ensure staff were of appropriate character to care for people. Staff we spoke with confirmed that checks were completed prior to them commencing work.

One person told us they were happy with the level of cleanliness at the service. They said, "They [staff] keep my room nice and clean". Our own observations found that the service was clean and well presented. However, we found that not all staff used personal protective equipment (PPE) consistently. PPE, such as gloves and aprons, is used to prevent cross infection occurring. While some staff used PPE when handling food, for example sandwiches at lunch time, we observed that other staff did not. We saw that PPE

was available throughout the service for staff to use. Its use was promoted by the provider's infection control policy. This meant that, despite the provider having a robust policy in place, people were not consistently protected from potential cross infection.

Medicines were securely stored in a locked medicines room. We saw that one opened bottle of liquid medicine was not marked with the open date. The member of staff, who was assisting us was able to demonstrate that the medicines had not been open beyond the allowed time period, because of the delivery date. This meant that staff used a system to ensure medicines were safe for people to take.

We saw that most people's medicines records were accurately and fully completed. However, we found some gaps in one person's medicines records for topical creams. The person was unable to confirm whether they had their topical creams applied.

We saw that staff had access to personalised guidance for each person who took 'as required' medicines. We saw that the guidance for each person was evaluated monthly to ensure it was still accurate and up to date. Only trained staff were permitted to administer medicines and that their competence was regularly assessed.

We spoke with staff who demonstrated that they were able to identify different types of abuse. Staff told us they would report suspected abuse to the management team. Staff were aware that the provider advertised a confidential telephone number so that people could report issues of concern. We saw that the provider had a policy concerning keeping people safe which was accessible to staff and offered guidance on identifying and reporting abuse. We looked at staff training records and saw that all staff had completed updated safeguarding training.

We saw that risk assessments had been completed which identified risks to people and how these could be managed or reduced. For example, we saw that one person was at risk of falling from bed. We found that a risk assessment in their care records stated that a padded mat should be used next to their bed to limit any injury caused by a fall. We saw that staff had ensured this type of mat was available next to the person's bed. This meant that staff were following guidance in order to reduce the risk of injury to this person.

Is the service safe?

We found that people had personal emergency evacuation plans in place. These provided guidance about how each person should be supported to evacuate the premises in the event of an emergency, such as a fire.

Is the service effective?

Our findings

Care records showed that people received mental capacity assessments to ascertain whether they had the capacity to make decisions about different areas of their care, such as the decision to live at the service. This was an improvement from our previous inspection of August 2013, where we had found a lack of mental capacity assessments and a breach of the related regulation. However we found that, where a decision had been made in people's best interests these were not always appropriately recorded to show how the decision had been reached and by whom.

We saw that some people had 'do not attempt cardio pulmonary resuscitation' orders in their records. This meant that attempts to resuscitate the person should not be carried out in the case of a sudden decline in their health. We saw that one form had not been appropriately completed by the GP who had signed to show its authorisation. Another form was dated 2012, but had not been reviewed, as required. We highlighted these issues to the deputy manager who undertook to address them as a matter of priority.

During our previous inspection we had found significant gaps in records relating to people being repositioned to relieve pressure on their skin. This had been a breach of regulations. During this inspection we again looked at the care records of people who required support to maintain healthy skin. We saw that repositioning charts were in place to record how and when people had been moved in order to relieve pressure on areas of their skin. We found examples in three people's records where repositioning was not completed within the prescribed time, but there were no significant gaps of long periods of delay (beyond an hour). This was an improvement on our findings from our inspection of August 2013, where significant delays were noted. However, this meant that staff were still not following guidance in care records and there was still scope for improvement.

We spoke to the deputy manager who told us that no one was affected by damaged areas of skin. We saw, from one of the people's records we looked at, that an area of damaged skin they had was improved and healed. This meant that, despite occasional inconsistent pressure area care for this person, their health had not been affected.

We found that staff maintained records of what food and drink people had received, to monitor and ensure people had adequate amounts. However, we found gaps in one person's records, although we saw people being offered drinks throughout the day. This meant that staff could not be sure that this person had received the hydration they needed (as outlined in their care records) in order to maintain their health. We also found that one person, who was at the service for a short stay, had a support plan in place for dietary and fluid intake. We saw that the standard section of the support plan had not been completed to show what kind of diet the person required. This meant that staff did not have the complete guidance they needed to be able to support this person's needs.

We saw that people were offered drinks throughout the day. People were given a choice of hot or cold beverages. We saw one person being supported by a member of staff to make their own hot drink. We observed lunch being served. We saw that people had a choice of soup, sandwiches and a pudding. Some people opted to have a hot lunch. We saw that people who required a soft diet were provided with soft foods, for example mashed potato.

Staff used appropriate encouragement and offered assistance at a pace which suited the person being supported, while assisting people to eat. However, we observed a member of staff, who was not trained to do so, attempt to assist a person to eat. We discussed this with this staff member and the deputy manager to prevent a reoccurrence of untrained staff assisting people to eat in future. We established that it was not a usual practice for this staff member to assist people with eating and the matter was an isolated one.

People were told us they were confident in the skill levels of staff and the suitability of the care they received. One person told us, "[Staff] look after me well". Our own observations confirmed that staff supported people in a skilled way. We observed several instances of staff assisting people to move about the service. We saw this was carried out safely and in line with recognised best practice.

We looked at staff records and spoke to staff about the support they received in carrying out their roles. We found that staff received appropriate support from the management team. For example, staff told us, and records confirmed, that they undertook an induction process in order to familiarise themselves with the environment and people's needs. One established staff member explained

Is the service effective?

that they had recently started a new role within the service. They told us they were given the opportunity to shadow experienced staff in order to understand the demands of the role prior to the application process.

We saw records which showed staff had been assessed and received feedback on their performance during periods of shadowing. We also found that staff had regular supervision meetings and appraisals, where their performance or any issues could be discussed. We saw that the management team addressed specific issues of performance with staff, when required.

We spoke with staff about their understanding of the Mental Capacity Act (MCA) and Deprivations of Liberty Safeguards (DoLS). The MCA sets out what must be done to make sure that the human rights of people who may lack mental capacity to make decisions are protected. This includes when balancing autonomy and protection in relation to consent or refusal of care. The MCA Deprivation of Liberty Safeguards (DoLS) requires providers to submit applications to a 'Supervisory Body' for authority to deprive someone of their liberty.

Staff demonstrated knowledge about how they should support people's rights and said they had received training which underpinned this knowledge. We spoke with the deputy manager and one of the provider's senior managers about DoLS applications they were considering for specific

people. We found that the management team had an understanding of the issues and considerations involved in making an application. This was supported by records concerning DoLS which had been applied for by the service. This showed that the provider was aware of the actions they needed to take to protect people's rights.

We saw staff offering people day to day choices and respecting people's responses to these. We saw some staff using techniques to offer choices which assisted people in the best way. For example, some staff took people to a platter of sandwiches so that they could see the choices on offer. This particularly assisted people with dementia to make an informed choice about what they wanted to eat. We saw that people were dressed in their preferred individual style. Some people were wearing pieces of jewellery and make-up. One person said how much they enjoyed wearing make-up and we saw they were wearing this.

We found that people were supported to access external healthcare professionals in order to support their health and well-being. Records demonstrated that staff ensured people had appointments with professionals, such as opticians and speech therapists. We saw that people with specific conditions, such as diabetes, attended appointments to meet their health needs; including eye and foot health appointments.

Is the service caring?

Our findings

People were positive about staff and described them as being kind and caring. One person told us, “The staff are kind and helpful”.

We saw that people’s care was subject to regular review. Care plans were personalised and gave details about what was important to people. We saw staff delivering care in the way outlined in people’s plans. We saw some staff communicating with people in the most effective way for the individual. This included visually demonstrating choices so that people could understand what their options were.

We saw that most staff respected people’s dignity and privacy. We saw staff assisting someone to move by using a piece of equipment which lifted them. Staff ensured that this person remained covered up during this process. However, we saw that some people’s personal care records were left open on a sideboard in a communal area on one of the units. This meant that there was a risk unauthorised people might be able to view their private care records. We later saw that staff had secured these records. We heard two members of staff discussing a personal aspect of a person’s care in a communal area where other people were present. This meant this person’s dignity was put at risk of being compromised.

We saw that staff treated people with compassion and kindness. We saw examples of staff checking that people were comfortable. Some staff took time to talk to people about their interests, such as their families or talked with them about visitors they had received. One person’s records, who was unable to talk to us about their care, showed they enjoyed walking and that this promoted their well-being. We saw a member of staff taking this person out for a walk. We spoke with this member of staff who demonstrated a good understanding of this person’s interests and how they encouraged the person in participating in these interests.

Records showed that staff maintained regular contact with people’s relatives. For example, one such record showed that staff had discussed the ordering of a person’s medicines with a relative.

We observed staff supporting people to be as independent as possible. This included supporting people to access and use the communal kitchenette areas. People’s daily records also demonstrated staff attempted to promote independence. For example, one person’s daily records stated, “[Person’s name] chatted to care staff whilst washing the dishes”.

Is the service responsive?

Our findings

We found that a number of different assessments, relating to people's health and care needs, had been completed by staff. For example, people were assessed for whether they required additional support. This was an improvement on what we had found during our inspection of August 2013, when we found a lack of specialised care plans. Care plans had been completed to provide staff with knowledge about people's needs. We saw that care plans were followed by staff. For example, one person was said to require a special mattress to support their skin health. We saw that this mattress was in place.

People we spoke with told us the provider was responsive to their needs. People said they were happy with the way support was provided. One person told us, "They look after me well". Care records contained detailed information about how staff should support people. These included people's likes, dislikes and personal preferences. We found that care plans reflected what people liked to do and what was important to them. Staff interactions with people demonstrated they had knowledge of people and their needs. For example, one person's records said that they liked to read a particular newspaper. We saw that this person had a copy of the newspaper they preferred.

We saw that people who were living at the service had completed preadmission assessments with staff. This meant that staff had the guidance they required to know about people's needs and preferences before they started

living at the service. Staff demonstrated a knowledge of people's needs. We also saw that people had a life history kept in their care records, to assist staff in understanding their backgrounds. This provided staff with information about people's experiences and how these might impact on their support. This information included details of family and spiritual needs. We observed staff chatting to people about their families, and showing knowledge of people's recent family news and events.

We saw that people's spiritual needs were considered in their care planning. We saw that one person enjoyed spending time with a chaplain who visited. The chaplain was at the service on the day of our inspection. We spoke with the chaplain who told us how they interacted with people at the service. We saw people enjoying a "choir" session led by the chaplain. People sang songs which took in to consideration their spiritual culture and religious diversity.

No one we spoke with told us they had cause to have raised a complaint with the service. People were positive about their experiences at the service. We saw that the provider had carried out a recent survey to establish people's view of the service. Answers were largely positive. We saw that the provider maintained a comments folder. This showed that there had been two issues raised recently. This record showed how the provider had addressed the issues with the person raising the complaint, in line with the provider's procedure.

Is the service well-led?

Our findings

People were positive about their experience of the service. One person told us, “It’s alright here. It’s as good as anywhere else”. Another person told us, “I like living here”.

Staff were positive about the support they received from the management team at the service. There was a registered manager in post. Staff commented on the positive changes the registered manager and the new deputy manager had brought to the service. One staff member told us, “The manager is very supportive and so is the [name of the deputy manager]. They are happy for you to make your opinions known. The manager says “come and see me”. The manager has made changes. He’s doing a good job”. Another staff member said, “[The manager and deputy manager] are brilliant; very effective and on the ball. They’re always there for staff and get things sorted out”.

We saw that staff received regular one to one meetings with their supervisors and appraisals. Staff told us these were constructive and they were able to raise matters such as the training they wanted. Staff also confirmed, and records showed, that performance management was discussed. This meant that the management team supported staff and addressed any issues with them.

We saw that incidents and accidents were reviewed to ensure risks to people were reduced. For example, the provider maintained records of, and analysed, instances

where people had sustained a fall. This allowed the manager and the provider to see any patterns in accidents and incidents, such as when they had occurred, so risk could be addressed in a focussed way. We saw that, where the provider had identified issues, these were reflected in people’s care plans. This included updates on how staff should support people to move safely. This meant that staff had the information they needed to support people in the way they needed, through appropriate analysis.

We saw that the manager completed regular audits across areas which could affect people’s experience of the service. We saw audits were carried out to assess fire safety, infection control, bed rail use and medications, among others. We found that the management team took action where shortfalls were found during the auditing process. We saw that these audits were effective. For example, we saw that the building was well maintained and that medications were well managed. We did, however, find that audits undertaken into care records had not identified some of the shortfalls we had found during our inspection.

We looked at the minutes of the regular area manager meetings. These detailed discussions about matters affecting people’s care, such as the effects of a judgement regarding Deprivation of Liberty Safeguards and audits carried out at the service. The meeting also discussed recent changes in legislation. This meant that the provider’s senior managers were involved in the running of the service and managers had the opportunity to be updated on matters which affected the service.