Methodist Homes

The Fairways Retirement Village

Inspection report

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Date of inspection visit:
12 October 2016

Date of publication:
30 November 2016

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 took place on the 12 October 2016 and was announced. We gave the provider 48 hours' notice to ensure the relevant people would be available on the day of the inspection. As this was a new service registered in 2014, this was the first rated inspection.

The Fairways Retirement village provides personal care to people living in their own home. At the time of the inspection, 17 people were receiving a service. The retirement village consists of houses and apartments which people had purchased. A range of facilities were provided as part of this package. The domiciliary care office was located adjacent to the apartments of some of the people using the service. Apartments were located at a ground and first floor level with a lift for access. The inner ground floor communal space was covered but allowed day light to come through. This space was used for activities and social interaction.

There was a registered manager in place at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was available throughout the inspection.

There were sufficient staff numbers to enable them to perform their roles effectively and people told us staff arrived on time.

The provider had ensured that staff had the knowledge and skills they needed to carry out their roles effectively. Relevant training was provided to ensure staff's knowledge was up to date.

Staff understood people's individual needs and their daily routines. Care was delivered to people in a person centred way.

People's rights were protected in line with the Mental Capacity Act 2005. People's capacity was considered in decisions being made about their care and support and best interest decisions were made when necessary. Staff received training to help them understand their obligations under the Mental Capacity Act 2005 and how it had an impact on their work.

There were systems in place that safeguarded people. Policies and procedures were in place to guide staff to make referrals to the relevant external agencies if the need arose. Staff we spoke with demonstrated an understanding of the process.

Systems were in place to safely manage people's medicines. A policy was in place to guide staff through the process of ordering, stock control and the disposal of any unused medicines. Staff also received regular training in this area to ensure they were competent to administer people's medicines.

People were involved in reviews of their care needs to ensure that staff had up to date information about how to meet people's needs. People's records demonstrated their involvement in the support planning and decision making processes. Care support plans and risk assessments were representative of people's current needs and gave detailed guidance for staff to follow. Staff understood people's individual needs and preferences which meant that they received care in accordance with their wishes.

People, relatives and friends that we spoke with told us people received a good quality of care and support. People, relatives and staff had developed positive relationships with each other.

Staff we spoke with felt the service was well led and the registered manager was available when needed. Staff meetings took place on a regular basis. Staff felt they worked well as a team.

There were systems in place to obtain the views of people who used the service and their relatives. There were audits in place to identify potential shortfalls in the delivery of service and if required an action plan to address this.

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 told us they felt safe with the staff who supported them and in the way their care was delivered.

Staff were knowledgeable in recognising signs of potential abuse and what to do if there were safeguarding concerns.

People had risk assessments in place and management plans to offer guidance to people and staff to minimise potential risks.

The registered provider followed safe recruitment practices to ensure new staff were appropriate to work with people.

Is the service effective?

Good

The service was effective.

People and their families told us staff were well trained and good at their job.

People were supported by staff who received regular support through supervision and training.

The registered manager and staff were proactive in ensuring people's health needs were met.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect.

Care plans reflected people wishes and considered their privacy and dignity.

People told us the staff were kind, caring and approachable.

Is the service responsive?

Good

The service was responsive.

People and their relatives spoke highly of the staff and the registered manager.

People had been involved in writing their plan of care and had consented to their care and treatment.

There was a range of activities which people could participate in which were part of the facilities offered to home owners.

Is the service well-led?

Good

The service was well led.

People and relatives we spoke with told us the service was well run.

There was a system of audits in place which identified shortfalls in the service delivery and addressed these through an action plan.

Staff told us they felt well supported by the registered manager.

The Fairways Retirement Village

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.

This inspection took place on 12 October 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that the relevant people would be available.

The inspection was completed by one inspector. Before the inspection, we reviewed all of the information we hold about the service, including notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send to us. We reviewed the Provider Information Record (PIR). The PIR was information given to us by the provider.

As part of the inspection we spoke with two people who used the service and one relative, the registered manager, administrator and three members of care staff which included a care worker from an agency. We received feedback from one health professional. We looked at the records relating to people's care and decision making. We also looked at records about the management of the service.

Good

Is the service safe?

Our findings

People told us they felt safe with the staff who supported them and in the way in which care was delivered. A relative told us "my loved one is supported by two carers and they are always careful and are guided by X when they give care".

There were sufficient staff available to offer people the support they required and to meet the allocated visit times. People told us they knew the member of care staff who supported them and this tended to be the same person. Care staff arrived on time and would usually call out to let people know they were arriving. The registered manager was recruiting for more care staff and in the interim was using an agency to provide cover. They requested the same agency workers to ensure continuity for people who used the service.

An emergency call out rota was in place in the event that either a member of care staff required assistance or there were unpreventable delays in staff attending visits.

The registered provider had systems in place that safeguarded people from abuse. Staff we spoke with had a good understanding of what safeguarding meant and the processes to follow to report concerns. Staff received training in safeguarding and from speaking with staff it was clear they also received regular updates to ensure they were up to date with the latest guidance. A member of staff told us "If we saw poor practice we would report it to the manager immediately" and "It is our job to protect people against abuse and anything that goes against their wishes and human rights".

We reviewed the personnel records for three members of care staff. There were recruitment procedures in place to help ensure that staff were suitable for their role. This included gathering information through references and a Disclosure and Barring Service check (DBS). The DBS provides information about any criminal convictions a person may have and whether they have been barred from working with vulnerable adults.

There was a clear pricing structure in place and invoices indicated the hours and type of service people received. The administrator told us they would only charge people for the time spent delivering care and if the visit was shorter this was reflected in the billing. Each person had a contract agreeing the care and support to be delivered. If additional visits were agreed, the contract was updated to reflect this.

People told us they were happy with the way they were supported with their medicines and found staff to be skilled in this area. Staff had received training in the administration of medicines and regular assessments were carried out to ensure staff remained competent to administer medicines. People's medicines were delivered by the pharmacy of their choosing and kept in secure storage in their home. Medicines Administration Records (MAR) were completed by staff when people took their medicines. Stock levels were checked when new supplies were delivered from the pharmacy. Between these times, staff checked the stock levels to ensure people received their medicines in line with the GP instructions.

The registered provider told us they had until recently experienced some medicine errors. Upon

investigation all but one of the errors were down to agency staff, either not recording accurately or a missed medicine. In response, the registered provider contacted the agency to inform them. They also insisted that any agency workers who are allocated to work with the service are competent in the management of medicine. In addition, the registered provider had set up a system of reviewing any new agency workers' knowledge and understanding of medicine administration.

Staff were knowledgeable about people's needs and the actions they needed to take to keep people safe. Care records demonstrated that staff involved people when delivering personal care which reduced the potential of harm. For example, when supporting a person to shower, taking time for the person to go at their own pace and the staff member to be led by this.

Risk assessments and subsequent management plans were in place to support people to be as independent as possible, balancing protecting people with supporting them to maintain their freedom. For example, the environment in their apartment and surrounding communal areas, using the swimming pool, medicines, falls, using lifting equipment and using a motorised scooter. Risk assessments were reviewed alongside care plans to make sure they were still required and if so continued to consider all aspects of potential harm and risk.

Processes were in place to review risks following incidents and make changes to the way staff worked where necessary. Staff adhered to these processes.

The office for the service is located onsite where people live. During the inspection we noted there was an error on the fire alarm panel. The panel gives the number of each apartment and the individual apartment number is highlighted in the event of a fire. The registered manager contacted the company who maintain the fire panel and the error was rectified the day following the inspection.

Good

Is the service effective?

Our findings

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

Staff had undertaken specific training in the Mental Capacity Act 2005 (MCA). Staff we spoke with demonstrated their understanding of the MCA and its principles. One person told us "The carers always ask permission from me before they carry out my care" and a relative said "The care staff are really good, they won't start care before X is ready". The care records demonstrated that people were involved in decision making and the guidance for staff reflected this. Care records reflected that people had signed to consent to their care and treatment, the use of different equipment and the sharing of information with other agencies.

Some people used a device which enabled staff to track their whereabouts whilst on the premises of the site. People had signed to consent to the use of this equipment. For one person, the registered manager was undertaking a mental capacity assessment as it was unclear if the person could fully consent to this equipment being used. The registered manager was working with the person and their family to consider the best interests of the person and their current circumstances.

Staff received regular supervision and an annual appraisal from their manager and records evidenced this. This was a way of monitoring staff delivering support to people in their homes. At these meetings, areas where personal or professional development was required were identified to maintain good practice. Team meetings were held where various topics were discussed around the delivery of care, rotas and any new learning and development.

People and families told us the staff were well trained and knew how to do their job to a high standard. The registered manager had recently signed up staff to undertake 'Ulcer Prevention' training and staff reported that this course would be interesting and relevant to their role. Although there were no incidents of pressure ulceration, this training was seen as being proactive to prevent any potential risks of pressure ulceration. Staff completed mandatory training as set by the provider such as, fire safety, health and safety, infection control, manual handling, safeguarding and equality and diversity.

More specific training was given in dementia awareness, epilepsy training and diabetes care. The administrator was currently studying for a level three in Business Administration to update their skills. A member of the care team had taken on the role of 'dementia friends champion' A Dementia Friends Champion is a volunteer who encourages others to make a positive difference to people living with dementia in their community. They do this by giving them information about the personal impact of dementia, and what they can do to help). A future development was for senior staff to attend training in supervision to enable them to directly line manage care staff.

An induction process of three months was available for new staff which included shadowing an experienced

member of staff, reading people's care plans and completing mandatory training including fire safety, first aid, living the values, health and safety and moving and handling. All new staff followed the Care Certificate training when starting their role. A member of the care team was an assessor in health and social care which contributed to the assessment of staff competencies.

Staff undertook specialist training in end of life care which was provided by a local hospice. The registered manager told us "We support people to die peacefully in their own home if that is their wish. We will do our utmost to support them and personal care planning is adjusted if the time comes". Some people had a 'Treatment and Escalation' plan in place which had been agreed with their GP. The registered manager told us they would 'always adhere to people's wishes at the end of their life'.

There were facilities onsite for people to use the restaurant which provided a full menu of meals and snacks throughout the day. Some people required support with meal preparation and with eating and drinking. Information was available to staff about people's food likes and dislikes and if any specialised diets were required. Where people may be at risk of malnutrition or dehydration then monitoring charts were put in place.

The registered manager told us some people preferred to eat all of their meals in the restaurant, other people cooked for themselves. If people had dinner parties, the restaurant would deliver cooked meals for the occasion. A breakfast club had been set up and people joined each other to socialise over breakfast.

People and their relatives told us they were confident in the staff in managing their health needs. People's care records and staff shift handover documents evidenced contacts being made with the GP and district nurse. Guidance was given to staff by health professionals as to how people's care should be given following any treatment. In addition, the care records highlighted how the staff and registered manager tracked people's wellbeing for potential risks, and gained consent to refer to the relevant professional, such as where a urinary tract infection was suspected.

Good

Is the service caring?

Our findings

The registered manager told us they promoted a happy environment and said "If the staff are happy in their work then this affects how they work, so we have happy people". We asked people to tell us about the attitude and approach of the staff who supported them. One person told us "They [the staff] are so happy and they brighten up my day", "The same person usually comes to see me, they are very polite and respectful. I look forward to them coming as we always have a nice chat. They help me in any way possible, nothing is too much trouble and they are very very good".

Another person commented "The staff are caring, kind, polite and so gentle when they have to move me". A relative told us "The staff all seem happy in their work and are respectful and kind". A health care professional told us "They offer a really good quality of care and the staff are always approachable with a smile".

The registered manager told us they gave people a high quality of care. Their approach was person centred, dignified and staff had formed lasting relationships with the people they supported. They said "We all care about the people we look after and I care about my staff as well". The administrator told us "We are a very caring team and we will do anything for anyone within our range of capabilities".

People told us some of the staff would 'pop in' for a cup of tea even if they were not due a visit. Staff told us "We give an excellent level of care and we treat people the way we would wish to be treated".

Compliments received through feedback to the service included "With many thanks for all your support and help, thank you for the birthday card and the cake. I do appreciate how kind you all are", "All the staff at whatever level are friendly, good at their job and there are excellent facilities and activities. I swim every week" and "Thank you for looking after us all year".

Good

Is the service responsive?

Our findings

At the Fairways retirement village there was a 'Residents Committee' consisting of people who used the domiciliary service and those who did not. The committee sought ideas from its members on activities they would like to participate in. Some of these activities were day trips out such as to country parks, coffee mornings, speakers, a bonfire night party, bingo sessions and an art and craft exhibition. The apartments which people lived in are enclosed within a main building. In the main throughfare there were seats and tables where people could sit and chat. This space was considered to be an 'outside' space with an inside planted tree area, a bowling alley and a large chequers game. We observed people met in this area, wearing their coats as if going outside.

A notice board was outside of the domiciliary care agency office which was adjacent to the outside space. This contained information about keeping safe such as 'cyber' abuse, tenant information and forthcoming events. People owned their properties and with this came a range of facilities they could use. This included use of the swimming pool, Jacuzzi, restaurant, cinema room, hairdresser, gym and relaxation bathroom. During the inspection we observed people going in and out of the main office to speak with the registered manager or the administrator. People were happy and friendly, with one person greeting a member of staff with "Hello beautiful". It was clear from our observation that people and staff had formed positive and caring relationships.

People told us they were very happy with the care and support they received from staff with comments such as "Fantastic care" and "Absolutely wonderful".

People's support needs were assessed before they started to use the service. The registered manager undertook an initial needs assessment to ensure the service could offer the care the person required. From this a more comprehensive care plan was devised along with risk assessments for any potential risks and management plans to mitigate such risks. The registered manager and the person agreed the number of hours per day they required the service. This was regularly reviewed to ensure the support level was appropriate, particularly if needs changed.

Staff understood people as individuals with their own preferences, likes and dislikes. Staff we spoke with demonstrated their understanding and this was in line with the documentation that we viewed. A member of staff told us "People tell us how they would like their care to be given and at what time. We always say what we are doing when we give care and wait for their permission. We ask people if they would like anything done differently and we always treat people as individuals".

Staff told us there was enough information and guidance in the care plans to inform them of people's wishes around their delivery of care. We spoke with an agency worker who was covering an afternoon shift. They told us "This is a fantastic service, the handovers are brilliant as they give more information than any other service I have been to. The care plans are so detailed and person centred, it's really easy to pick them up and know about that person and the way they prefer their care to be given".

Care plans were person centred because they demonstrated that people had been involved in their care planning. For example, people expressed their preferences such as 'Please ring the door bell and call out 'hello'. I would then like you to get the bedroom ready so that I have privacy. Please close the curtains and put the light on' and 'I will walk into the shower using my frame, pull the shower curtain around me and make sure I am sat down safely'. We looked at four care records which evidenced that each person had discussed their preferred routines and the care plans had been written to the person's instructions and considered what tasks the person could do for themselves.

The care plans were comprehensive and gave clear guidance to staff on the way people wanted their care to be given. Information included, personal background information, likes and dislikes and individual support plans for all activities of their daily living needs. Care plans were reflective of people's current level of need. There was guidance in place for staff to follow which included, moving and handling, skin integrity, health, nutrition, night and day routines. Management plans were in place where risks had been identified such as, with falls or dehydration and care plans had been written around minimising these risks. Care plans were reviewed on a monthly basis to ensure they were current and reflected any changes in the type of support that people required. Care plans were developed with people and people had signed to say they agreed with what had been written.

Staff completed daily records of the care they had given including any recommended treatment as advised by health professionals. These records described all of the tasks undertaken. A separate record was kept for each person of visits from health and social care professionals with follow up review dates where required. People and relatives told us they were happy with the way care and support was assessed and reviewed and they were involved in this process.

There were arrangements in place to respond to complaints. A complaints policy and procedure was in place and this identified other organisations and agencies that concerns could be reported to if necessary, this included the contact details of the Care Quality Commission. Records of compliments and complaints were kept and this helped the registered manager know what was going well in the service and any areas that required improvement.

There had been one complaint during made in 2016 and we saw this had been dealt with to the satisfaction of the complainant. One person told us "It is such a super team, I can't fault them and have no complaints", another person said "On the whole I am happy with the care and support I receive, it's all very good". A relative told us they had no complaints but would know how to raise one and commented "They [the care team] are absolutely lovely, amazing staff, A1".

Good

Is the service well-led?

Our findings

People we spoke with told us the service was well managed and they could see the registered manager when they wished. On the day of the inspection, several people dropped into the office, either for a chat to say hello or to enquire about something. We observed there was a positive atmosphere in the office and there was a 'can do' culture evidenced through our discussions with staff and people who used the service. People told us the office door was always open to them.

The registered manager told us they were proud of the service they delivered and of their team. They encouraged a positive culture and had an open door policy. They commented "I lead by example. I am always here for staff, I listen and work through any issues they may have. I can tell if something is troubling a member of staff and I am always here to support them". Staff were positive about the registered manager and the level of support which was offered to them, both in and out of the workplace.

The registered manager told us as the service was fairly new they were still setting up new things to do and try. The vision for the future of the service was to create a village community. They told us "already people are wanting to be more neighbourly, checking on each other to make sure they are well. We will knock on someone's door if we haven't seen them for a while, to make sure they have enough food in and don't need anything. Staff will often visit people out of their allocated hours. It's the small things that matter to people".

The service received feedback from people who used the service and their families. The annual survey was due to go out shortly after the inspection. We were told the feedback given would be analysed by the head office and any issues raised would be addressed and picked up in the service development plan.

There were systems in place to monitor the quality and safety of the service provided. There was a regular programme of audits in place. Checks included: medication, staffing, care planning, environment, cleaning and infection control, fire and equipment and concerns/compliments. These checks were undertaken by both the registered manager and through the provider's quality assurance team. If actions were identified a plan was put in place to address the shortfalls and this would be monitored by the quality assurance team.

The registered manager received supervision and support from the regional manager. They attended a manager's conference once a year and had regular support meetings with their peers.

To keep up to date with best practice, the registered manager accessed resources and information from the provider, CQC, Age Concern and the Alzheimer's website. There were close links with local health and social care professionals such as the GP, district nurses and the local hospice.