Methodist Homes

Handsworth

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

Summary of findings

Overall summary

Our inspection took place on 14 September 2016 and was unannounced. At our last inspection in January 2014 we found the provider was meeting all the standards we looked at.

Handsworth is a well presented home in a residential area of Bowden close to Manchester. It is registered for up to 43 people. The provider is Methodist Homes (MH). It benefits from an accessible garden to the rear with raised planters. Parking for several cars is available to the front of the home. All rooms have their own toilet and some rooms benefit from ensuite shower rooms.

There was a registered manager in post at the time of our inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 had assessments and care plans that identified areas of risk associated with their care and support, however there was limited guidance in place to show staff how to minimise risk and some actions identified were not always followed effectively. For example we saw in one care plan the person's weight was to be measured weekly, however records showed this was done at irregular intervals.

The provider ensured staff were knowledgeable about the risks of abuse and had policies, practices and training in place to ensure staff understood their responsibilities under safeguarding.

Appropriate background checks were carried out before new staff began working in the service.
The registered manager and staff did not fully understand the principles and responsibilities in accordance with the Mental Capacity Act (MCA) 2005. We found staff did not fully understand capacity, which meant people may not receive appropriate support to make decisions.

Appropriate arrangements were in place to manage the medicines of the people who used the service.

Staff received a thorough induction which included checks on their competencies. We saw there was a programme of training in place which included mandatory training and regular refresher courses. A programme of regular supervision meetings and annual appraisals was in place.

We observed the lunchtime service and saw it was relaxed, with people assisted to make choices in a patient and caring way. People were supported to eat their meal and we saw the staff members provided this support when needed.

We saw the provider had robust systems in place to ensure any complaints or concerns were recorded and investigated. We saw accidents and incidents were reported. We were able to see what actions had been taken in response to these reports.

We received consistently positive feedback about the registered manager. The audits were detailed and we saw evidence which showed any actions resulting from the audits were acted upon in a timely manner.

We have identified breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 during this inspection. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Some actions identified to minimise risk were not always followed. For example we saw in one care plan the person's weight was to be measured weekly, however records showed this was done at irregular intervals.

People told us they felt safe receiving care and support at the service.

Is the service effective?

Requires Improvement

The service was not always effective.

We found staff did not fully understand capacity, which meant people may not receive appropriate support to make decisions. People did not always sign their care plans and evidence of consent was not always evident.

People said they had good choice of quality food. We saw people were provided with appropriate assistance and support and staff understood people's nutritional needs.

People told us the way their care, treatment and support was delivered was effective and they received appropriate health care support. We saw evidence which demonstrated that people who lived at the home were referred to relevant healthcare professionals as appropriate.

Is the service caring?

Good

The service was caring.

People and their relatives expressed high opinions about the staff's caring nature. People said staff were kind and caring, treated them with dignity and respected their choices.

We found information about people's life histories and personal preferences in their care plans. When we spoke with staff they knew about people's likes and dislikes.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Systems were in place to assess people's needs and care plans were regularly updated. Care plans and risk assessments were person centred, although many care plans were not routinely signed by people or relatives following review.

People told us they knew how to make a complaint if they were unhappy and they were confident their complaint would be investigated by the registered manager and appropriate action taken.

People told us a range of activities were available and they participated in these. However, they were not recorded in people's care plan.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People who used the service, their relatives and staff gave positive feedback about the registered manager and they were given regular opportunities to contribute to the running of the home through meetings and annual surveys.

The provider had systems in place to monitor and improve the quality of the service and had taken action to address any emerging trends.

Handsworth

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.

Our inspection took place on 14 September 2016 and was unannounced. The inspection team consisted of two adult social care inspectors and an expert-by-experience who had experience of older people's care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

At the time of our inspection there were 38 people living at the service. During our visit we spoke with 10 people who used the service, four relatives of people who used the service, seven members of staff which included the registered manager and the provider. During the inspection we spent some time looking at documents and records that related to people's care and the management of the service. We looked at four people's care plans.

Before the inspection we reviewed the information we held about the service including previous inspection reports and notifications sent to the CQC by and about the service. In addition we contacted Healthwatch and the local authority who commission services from the provider to ask whether they had any feedback to share with us. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. They did not provide any information of concern.

We sent a provider information request (PIR) before this 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 what the provider had told us before the inspection.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe, and well looked after, living there. One person said, "I haven't lived here long. It's not the same as home but I feel a lot safer than when I lived in my flat. There are people around me and if I can't sleep at night the staff come and check up on me and tuck me in. I then go to sleep."

Some people had a call bell around their necks and all knew what they were for and how to use them. Two people said, "Staff do come, not always straight away, and sometimes at night you can wait a while but we do feel safe."

We saw people had assessments and care plans that identified areas of risk associated with their care and support, however there was limited guidance in place to show staff how to minimise risk and some actions identified were not always followed through effectively. For example we saw in one care plan the person's weight was to be measured weekly; however records showed this was done at irregular intervals. On one occasion there was a gap of over eight weeks between weight being taken, and in another instance it was taken only three days apart. In another care plan we saw a risk assessment for the storage and usage of medicinal creams. This was a generic risk assessment which did not identify specific risks to that person. The registered manager said this would be addressed.

We looked at a sample of medicines and records for people living at the home as well as systems for the storage, ordering, administering, safekeeping, reviewing and disposing of medicines. Medicines were stored securely and the medication trolley was stored securely when not in use. We found there were adequate stocks of each person's medicines available and daily temperatures were taken of the medicines fridge.

Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs. We saw that controlled drug records were accurately maintained. The administering of these medicines and the balance remaining was checked by two appropriately trained staff.

The medicines administration records (MAR) contained a picture of the person to help staff identify who medicines were for, information relating to specific times medicines were to be given, for example 'before food' and any allergies the person had. We looked at 12 MAR sheets and saw they were correctly completed with no gaps. Some medicines were given 'as and when 'needed, and we saw there was clear guidance provided for staff to ensure people received these safely when needed. One person we spoke with told us, "They always ask me if I want any pain killers."

We saw medication competency assessments were carried out for staff giving medication and where necessary recommendations and feedback were given.

In the PIR the provider told us, 'MH Safeguarding Policy ensures that staff undertake training-detailing how Safeguarding issues are raised.'

We spoke with four care staff who demonstrated a good understanding of protecting vulnerable adults. They told us they were aware of how to detect signs of abuse and were aware of external agencies they could contact. They told us they knew how to contact the local safeguarding authority and the Care Quality Commission (CQC) if they had any concerns. They also told us they were aware of the whistle blowing policy and felt able to raise any concerns with the registered manager knowing that they would be taken seriously. The provider's policy on safeguarding included information on staff's roles and responsibilities, referrals, identification of abuse, prevention of abuse, types of abuse and confidentiality.

We saw personal emergency evacuation plans (PEEPS) were in place for people who used the service. PEEPS provided staff with information about how they could ensure an individual's safe evacuation from the premises in the event of an emergency. We saw evidence of PEEPS based on people's physical abilities, ability to understand verbal instructions and willingness to follow instruction.

During the inspection we looked at the recruitment records of five members of staff. We saw these contained records of interviews and tests used to assess their suitability for their role. In addition the provider had undertaken background checks including employment references and checks with the Disclosure and Barring Service (DBS). The DBS is a national agency that holds information about people who may be barred from working with vulnerable people, and making checks with them helps employers make safer recruitment decisions.

Staff disciplinary procedures were in place and the registered manager gave examples of how the disciplinary process had been followed where poor working practice had been identified. This was evidenced in files.

We completed a tour of the premises as part of our inspection. We inspected seven people's bedrooms, bath and shower rooms, the laundry, kitchen and various communal living spaces. We saw fire-fighting equipment was available and emergency lighting was in place. During our inspection we found all fire escapes were kept clear of obstructions. We did find some areas of the home was showing signs of wear and tear. The registered manager told us there was a five year maintenance/replacement programme. We saw certificates confirming safety checks had been completed for gas installation, electrical installation, legionella and boiler maintenance.

Requires Improvement

Is the service effective?

Our findings

Throughout our inspection we saw that people who used the service were able to express their views and make decisions about their care and support. We saw staff seeking consent to help people with their needs. People's comments included; "Oh yes it is lovely here" and "I never feel pressured into doing something I don't want to do."

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS)

We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

In the PIR the provider told us, 'From admission all residents have a comprehensive bespoke care plan including placing authority information, based on initial assessment and contain risk assessments/actions to be taken on tissue viability, nutritional needs, weight recording, continence, personal hygiene and falls risk assessments.'

We found care plans contained limited assessments of people's capacity to make decisions, and those in place were not decision specific. Staff used a form which contained prompts to direct them. This assisted staff in making decisions under a series of headings such as 'treatment decisions', 'care decisions', 'risk or danger decisions' and 'accommodation decisions'. Each section contained the prompt, 'Tell us about the specific decision you are asking the person to make.' All capacity assessments were recorded in the 'accommodation decisions' section, however the decision to be made was recorded as a statement. For example, one capacity assessment stated, '[Name of person] has lived at Handsworth since [date] but is unable to establish address, day, date, year,' as the specific decision. In the person's mental capacity support plan we saw monthly updates recording, '[Name of person] has no capacity,' followed by, '[Name of person] has little capacity to make decisions at the moment.' We saw another capacity assessment that had used the statement '[Name of person] has lived at Handsworth since [date] and says he is happy here,' in the accommodation section of the capacity assessment, and this had been used to conclude '[Name of person] does not lack capacity.' This meant the provider was not using capacity assessment tools effectively to determine people's capacity to make specific decisions about their care and support.

We asked a senior member of staff to identify people who lacked capacity to make decisions so that we

could look at their care plans. The member of staff we asked was uncertain who lacked capacity. They identified two people, however their care plans showed they did not lack capacity. They asked a colleague which persons lacked capacity. This member of staff suggested they look at the DoLS file as this would show who lacked capacity. We concluded staff did not fully understand capacity, which meant people may not get appropriate support to make decisions. We discussed this with the registered manager who told us they would arrange for additional training to be provided.

People did not always sign their care plans or their consent recorded in their care plans for areas of their lives such as the decision to reside at the service or to have medicines administered. One person's care plan stated they had capacity, however someone else had signed forms in their care plan. The person did not have Lasting Power of Attorney (LPOA) for health matters and there was no record of either the person who used the service giving permission for the person to sign or an indication they lacked capacity to make these decisions. In another care plan we saw consent to photography, outings and access to care plans had not been signed by the person. There was a note on the form that stated, 'Discussed with [name of person] on 2/8/16. In a third care plan we saw the member of staff completing the review of consents had signed instead of the person or their representative. The registered manager said all the above would be addressed.

We saw the registered manager maintained a log of approved DoLS and DoLS that had been applied for. Some had expired, however we saw evidence the registered manager had applied to renew these in good time and was awaiting the decision of the approval body.

We saw some rooms had door sensors to alert staff if the door was opened. We asked the registered manager about this and they told us, 'This is to alert staff if the people wander independently as they may enter another room.' We told the registered manager this was a restriction which would mean either the person having to give their consent or trigger an application for a DoLS. One of the people whose room had a sensor had been recorded as having capacity to make decisions. There was no record of consent to the sensor in their care plan. The person was at high risk of falling and their care plan stated, 'Will try to mobilise independently but is unsteady.'

This was a breach of the Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff we spoke with said they had received training in the Mental Capacity Act 2005 (MCA) and on the Deprivation of Liberty Safeguards (DoLS). Training records looked at confirmed this.

Records showed that arrangements were in place to ensure people's health needs were met. We saw evidence that staff worked with other healthcare professionals for people to access other services in cases of emergency, or when people's needs changed. This included GP's, hospital consultants, community mental health nurses and dentists.

We spoke with four visitors who told us they were pleased with the care, treatment and support their relative's received. They said the registered manager and staff were quick to inform them of any significant changes in their relative's general health which they found very reassuring. Comments included "I am confident my relative is safe and is being well cared for" and "The manager always informs me if my relative is seen by their GP or if staff have concerns about their general health or well-being."

The registered manager confirmed that following induction training all new staff completed a programme of mandatory training which covered topics as dementia awareness, infection control, emergency first aid and health and safety. Staff spoken with told us training was discussed during their one to one supervision

meetings. The training matrix showed most staff were up to date with their required training. If updates were needed they had been identified and booked to ensure staff's practice remained up to date.

The staff we spoke with confirmed they received regular supervision and yearly appraisals. Staff told us this was a two way process. They said they felt comfortable to talk with the registered manager about anything and felt supported.

We observed lunch time in the dining room. People had set places and tables with three to six people. Most people were encouraged to eat in the dining room and menus were on the tables.
Three people had their meals in their rooms which was their preference and one person was asleep in the conservatory and the staff attempted to wake them. The person was given a drink and initially assisted and then drank independently. The senior care worker explained that their routine was to eat then sleep. The staff on duty were in the dining room serving and assisting people there as well as those who were eating in their rooms.

We saw in one care plan the person required adapted cutlery and crockery in order to remain independent with eating. We checked the person at lunchtime and saw these had been provided.

We spoke with members of the catering and care staff and they had a good understanding of people's dietary needs. We saw the food looked appetising and was well presented. People we spoke with told us they enjoyed the meals provided and there was always a good choice. Comments included, "The food is very good and there is always a good choice" and "The food and service is first class."

Good

Is the service caring?

Our findings

In the PIR the provider told us, 'We treat residents with same dignity and compassion as if looking after our own relatives.'

The home had a warm and homely atmosphere. Feedback from people who used the service and their relatives about the attitude of staff was good. People told us they were happy living at the home. Comments included; "I am well cared for" and "All I have to do is ask and it happens."
People said they felt the care was good. One person said they were delighted with the care, "Couldn't be looked after better. I would recommend this place."

Some other comments included: "All the staff know me and are very good and look after me. I like the attention. At night I get cups of tea if I can't sleep." "I realise that I am one of 40 and understand that I would like one-to-one attention. The carers are very attentive and look after me well." "The staff call me by my first name. They are all friendly. I can ask any of them to help me and they do help." "I enjoy reading and like to order my books over the telephone. I recently struggled to hear on the phone so I asked a member of staff and they ordered it for me."

One of the relatives said "It was a big decision to move mum here and it's not been easy. She has settled in well and is adjusting. The staff care for her and let her be independent."

The staff we spoke with were able to tell us how individuals preferred their care and support to be delivered. They also explained how they maintained people's dignity, privacy and independence; for example, by encouraging them to make choices about how they spent their time at the home and always asking them for their consent before assisting with their personal care needs. This demonstrated the staff had a clear knowledge of the importance of dignity and respect when supporting people and people were provided with the opportunity to make decisions about their daily lives.

We saw all people who used the service were at ease and relaxed in their environment and with staff. We saw people responded positively to staff with smiles when they spoke with them. Staff were seen knocking at bedroom doors before entering, even when it appeared that the room was empty. We observed staff included people in conversations about what they wanted to do and explained any activity prior to it taking place. People looked well cared for, clean and tidy. People were dressed with thought for their individual needs and had their hair nicely styled..

Throughout the day we saw visitors arriving to see people. We observed visitors were able to visit without restrictions. We saw staff made visitors welcome and provided hot beverages.

We saw some evidence of people's involvement in their care plans. There was a basic personal profile which contained information about people's family, important people in their lives, religion, previous occupation, holidays, favourite foods, drinks and television programmes as well as music and books the person enjoyed. In addition there was a one page summary of the person's life to date, meaning staff had access to

information which would help them develop meaningful relationships and conversations with people who used the service.

There was information in sections entitled 'my proudest moment', 'what I struggle with now', 'what makes me sad/angry/worry'.

People's care plans were kept in their rooms, meaning they and their relatives had access to them at any time. We discussed with the registered manager this meant staff had to go to people's rooms to complete records or refer to information they needed. The registered manager told us this was a decision made by the provider.

The care files held 'Do not attempt cardio-pulmonary resuscitation' (DNACPR) decisions where appropriate. We saw these were valid and completed correctly.

Requires Improvement

Is the service responsive?

Our findings

In the PIR the provider told us, 'A full domiciliary assessment of residents' care needs, abilities, interests, aspirations, health and spiritual needs is carried out by a trained manager or competent person from the senior team prior to admission, involving the resident and representative to ensure the admission is appropriate. We ensure that each resident is fully aware of how we will meet their needs; we achieve this by writing their care plan with them and their representatives.'

Care plans we looked at contained a pre-assessment of people's care and support needs, meaning the provider had made sure they were able to meet the person's needs before they started to use the service. This information had been used to write further care plans for people including care plans to for nutrition, mobility and dexterity, personal care, spiritual well-being and a 'final wishes' care plan.

We saw evidence in care plans that risk assessments were reviewed set intervals and in response to incidents such as falls. The review document concluded with the statement, 'I have been fully consulted in respect of the contents of this assessment.' However, in one care plan we saw a member of staff had signed instead of the person named on the care plan.

People who used the service said their choices were respected.

We spoke with people about activities provided in the home. Four of the people spoken with said the activity co-ordinator was "Fantastic very enthusiastic" and "I don't know how she comes up with so many ideas. She is new. We have competitions. I never thought I would enjoy them." Another person said, "The activity co-ordinator is great. She brings me the newspaper to read which I enjoy". On the day of our visit we observed activities. One of these was 'Reminiscing' and the topic was trains. It was held in the garden and nine people were actively participating.

With regard to other activities held at the home, the 'seize the day' initiative was being publicised but there was no evidence of this being acted on either in the care plans we looked at or in displays around the home. 'Seize the day' is intended to capture wishes of residents for things they have never done or not done for a long time, and find ways to make these things happen. Although care plans contained details about activities people enjoyed, we did not see any evidence people had actually participated in these activities as their involvement was not recorded on their care plans.

Daily notes were basic, repetitive and lacked any meaningful information about how people spent their days.For example, the entries for three days for one person were: 'See night report. All support plans followed. [Name of person] seems content.''See night report. All support plans followed. [Name of person] appears cheerful and chatty.''See night report. All support plans followed. [Name of person] seems well, no concerns.' The above entries provided very limited details about the person's care for that day and did not highlight the activities which they undertook as well as their general well-being.

We looked at the provider's policies and procedures for recording and resolving complaints and concerns.

We saw all feedback including verbally raised concerns was recorded together with a clear course of action. There was detailed information about the issues and clear recording of action taken to investigate and resolve the concerns. This included ensuring the person raising the concern or complaint had the opportunity to discuss it with senior staff during any investigation and given feedback on the conclusion..

People who used the service and their relatives told us they were aware of the complaints procedures and would not hesitate to make a formal complaint if necessary. One person said, "All the staff are very approachable and although I have never had to make a complaint I am sure they would act appropriately if I had concerns about the care I receive." Another person told us, "I am very pleased with the care I receive but if I had any problems I would without doubt raise them with the manager to sort out."

Requires Improvement

Is the service well-led?

Our findings

In the PIR the provider told us, 'Each Home Manager has an Area Manager who reviews their performance to ensure they understand responsibilities and provide support; 1:1's and annual appraisals: Succession planning/training means Deputy Home Managers can act up in the Home Managers absence.'

There was a registered manager in post at the time of the inspection. People who used the service, families and staff we spoke with during the inspection spoke highly of the registered manager. They told us they thought the service was well-led. Relatives and most of the people knew the manager by their first name and felt they could approach them at any time. One person said, "No one is out of reach. I can go and talk to the manager at any time. I go to her office and if she's busy I sit in the chair and wait. She always listens to me."

The registered manager told us they monitored the quality of the service by quality audits, resident and relatives' meetings and talking with people and relatives. We saw there were a number of audits, which included care plans, health and safety and medication. However issues in relation to care plans, example consent not been signed and MCA assessments that had not been undertaken had not be identified in the audits.

Records showed the registered manager had systems in place to monitor incidents to minimise the risk of re-occurrence. We saw the date, nature of the incident and outcomes were recorded. These were signed by the registered manager and any themes or trends were identified.

In the PIR the provider told us,' The Home Manager has an open door policy, good practice is shared at staff meetings. I lead by example with honesty and include integrity, building trust and will support the staff team fully. I challenge poor practice and ensure a positive open culture exists within the home.'

We saw relative/resident meetings had taken place. We looked at meeting minutes for the last meeting in August 2016 and discussions included health and safety, induction for new residents, the kitchen, activities for people and staffing. One person we spoke with had attended the monthly residents' meetings and recently completed a satisfaction survey. They expressed how useful this was as they were able to express their feelings and made a comment about how lovely the shepherd's pie was although sometimes 'the meat is a bit tough when we have Sunday dinner'. The person also commented that their concerns about the food were taken on board by the registered manager.

We saw the provider carried out an annual resident satisfaction survey. We saw the 2015 survey covered a range of areas and we saw the majority of responses were positive.

We saw staff meetings were held on a regular basis which gave staff the opportunity to contribute to the running of the home. We saw the meeting minutes and discussions included staff issues, resident and relatives meetings, training and medication.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Evidence of consent was not always available and staff did not fully understand capacity, which meant people may not receive appropriate support to make decisions.