Methodist Homes

Elmside

Inspection report

Elmside Walk
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Date of inspection visit:
19 June 2018

Date of publication:
23 July 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection was carried out on 19 June 2018 and was unannounced. At their last inspection on 13 July 2017, they were found to not be meeting the standards. This was in relation to governance systems, the number of skilled and knowledgeable staff, care plans not being up to date and care needs not being met. Following the inspection, they sent us an action plan stating how they would address and resolve the issues. At this inspection, we found that they had made the required improvements and were now meeting the standards.

Elmside is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Elmside provides accommodation for up to 69 older people, some of whom live with dementia. The home is not registered to provide nursing care. At the time of the inspection there were 65 people living there.

The service had a manager who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the 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 and associated Regulations about how the service is run. The registered manager was new in post following the last inspection.

People, relatives and staff felt the service was well run and there were systems in place to monitor the quality of the service and address any shortfalls. The management team worked with other agencies to improve and maintain standards.

People felt safe and were supported by staff who knew how to reduce risks, were trained and had regular supervision. Lessons learned were shared and any incidents were reviewed. Medicines were managed safely and there were effective infection control practices.

People were supported by sufficient staff who were recruited safely. However, staff felt at times they were short staffed.

People are supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice. The principles of the Mental Capacity Act 2005 were adhered to and people were supported to eat and drink enough and risks were monitored. There was regular access to health professionals and the design of the building suited people's needs.

People were treated with dignity and respect. We found staff were kind and friendly. Confidentiality was promoted and people were involved in their care.

People's care needs were met in a way they liked and care plans included the appropriate information to help ensure care was provided in a person centred and safe way. Where people were supported at the end of their lives, this was done with dignity and kindness. People enjoyed the activities provided and complaints were responded to and feedback was sought.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe and were supported by staff who knew how to reduce risks.

People were supported by sufficient staff who were recruited safely. However, staff felt at times they were short staffed.

Medicines were managed safely.

Lessons learned were shared and any incidents were reviewed.

There were effective infection control practices.

Is the service effective?

Good

The service was effective.

People were supported by staff who were trained and had regular supervision.

The principles of the Mental Capacity Act 2005 were adhered to.

People were supported to eat and drink enough and risks were monitored.

There was regular access to health professionals and the design of the building suited people's needs.

People and their relatives told us that they felt staff were skilled and knowledgeable to support people living at the home.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

Staff were kind and friendly.

Confidentiality was promoted.

People were involved in their care.

Is the service responsive?

Good

The service was responsive.

People's care needs were met in a way they liked.

Care plans included the appropriate information to help ensure care was provided in a person centred and safe way.

Where people were supported at the end of their lives, this was done with dignity and kindness.

People enjoyed the activities provided.

Complaints were responded to and feedback was sought.

Is the service well-led?

Good

The service was well led.

People, relatives and staff felt the service was well run.

There were systems in place to monitor the quality of the service and address any shortfalls.

The management team worked with other agencies to improve and maintain standards.

Elmside

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. We also reviewed the action plan that the provider sent to us following the last inspection.

The inspection was unannounced and carried out by two inspectors and an expert by experience. An expert by experience is a person who has experience of using this type of service or supporting a person using this type of service. In addition, there was a member of staff from the CQC business team observing the inspection for development purposes.

During the inspection we spoke with six people who used the service, five relatives, seven staff members which included agency staff, the regional support manager and the registered manager. We also received information from service commissioners and health and social care professionals. We viewed information relating to six people's care and support. We also reviewed records relating to the management of the service.

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

Good

Is the service safe?

Our findings

People and their relatives told us that they felt safe living at the service. One person said, "I feel safe here." A relative said, "We think [person] is 100% safe here, and we always we know what medication [they're] on and there plenty of staff around during the week." We observed people respond to staff and they were comfortable and happy to see them. Relatives told us that they felt people were safe.

Staff had been trained in how to safeguard people from avoidable harm and were knowledgeable about the potential risks and signs of abuse. Staff were able to describe how they would report any concerns within the organisation and to external agencies, for example, the local authority safeguarding team. Information and guidance about how to report concerns, together with relevant contact numbers, was displayed in the home and was accessible to staff and visitors. One staff member told us, "I know about safeguarding and I would report any bruises, body map it and record it. I know the numbers are on the posters on noticeboards to contact the Local Authority or CQC."

Where potential risks to people's health, well-being or safety had been identified, these were assessed and reviewed regularly. Risk assessments were in place for areas including falls, skin integrity, the use of equipment and behavioural needs. These assessments were detailed and identified potential risks to people's safety and the controls in place to mitigate risk. We noted that all accidents and incidents were reviewed to ensure remedial action had been taken and the risk of a further incident was reduced. For example, a trend had been identified as an increased number of incidents had occurred on Cedar unit during the morning. As a result, an additional staff member was added on the morning shifts.

We checked a random sample of pressure mattresses for people who had been assessed as being at risk of developing pressure ulcers and we found that they were at the appropriate setting for their weight. We noted that this information was displayed in the medicines room to raise staff awareness and the mattresses were checked regularly. Records confirmed that people were supported to reposition at intervals and staff told us this was effective as when people had an area that was fragile or sore, this was healed through an effective care plan.

There were regular checks of fire safety equipment and fire drills were completed. The provider was implementing a system to ensure all staff were included in a drill at regular intervals. Staff knew how to respond in the event of a fire. The provider ensured that other checks, such as electrical or health and safety assessments, were also completed to help maintain people's safety.

People told us that they felt there were enough staff to meet their needs. Relatives told us that there were enough staff available to meet people's needs. One relative said, "Staffing levels are ok." However, one relative told us, "The weekends are not as good as the weeks, staffing is a little thin." Throughout the course of the inspection we noted that there was a calm atmosphere in all units in the home and that people received their care and support when they needed it and wanted it. Call bells were answered in a timely manner and staff went about their duties in a calm and organised way.

However, some staff told us that at times shifts were not covered and they had to work short staffed. One staff member said, "On a good day we have one agency working [out of six staff] on a bad day we have four agency and two permanent staff." They did go on to say that this had not impacted on people's welfare but had made the staff on duty very busy. One staff member said, "It is busy here but the staff and the management are fantastic." A third staff member said, "We need more staff really. It would be nice to have time to sit with residents but we are short at times." The home used agency staff when needed to cover shifts but they were usually agency staff members who had worked at the service before so knew people well but the provider expected for agency staff to work with an employed member of staff.

In addition, the handover sheet included key information to ensure they had the information needed to support people safely. We discussed this with the registered manager who told us that shifts were not left short as the home at times was staffed over the dependency levels. We reviewed the rota and found that in most cases shifts were covered, albeit at times with a high number of agency staff.

Safe and effective recruitment practices were followed to help make sure that all staff were suitable for working in a care setting. They ensured all required documentation was received before a member of staff commenced employment. This included written references and criminal record checks.

People's medicines were managed safely in most cases. People told us that they received their medicines when needed. Medicines were stored safely and administered by trained staff. Staff received regular competency assessments. We found that there were daily counts in place and these helped identify any discrepancies. We checked a random sample of boxed medicines and those in the pharmacy blister packs and found that most stocks were accurate with the records. However out of the 15 boxes we counted, one box did contain the incorrect quantity according to records. However, the provider had a robust system in place for monitoring these issues and we saw in records that these areas were addressed with staff as needed.

There were systems in place to help promote infection control. These included cleaning regimes and schedules and training for staff. We saw that staff used gloves and aprons appropriately and the home was clean and fresh on the day of our inspection.

Lessons learned were shared at team meetings, supervisions or as needed. We noted that any issues were discussed and remedial actions put into place. One staff member said, "They [management] always share with us if anything happens like complaints and what we need to do to improve."

Good

Is the service effective?

Our findings

Staff received training to support them to be able to care for people safely. This included basic core training such as moving and handling and safeguarding. Staff were also receiving training to become champions in key areas such as falls, care planning and nutrition, to enable them to support their colleagues to provide effective care. One staff member said, "I think the training could be better. Face to face training is good but we only have computer training." We noted that the homes training matrix showed that training compliance was over 90% in most areas. Another staff member said, "I had a good induction and I shadowed before I was put on the floor. I was also observed for how I work and manual handling. I have regular supervision."

New staff received an induction before starting in the home and then worked alongside a more experienced staff to enable them to get familiar with the people they supported. Agency staff told us they had an induction when they started working at the home and they worked with a permanent staff member until they learnt the routine in the home. One agency staff said, "I had an induction when I had my first shift here and worked with a permanent staff member. I can now work on my own because I know people."

Staff told us they felt better supported by the registered manager than the previous manager They told us the management team now was approachable and listened to staff as well as support them. Supervisions were carried out regularly and staff told us they had to opportunity to give and receive feedback about their work. One staff member said, "I have regular supervision and it`s nice to be praised and receive feedback about how well you are doing or if there is anything you need to improve on."

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The management team had a clear understanding of when it was necessary to apply for an authority to deprive somebody of their liberty in order to keep them safe. They had awareness of what steps needed to be followed to protect people's best interests and how to ensure that any restrictions placed on a person's liberty was lawful and they had their human rights to freedom protected. The appropriate applications and documentation was in place. We found that the capacity assessments completed by the home demonstrated how people were supported to be involved in decisions and when they were assessed as not being able to make an independent decision, best interest decisions were documented.

Staff were knowledgeable about capacity, best interest decisions and how to obtain consent from people with limited or restricted communication skills. Staff explained what was happening and obtained people's consent before they provided day to day care and support. Staff offered people choices each day even when they were assessed as not having capacity to make some decisions. Staff acknowledged that this did not

mean they could not make any decisions and how they wanted to spend their day, what to eat and what they wanted to wear. Appropriate support was given to people and staff checked if they were happy to be helped or not. For example, a person who was not able to communicate verbally had a printed and laminated alphabet and YES and NO words. Staff asked them a question and waited until the person indicated a yes or no answer before they helped the person eat.

'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) decisions were in place, and it was clear that people had been involved with making the decisions and, where appropriate, their family members as well. There was a log of these held by the management team to ensure they were reviewed as needed.

The home was designed in a way so that people could move around easily, whether this was independently or with the use of mobility aids. Equipment was well situated in bedrooms and bathrooms to enable people to be independent where possible. There were large comfortable lounges with ample seating for everyone and designated dining areas so people could enjoy a meal together if they wished. The environment throughout the home was warm and welcoming and appropriate for the people who lived there. People's individual bedrooms included personal items to help create a homely feel. People had memory boxes outside their rooms which help other get to know them as people. There was an accessible garden that people had enjoyed in the better weather, a library and a coffee shop area that people could also use. One person told us, "I love the garden and the sunshine. I'm out here a lot." However, we discussed with the management team how they could improve on the environment for people living with dementia, for example clearer signage and information to help orientate people including an easier to read clock and they told us that they would consider developing these areas.

People were supported to enjoy with a variety of food and their individual likes, dislikes and dietary needs were well known by staff. People were offered drinks and snacks throughout the day. We heard people ringing the bell and telling staff they were ready for their breakfast in the morning and what they wanted. One person told us, "I enjoy the food." A relative said, "The foods excellent and my [relative] can choose what she wants to eat." Another relative said, "The foods excellent. [Person] is always given a choice and there are great vegetarian options. The choice is amazing as food is an important part of life here." We found that the chef was aware of people's dietary needs and communicated well with the staff team to ensure they had up to date information.

People were provided with a good choice of food and they were supported to choose where they wanted to eat their meals. Throughout the day we noted there was good communication between staff and the people who used the service and they offered people choices; these were respected which contributed towards people feeling that they had control in their lives. For example, during the lunch service people were provided with a choice of two main courses, two desserts and accompanying drinks. Where people struggled to understand the choices offered we noted that staff provided them with plated options so that they could make meaningful choices based on the look and smell of the food. We noted that some people opted to eat in the communal dining room and some chose to eat in their rooms.

We observed the lunchtime meal served in the communal dining rooms and we noted that people were provided with appropriate levels of support to help them eat and drink. This was done in a calm, relaxed and patient way that promoted people's independence as much as possible. We heard staff interacting with people in a kind and considerate manner indicating that nothing was too much trouble. In the main dining room, tables were nicely laid with cloths and condiments were on the tables to support people to be independent. The Minister who had come for the service in the chapel was wonderful and made lunch a social occasion for people. They knew them all by name would ask about their friends, relatives or those who were poorly and seen to chat and interact with many people. In Cedar unit the dining area was not

prepared in advance of lunch and this could be improved to help people living with dementia understand the prompts that it was a mealtime and improve the dining experience.

Assessments had been undertaken to identify if people were at risk from poor nutrition or hydration. We noted that these assessments were kept under review and amended in response to any changes in people`s needs.

People's day to day health needs were met in a timely way and they had access to health care and social care professionals when necessary. For example, GP, speech and language team (SALT) and a chiropodist. One relative told us, "They always inform us when [person's] going or seeing a doctor."

Good

Is the service caring?

Our findings

People told us that staff were kind and caring and we noted that people were relaxed in the company of staff. Relatives told us that staff were kind and attentive.

Staff were calm and friendly with people and we observed them interact with people in a warm and caring way. We found staff to be kind and attentive and communicated well with people. For example, we saw staff adapt their approach depending on who they were supporting or speaking with.

Staff respected people's dignity and made sure that they supported people in the way they wished whilst encouraging them to remain as independent as possible. During our inspection we noted that staff were always courteous and kind towards people they supported and to their colleagues creating a pleasant atmosphere in the home. We saw staff promoting people's dignity and privacy by knocking on people's doors and waiting before entering people's rooms. People's records were stored discreetly in people's rooms or in the medicines office in order to promote confidentiality for people who used the service.

People and relatives, where appropriate, were involved in planning their care. Plans detailed ways in which staff could try to encourage people's involvement by offering choices and supporting them to live independently where possible.

People were encouraged to maintain relationships in whatever form they took. This included with family members and friends. We noted that two relatives shared a room and their wishes were clearly documented and known by staff. Relatives and friends of people who used the service were encouraged to visit at any time and felt welcome. We noted from the visitor's books and our observations on the day that there was a regular flow of visitors into the home. A relative told us, "We choose this place because it's local and we can visit whenever we like to."

People's religious beliefs were supported and there were regular services, bible readings and community gatherings. One relative told us, "We choose this home because of [their] religious beliefs and links; that why [person] is here." We saw that there was a record of everyone having the opportunity to take part in the services, and there was also one to one prayer times offered.

Good

Is the service responsive?

Our findings

When we last inspected the service on 13 July 2017 we found that care plans were not always up to date and care needs were not always met. At this inspection we found that these shortfalls had been addressed and new care plans had been developed and people felt their needs were met.

People and their relatives had been involved in developing people's care plans and we found that the care plans were reviewed regularly to help ensure they continued to meet people's needs. We saw that people's relatives were kept informed about matters that affected people's care, support or wellbeing. For example, where a person's health had declined. Most plans included detailed information which clearly guided staff on what people's needs were but also their preferences, likes and dislikes. There was also information about their lives, history and families. We tested staff`s knowledge about peoples` preferences, likes and dislikes and also risks; they were able to tell us what we wanted to know. We also asked agency staff about people and they were able to tell us what people liked and also what allergies people had. One agency worker said, "I know about food allergies people have here and I also know what they like. I am able to work on my own now but staff [permanent] are good if I need to ask any questions."

People told us that their needs were met. Relatives also told us that people's needs were met. However, one relative said, "Sometimes in the evening instructions are not always followed, for instance [person's] teeth need to come out to avoid infections, this is not always done." During the inspection we observed staff being prompt in supporting people and responding to their needs in a way that confirmed they knew people well. This included ensuring they had items around them that they enjoyed using and personal care at a time that suited them. We noted that people were clean and comfortable. However, we did also note that one person, whose care plan stated they must be wearing a fleecy cardigan and socks, told us they felt cold. They did have a blanket but no cardigan or socks. We raised this with a staff member who supported the person to be dressed in a way they wanted and ensured they felt warm.

The service did not provide nursing care but at times they provided end of life care for people. The staff had been prepared for this by ensuring people had their wishes documented in their care plans. Care plans showed that people were asked to think about their wishes in relation to end of life care and it was documented if they had any specific wishes or if they had declined to talk about this matter when they moved in to the home. Where people were nearing end of life action was taken to keep them as comfortable as possible and to remain at Elmside if this was their choice.

There were a variety of activities provided for people to access at will. For example, there were chair exercises, arts, music therapy, reflexology, religious services and bible reading, a bowls club and recently Spanish lessons had started and six people had signed up. One person told us, "I like the quizzes they are good for my brain." However, they went on to say, "I don't always know what activities there are, they usually give us a card saying what's going on. We're supposed to get a programme each week." Another person said, "This afternoon we are going for a walk around the gardens." They went on to say, "I get a paper every day which is good for mind, they get that for me." A relative told us, "[Person] always goes to the service in the chapel. [Person] loves to talk and is allowed to give talks on their love of music. [Their] last talk was on

the opera Carmen." However, we noted for the majority of people living on Cedar unit and who were also living with dementia, they spent most of the morning sitting in the dining room with nothing to do. One person had told us they enjoyed knitting but there was no knitting around them. We asked a staff member why people were not in the lounge during the morning and they said, "People feel it's more sociable in here and it's easier to push fluids." Unfortunately, we did not observe a social environment as most people were simply sitting in their wheelchairs at the tables without interaction other than when staff asked if they would like another drink. We were told that the previous evening people had enjoyed a 'World Cup' party in the lounge and some enjoyed a shandy. We also saw that entertainers came into the home. However, activities for people were sitting in Cedar unit needed further development to ensure people regularly had a purpose and the opportunity to do something between events and care needs being met.

There was involvement with the community. Visitors and volunteers attended the home and church service that were held regularly. There was a 'Friends on Elmside' group that raise money for events.

Complaints and minor concerns raised had been investigated and responded to. People told us that they felt able to raise concerns with staff or a member of the management team. Relatives told us that they knew how to raise concerns but had not needed to. We noted that when a complaint was received an action plan was developed to help ensure all remedial action was taken.

The provider had a survey where people were asked for their views. The feedback from this had been positive. There was also a suggestion box with cards so people could share their views. There were resident and relative meetings were people decided on menus and activities and were asked for their views on the service. We also saw, where suggestions were made at one meeting, they had been actioned by the next meeting. For example, tidying the garden, updates to menus and for the chef to meet with people.

Good

Is the service well-led?

Our findings

At our last inspection on 13 July 2017, we found there were shortfalls in relation to leadership and governance systems at the home. Following the inspection, we met with the provider and they sent us an action plan stating how they would make the required improvements. At this inspection we found that the improvements had been made and they were now meeting the standards.

During the course of the inspection we saw the registered manager interact with people who used the service, relatives and staff in a positive, warm and professional manner.

People and their relatives told us that they felt the service was well run. A relative told us, "It's always easy to access the managers and we have had things resolved through these chats." Another relative told us, "The management, they are very obliging and caring." A third relative told us that the registered manager and deputy manager were, "Very nice and there is no lack of communication. Specialist care is available and we know about it if it's used.''

Staff told us that the management team was approachable and that they could talk to them at any time. They said that the management was always open to suggestions from the staff team and that they listened to everybody. One staff member said, "The management team is very approachable and I feel confident to ask them anything." Another staff member said, "I have regular supervision and staff meetings and I can raise any issues I have."

The registered manager started at the service following the last inspection. A staff member said, "The management team is much more approachable and supportive now." The registered manager told us, "We have worked so hard to get things where they need to be, there was a lot to do but [the provider and management team] are so supportive and it is a great home now."

There were quality assurance systems in place. These were used consistently and appropriately. As a result any issues found were addressed. For example, any issues found in relation to medicines were addressed through supervisions and competency checks. We noted that the registered manager did a weekly walk round where they reviewed care plans, checked medicines, spoke with people and staff, checked the environment and then reported back to staff with their findings. However, in addition to this people and staff told us, and we saw during the day, that the registered manager and the deputy manager were regularly walking around the home checking on how things were running. There was an internal auditing system and actions from these were shared throughout the provider and management team. Information that fed into this included accidents and incidents, staffing, training, maintenance or environmental issues, complaints and feedback from other agencies. The registered manager told us that the systems in place meant that issues were resolved. There were regular regional director and area manager visits and they completed checks to ensure the home was working well.

The management team worked with the local authority to ensure they were working in accordance with people's needs and obligations with the commissioning contract. A recent monitoring visit form the local

authority had been positive and previous actions signed off as completed. The service was also supported by a local care association who provided support with activities and training to help keep knowledge up to date.

Staff told us that there were regular staff meetings held to enable them to discuss any issues arising in the home. We saw minutes of a staff meeting and noted the agenda included many areas such as respecting residents, care, falls and other incidents, training and team work.

Providers of health and social care are required to inform the Care Quality Commission, (CQC), of certain events that happen in or affect the service. The registered manager had informed the CQC of significant events in a timely way which meant we could check that appropriate action had been taken.