Heart of England Properties Limited

Perton Manor

Inspection report

Wrottesley Park Road
Wolverhampton
West Midlands
WV8 2HE
Tel: 01902 843 004

Date of inspection visit: 04 March 2015
Date of publication: 05/06/2015

Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Overall summary

We inspected Perton Manor on 4 March 2015 and it was unannounced. At the last inspection on 20 August 2014, we asked the provider to make improvements to ensure that care and treatment was planned and delivered safely. We also asked for improvements to be made to how the quality of care was assessed and monitored. We found that some improvements had been made, but further improvements were still required.

Perton Manor is registered to provide accommodation and nursing care for up to 50 people over two separate units. People who use the service have physical health and/or mental health needs, such as dementia. The 'west wing' was primarily for people who had nursing needs and the 'east wing' was primarily for people who suffered from dementia who may have behaviours that challenged. At the time of our inspection there were 44 people who used the service.

The service had a registered manager. 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

Summary of findings

the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of the inspection the registered manager was unavailable.

People who used the service were not always protected from harm. The provider had a system in place to ensure people were safe from harm but this was not effective.

We found that improvements were needed to the way the provider monitored the quality of care. Improvements were also required to ensure incidents were monitored and managed to prevent further harm from occurring.

We found that there were enough suitably qualified staff available to meet people's assessed needs. The provider had a system in place to ensure that staffing was provided in accordance with people's dependency needs.

People's risks were assessed. We saw that staff supported people in a safe way and they were aware of people's individual risks.

Staff received regular training which ensured they had the knowledge and skills required to meet people's needs. Staff told us that they felt supported by the manager.

Some people who used the service were unable to make certain decisions about their care. We found that mental capacity assessments had been carried out in accordance with the Mental Capacity Act 2005. We saw that decisions were made in people's best interests when they are unable to do this for themselves.

People told us that the quality of the food was good and they were given meal choices. We saw that assessments were in place to ensure that risks of malnutrition were reduced.

Staff treated people in a caring and kind way and respected their dignity. Staff supported people to make choices about their care.

People told us that staff knew how they liked there care provided. We found that staff understood people's preferences in care and people's social needs were being met.

Staff told us the management team were approachable and that they listened to them. People were encouraged to feedback their experiences and these were acted on to improve the quality of care provided.

The provider had an effective system in place to investigate and respond to complaints.

We identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service was not consistently safe.

People who used the service were not always protected from harm. The provider had a system in place to ensure people were safe from harm but this was not effective. Risks were assessed and managed in a way that kept people safe. There were enough suitably qualified staff available to meet people's needs.

Requires Improvement

Is the service effective?
The service was effective.

Assessments had been carried out where people lacked mental capacity which ensured decisions were made in their best interests. People were supported with their health needs and staff had received training to carry out their role effectively.

Good

Is the service caring?
The service was caring.

People were happy with the care they received and the staff were kind and caring. People were treated with dignity because staff listened to people's choices and were sensitive when they provided support.

Good

Is the service responsive?
The service was responsive.

People were involved in their care. We found that staff knew people's preferences in how their care needed to be carried out. People participated in hobbies and interests that were important to them.

Good

Is the service well-led?
The service was not consistently well led.

Some improvements were needed to the way incidents were monitored and assessed. Checks were in place but these were not always effective. The management team was open and transparent and had a clear vision for the future of the service which included the implementation of projects.

Requires Improvement

Perton Manor

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 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 3 March 2015 and was unannounced. The inspection team consisted of three inspectors.

We reviewed the information we held about the home, which included information we had received from the service. This included notifications of incidents, deaths and safeguarding. We also spoke with commissioners and health professionals to understand their experiences of the service.

We spoke with four people who used the service, seven relatives, seven care staff, a nurse, the care manager, clinical manager and the business manager. We viewed five records about people's care and medication. We also looked at records that showed how the service was managed.

We observed care and support in communal areas. Some people had communication difficulties, so we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we asked the provider to make improvements to the way they safeguarded people from harm. This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan outlining how they would make these improvements. At this inspection we found that improvements were still needed. We had concerns that one person was not being safeguarded from harm because they were receiving care against their wishes. The person told us that staff sometimes held their wrists so staff could assist them to wash against their will. We looked at this person's records and saw that they had been assessed as able to consent and make a decision around their personal care. We did not see any guidance for staff in the care records of the actions they needed to take if this person became refused their care. The records showed that this person had been restrained by staff during personal care on four occasions since the provider had been informed that this person was able to make decisions about their care.

Staff told us of the various signs of abuse that people could display and how they would report any concerns, but the staff we spoke with had not recognised that this person was at risk of harm because they were being restrained against their wishes. We saw that the registered manager had reported any allegations of abuse to the local safeguarding authority and had notified us as required. The registered manager had monitored the restraints carried out at the service but they had not recognised that this person was at risk of harm.

We spoke with the care manager and business manager about our concerns. They told us that there was a meeting arranged with the person and their family on the day of our inspection to discuss their care. We spoke with the person's relative who was unaware that restraint was being used. The care manager told us that restraint would no longer be used and care plans would be updated to show the methods to be used if the person displayed behaviour that challenged. After the inspection we referred our concerns to the local safeguarding authority.

This was a continued breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection we asked the provider to make improvements to the way they assisted people to move, and how they supported people with their risk of falls. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan outlining how they would make these improvements. At this inspection we found that improvements had been made. We observed staff assisting people to move safely in the communal areas of the home. We saw that people were supported appropriately and where equipment was used to help people to move staff explained what they were doing and ensured that people were comfortable throughout the support. We saw that risk assessments had been completed and contained guidance for staff which ensured that staff knew how to support people safely.

Relatives we spoke with were happy with the care provided and told us that they felt their relatives were safe. One relative said, "I have no worries when I leave". Staff we spoke with were aware of the safeguarding procedures and had undertaken training.

We saw that there had been new systems implemented by the registered manager to record incidents at the service. Incidents had been recorded that showed when people had been physically held (restrained) for their safety or best interests. The monitoring contained a summary of where the incident had taken place, which staff were involved, time frames and if any injuries had occurred. The registered manager had detailed what action had been taken to reduce the risks, for example; one to one support had been applied for where an individual required constant support to keep them safe. We found that the monitoring did not give details of the level of restraint used, and what action had been taken before the restraint such as; distraction techniques, which meant that it was difficult to assess and make improvements to lower further incidents.

Relatives we spoke with told us that there were enough staff available. One relative said, "They only have to call staff if they need help and they come straight away". Staff

Requires Improvement

Is the service safe?

we spoke with told us they felt there were enough staff to enable them to carry out support in an unrushed way. We saw there was a system in place to assess the staffing levels against the dependency needs of people who used the service. We saw that some people had continual support from staff if they needed constant support and monitoring. The provider had a contingency plan in place in the event of staff sickness. Additional temporary staff were used to address staff gaps when required. The provider used consistent staff from a single recruitment agency so that people received continuity of care.

The provider had a recruitment policy in place. Staff we spoke with told us that they had completed application forms and they had been subject to checks that ensured they were suitable to support vulnerable people. The records we viewed confirmed that all the necessary checks had been undertaken by the registered manager.

People we spoke with told us that they were given their medicines when they needed them. One person said, “I get my tablets when I need them and if I say I am in pain I am always offered pain relief, they [the staff] look after me and make sure I’m feeling better”. We observed medicines being administered to people. The nurse checked the Medicine Administration Records (MARs) which ensured they had administered the correct medicines and a record was made to show people had taken their medicine. We saw that medicines were stored securely and when medicines were being administered to people the medicines were locked in a medicine trolley.

Good

Is the service effective?

Our findings

Staff we spoke with told us they received an induction and regular training. One newly employed member of staff told us they had a mentor to help them learn their role and they had been observed supporting people by the manager. Staff explained what they had learnt from the dementia training they had received. Staff showed understanding of why people anxious and upset, for example; not understanding what is happening, people being too close and being frightened. One member of staff said, "I try to talk about people's family and friends and their past. I try to provide reassurance". Staff told us that they had regular supervision with the manager and they were approachable when they needed any advice or support.

Staff we spoke with had an understanding on the Mental Capacity Act 2005 and their responsibilities around this. We saw that mental capacity assessments had been undertaken where people lacked capacity to make decisions and the support required was detailed in the care plans. We found that the mental capacity assessments were broad, covering health and welfare rather than where people needed support to make informed decisions for specific areas such as; medicines.

We spoke with one person about their room being locked and they told us that they had consented to this. They said, "I feel safer with the door locked, I like it this way and I can get out if I need to". We found that Deprivation of Liberty Safeguards (DoLS) applications had been made where people's bedroom doors were locked and the handles had been modified so that people were able to open their doors from the inside with ease. The DoLS that had been authorised by the local authority had been recorded in the care plans for staff to follow. Staff we spoke with were aware of how to support people and the restrictions in place to keep people safe. We saw that the DoLS care plans were reviewed monthly which ensured the assessments were appropriate.

We carried out an observation at lunchtime to understand people's mealtime experiences. We found that people were offered a choice of meal, although there were no menus or picture prompts available to help people understand their choices fully. We saw that staff sat with people and engaged and interacted with people throughout the meal. Staff assisted people to eat in a caring and patient way, giving encouragement and time so people could enjoy their food. We spoke with one person who told us, "The meal was good". A relative we spoke with said they were happy with the food and their relative had put on weight since being at the home. We saw records that showed nutritional assessments had been completed. Where people were at risk of weight loss they had been referred to a dietician and their weight was monitored monthly. We saw that people who were at risk of weight loss were given supplements that ensured they received sufficient amounts to eat. We observed people being offered drinks throughout the day and staff helped people with their drinks.

We saw that people had access to visiting health professionals and relatives we spoke with told us that people's health needs were met. One relative told us, "If [person who uses the service] is unwell then the doctor is called and I am always informed when they have been unwell". We saw that people had received visits from various professionals which included the GP, a tissue viability nurse, a chiropodist, community psychiatric nurse and a physiotherapist.

Good

Is the service caring?

Our findings

People we spoke with told us that staff were caring and compassionate. One person said, “Staff treat me very well”. One relative said “Carers are brilliant. They are really good” and “The staff are caring”. We saw that staff took time to speak to people in a caring way throughout the day. We saw one person was upset and anxious and staff sat with this person and provided comfort by holding their hand and giving them reassurance.

People told us that they felt their dignity was respected. One person said, “The staff are very respectful” We saw staff speaking with people in a respectful manner. For example; staff sat down with people and talked to people face to face. Staff were respectful to people’s privacy and were discreet talking quietly when asking people if they needed support with personal care. Staff we spoke with told us how they protected and maintained people’s dignity. One staff member said, “It is really important to make sure people feel comfortable. I give reassurances constantly and always ask if people are comfortable with what I am doing”. Another member of staff said, “I make sure people are covered up. I ask people if they want to be left when using the toilet and I stand outside. I knock on doors and use people’s preferred names”.

People told us that they were able to choose how they received their care. One person told us that they liked to choose their own clothes and the staff listened to their choices. One person said, “I’m late to bed and a late riser. I always have been, it’s great as staff ask me what time I want to get up and then come and wake me at the time I’ve asked for”. We saw that staff gave people choices and respected their wishes for example; one person was asked if they wanted to join in with an activity and they replied ‘no’, the staff member asked again and the answer was still no. The staff member respected their wishes and also gave them the opportunity to join in later if they changed their mind.

Good

Is the service responsive?

Our findings

People told us they were encouraged to be involved in hobbies and interests that were important to them. We saw that people participated in celebrations of different cultures and religions. For example; Diwali and St. Patricks Day. The provider employed wellbeing advisors at the service who provided a range of activities both individually or in small groups. We spoke with the wellbeing advisors who told us that they ensured that activities took account of people's preferences. This meant they could organise appropriate hobbies and interests that people would enjoy.

People and relatives we spoke with told us that they were involved in the planning of their care and staff carried out support in a way that met their needs. One relative told us, "The carers know him and what he likes". The records showed that people's personal preferences were documented in their care plans. We saw that people were supported with their cultural needs and the provider ensured that certain foods were available that met people's cultural and religious needs. Staff we spoke with knew people's preferences well and we observed staff supporting people in line with their likes and dislikes as documented in their care records. For example; one person told us that they liked to go to their bedroom after lunch and we saw that this was documented and this person was supported to their room as requested..

We saw that the provider responded to changes in people's needs. For example, we saw that staff had informed the manager when there had been deterioration in a person's physical and emotional wellbeing. The records for this person showed that action had been taken to review their plans of care in response to their changing needs. This ensured that people received care and treatment that met their individual and changing needs.

People we spoke with told us that they would speak to the staff if they had any concerns about the quality of care provided. All the relatives we spoke with told us that they would not hesitate to raise concerns about their relatives' care. One relative told us that they had raised a concern with the registered manager and they were happy with how their complaint was dealt with. The provider had a complaints policy in place and we saw that complaints had been investigated by the registered manager. The registered manager had responded to the complainant informing them of the outcome and actions taken as a result of the complaint.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we asked the provider to make improvements to the way they assessed and monitored the quality of the service. This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider sent us an action plan outlining how they would make these improvements. At this inspection we found that further improvements were required.

We saw that the manager had made improvements to the systems in place to check the quality of the service provided. There were various audits that were carried out on a monthly basis such as care record audits, infection control audits and checks on the health and safety of the service. We viewed records that showed the action that had been taken by the registered manager when problems had been identified. Further improvements were needed to ensure these checks were effective as some concerns we identified had not been identified by the registered manager. For example, we found that some pressure relieving cushions were not appropriate to use and found that the provider did not have a system in place to check that the cushions were in good condition. The care manager told us, "This is really useful as we hadn't been doing this, so we will take this on board straight away". We also saw that there was a system in place to check that the fridge temperature where medicines were stored was at the correct level. We found that there were some gaps in these records, which meant people could not be assured that their temperature sensitive medicines were stored safely.

We found that there had been some improvements made to the way incidents were monitored, but further improvements were required to ensure action could be taken to reduce the risks of further incidents from occurring. For example, the registered manager had started to monitor the use of restraint but this monitoring did not analyse details of the level of restraint carried out and if any trends had been identified such as; certain times of day, certain areas or staff on duty. We did not see that staff had received support or a briefing after incidents where restraint was used. The care manager told us that they were in the process of developing a system that ensured staff were supported and given an opportunity to discuss any concerns after restraint had been used.

People and relatives had been involved in giving feedback about the service. We were told that there had been improvements made to the home recently and people told us that they felt listened to and their concerns were acted on. We saw that questionnaires had been analysed and actions had been completed to improve care. For example, The care manager told us that coffee meetings for relatives had been recently implemented so that any concerns can be discussed and it provided a support network for relatives.

People we spoke with told us that the registered manager was very approachable and they saw them regularly. Staff we spoke with told us they could approach the registered manager with any problems they had and the manager had always acted on concerns raised to make improvements within the service. Staff we spoke with told us that they felt supported and they attended monthly meetings where they raised any concerns. Staff we spoke with understood the values of the service and told us improvements had been made at the service. One member of staff said, "It is important to me to ensure that people feel safe, happy and comfortable. I like to see people smiling".

We saw evidence that weekly management meetings were held and the management team were developing different ways of managing the service. The management team explained that they had discussed the feedback and outcome of the last inspection and looked at ways forward to develop the service. We were told and saw evidence of new projects to be implemented at the service. For example, the registered manager was going to start a relative's awareness programme, with the aim of helping relatives understand dementia and its effects on people.

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 did not take formal enforcement action at this stage. 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 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person must make suitable arrangements to ensure that service users are safeguarded against the risk of abuse by means of taking reasonable steps to identify the possibility of abuse and prevent it before it occurs.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.