Methodist Homes

Queensway House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on the 2 February 2016 and was unannounced. At our last inspection in August 2013 there were no issues identified in the areas we inspected.

The service offers accommodation and nursing care for up to 22 people with enduing mental health needs. At the time of the inspection 22 people were using the service. Not everyone was able to speak to us due to their communication difficulties.

There was a registered manager in post. 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.

There were insufficient staff to keep people safe and to meet their individual needs. The registered manager was actively recruiting new staff using safe recruitment procedures.

People's medicines were not always managed safely. The provider could not be sure that people had their prescribed medicines at the times they needed them.

Risks to people were assessed and reviewed. However accurate records of all incidents were not kept to ensure that care being delivered was safe and appropriate.

People were not always treated with dignity and respect and their independence was not always promoted.

Systems the provider had in place to monitor the quality of the service were not always effective.

The provider followed the principles of the Mental Capacity Act 2005 and ensured that people were consenting to or being supported to consent to their care, treatment and support.

When people lacked capacity to make decisions, they were supported to make decisions in their best interests with support from their representatives.

People's health care needs were met and they had sufficient to eat and drink to maintain a healthy lifestyle.

People received care that was personalised and reflected their individual preferences. When people's needs changed, staff responded and reviewed the way they delivered care to them.

People's religious needs were met.

The provider had a complaints procedure and people and their representatives were encouraged to have a

say in the way in which the service was run.

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 consistently safe. There were insufficient staff to meet people's individual needs. Medication was not always managed safely. Risks to people were not always recorded and reported.
People were safeguarded from abuse.

Is the service effective?

Good

The service was effective. Staff felt supported and received training to fulfil their role. The provider was following the guidance of the MCA and supporting people to consent to their care. People's nutritional needs were being met and people received support from a range of health professionals when required.

Is the service caring?

Requires Improvement

The service was not consistently caring. People were not always treated with dignity and respect. Opportunities for people to be independent were limited due to the lack of available staff. People's privacy was respected.

Is the service responsive?

Good

The service was responsive. People received care that met their individual needs and people's care needs were regularly reviewed. People were encouraged to be involved in activities and hobbies of their choice. The provider had a complaints procedure and people's representatives knew how to use it.

Is the service well-led?

Requires Improvement

The service was not consistently well led. The quality monitoring systems the provider had in place were not always effective. Staff performance was not always managed. Staff felt supported to fulfil their role.

Queensway House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, 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 the 2 February 2016 and was undertaken by one inspector and an expert by experience. An expert by experience is a person who has
personal experience of using or caring for someone who uses this type of care service.

We spoke with three people who used the service, three care staff, one nurse, the deputy manager and registered manager.

We observed care and support in communal areas and also looked around the service.

We viewed four records about people's care and records that showed how the home was managed, including quality monitoring systems the provider had in place. We looked at how medication was managed and medication administration records for four people.

Requires Improvement

Is the service safe?

Our findings

We observed there were times when there were not enough staff available to meet people's needs safely. One person who was sitting in the lounge required the bathroom and they were unable to call for assistance. We raised staff awareness to this as there were no staff present in the lounge area. We saw that two staff came to support the person and a member of staff said to the rest of the people who were sat in the lounge: "We are just going to the bathroom if anyone wants anything come and get us". It was unclear who would have been able to understand and follow this instruction due to the needs of the people using the service. At lunchtime we saw that the dining room was busy and staff were having difficulty in responding and meeting everyone's needs. For example, one person had been brought to the table first, and was sitting waiting for a long period of time before being presented with their meal as staff were busy elsewhere. They began to get anxious and banged the table, which disrupted other people's dining experience. Another person was being supported to eat by a member of staff who had to leave them to attend to this person as the other staff were supporting elsewhere. This meant that this person was left to wait to be supported to eat mid way through their meal.

We discussed our observations with the registered manager who informed us that they had completed a dependency tool and recognised there were insufficient staff. They were in the process of recruiting new staff and were increasing the staffing hours throughout the day and night. However the use of agency staff had not been considered to increase the staffing levels until the new staff had been recruited.

We saw new staff were checked for their suitability to work and they had received a meaningful induction prior to starting work at the service. The files provided evidence that pre employment checks had been made. These checks included application forms detailing previous employment, identification and health declarations, references and satisfactory disclosure and barring service check (DBS). The DBS is a national agency that keeps records of criminal convictions. This meant that an effective recruitment process was in place to help keep people safe.

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Registered nurses were responsible for the administration of medication and they received annual competency checks from their manager. However, care staff administered topical creams and food supplements and the nurses were signing to say it had been given. The nurses were not present at the times the creams or supplements were given, so could not be sure that people had received these as prescribed. We discussed this with registered manager who informed us that they would put in place a system to ensure the staff responsible for administering the creams and supplements signed to say they had been given. Medication was kept in a locked cabinet in a clinical room. People had clear and comprehensive medication care plans which informed staff how people liked to have their medication dependent on their personal preferences. When people were prescribed as required medication (PRN) there were protocols which detailed the signs and symptoms people may exhibit at the times they may require it. This supported the staff to recognise people's needs for their medication when they were unable to verbally communicate.

Some people's behaviour at times put themselves and others at risk of harm. We saw there were clear and comprehensive plans as to how to support the person at these times to keep them safe. Some people

required low level holding (restraint) when they became anxious. Staff were trained in how to complete this safely. Other risks to people were assessed and regularly reviewed. When incidents and accidents occurred risk assessments were updated and plans put in place to minimise the risk of the incident occurring again. For example some people had sensor mats to alert staff to their movements by their beds when there had been incidents of them being found fallen on the floor. Another person had a surgical device fitted which maintained their wellbeing. We saw there were clear plans as to how to manage the device safely and regular checks of the device were undertaken by trained staff.

People who used the service were protected from abuse and the risk of abuse as staff we spoke with knew what constituted abuse and what to do if they suspected a person had been abused. One staff member told us: "I would report anything not right to the nurse or manager if I was concerned, the residents aren't here to be abused". The safeguarding procedure was clearly visible for staff and visitors to follow if necessary. The registered manager had raised safeguarding referrals with the local authority in the past.

Good

Is the service effective?

Our findings

Staff told us they felt supported to fulfil their role. One staff member said: "The managers are lovely". Staff had received training on specific people's needs. For example, one person had a specific medical device which some staff had been trained to maintain. A staff member told us: "I'm not trained to change the device so I wouldn't touch it". This meant that only competent staff were fulfilling the tasks allocated to them. Staff had regular support and supervision with a named nurse every four to six weeks where they were able to discuss their own personal development. The provider was also supporting the nurses with their revalidation. Revalidation allows nurses to demonstrate that they practice safely and effectively and requires the nurse to spend time completing assessments and collecting evidence to support the revalidation.

We saw that people who used the service were consenting to their care as the provider was following the guidance of the Mental Capacity Act 2005 (MCA). The 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's mental capacity had been assessed and we saw if people required support to make decisions this was done with them and their legal representatives. Decisions were being made in people's 'best interests' following the guidance of the MCA.

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 are called the Deprivation of Liberty Safeguards (DoLS). We found that people were being lawfully restricted of their liberty because DoLS referrals had been made. The registered manager was able to show how they were restricting people in the least restrictive way whilst they waited for the DoLS referrals to be authorised. This meant the provider was following the principles of the MCA and DoLS procedures and ensuring that people were consenting to their care.

People's nutritional needs were met. We saw people had access to a choice of food and drink. People had two choices at meal times. People's food and fluid intake was monitored and action was taken if there were any concerns or noted weight loss. Two people required a soft and pureed diet to prevent choking. We saw one person who had been on a soft diet was referred back to the speech and language therapist as their needs had changed. This person now required a pureed diet. This meant that staff had recognised and responded to this person's change in nutritional needs.

People received support from a range of health care professionals when they needed it. People were supported with their mental health by a consultant psychiatrist and their GP reviewed them annually or when required. We saw one person was diagnosed with epilepsy. They had a clear and comprehensive care plan which informed staff how to care for this person when they were experiencing a seizure. Records confirmed that staff had followed the action plan and had called the paramedics following the person being unwell for a period of five minutes.

Requires Improvement

Is the service caring?

Our findings

One person told us that staff were kind to them and from our observations most interactions between staff and people were respectful. However we observed that not all staff treated people with dignity and respect at all times. We observed that one person was sitting on the window sill in the lounge and a member of staff told them to 'get off and sit in a chair'. No explanation was given as to why the person was being requested to move and there was no added please or thank you as acknowledgment of the fact that the person complied and moved. Another person required a health intervention and a member of staff went to support them. The person became unsettled about having to leave the dining room and the staff member was heard to say: "Come on you've got to have it done", in an abrupt manner. Another person was requesting to go to their room, we heard the staff member say: "Quickly then, I will let you in your room, come on". Again this was said in an abrupt manner. We reported our concerns to the registered manager who assured us they would address this and refresh the values training staff had received.

People had their own rooms and some people had their own flats where they were able to spend time alone. We saw staff knocked on doors before entering and one person who used the service told us: "Most staff knock before they enter but not all". This meant that some staff were not respecting people's right to their privacy.

Some people were independent and came and went as they pleased. Other people required more support and guidance to participate in independent living skills. We saw that the flat areas were not utilised to the best of their advantage and some people who could have been supported to prepare simple snacks themselves were brought their lunch on a tray or supported to the dining room. We discussed this with the registered manager who agreed that more could be done to promote people's independence and that the increase in staffing numbers would help this.

Regular meetings for people who used the service took place. People who were able to had as say in how the service was run. Some people were unable to communicate and say what they thought of the service they received, we saw that everyone had a named nurse and keyworker who worked closely with the person and advocated on their behalf.

Good

Is the service responsive?

Our findings

Prior to admission into the service people's needs were assessed to ensure the service could meet their needs. We saw when people's needs changed the staff responded and ensured that people were supported by the appropriate agency to have their care needs met. Regular reviews were held with people and their representatives to ensure that care being delivered was relevant to the persons current care needs.

People's care plans were detailed and comprehensive and gave staff all the information they required to care for people responsively. All the staff we spoke to knew people well and knew their likes, dislikes and preferences.

Some people's mental health fluctuated due to their diagnosis. For example people diagnosed with 'Bi Polar' disorder experience periods of 'high' and low' moods. We saw that staff knew how to respond to support people when they experienced a change in their mood. One person often threw their food and drink when they were experiencing a low mood, so staff put in place the use of plastic crockery at these times. However when the person was well they used porcelain crockery as staff recognised it was safe to do so. This meant that the staff were responding to this person's changing needs.

People were supported to engage in planned activities. The provider employed an activity coordinator two days a week and a reflexologist. We observed a musical therapy session take place and those who wanted to attended and sang along. The service kept chickens within a secure garden area and pet dogs visited which some people really enjoyed. We were told that people were able to access the local community at times supported by staff and trips to Trentham gardens had taken place.

The provider employed a chaplain who arranged religious services for anyone who had a religious need. The chaplain arranged for people to receive input from which ever denomination the person believed in and not just services and support for people of the Methodist faith. This showed that the provider was responding to people's individual religious preferences.

The provider had a complaints procedure and we saw that people's representatives knew how to use it. There had been one formal complaint which had been dealt with at stage one of the procedure. Relatives of people who used the service were invited to attend a monthly meeting to discuss any concerns they may have. We saw minutes of these and saw that when people had made suggestions they had been acted upon.

Requires Improvement

Is the service well-led?

Our findings

The registered manager told us that they completed a monthly dependency tool and this was how they had identified that the staffing levels needed to be increased. They had begun to actively recruit so that the levels would be sufficient to meet people's needs, however the use of agency staff had not been considered to ensure that people received care that was safe and met their needs during the recruitment process.

We saw that some records of when people had been restrained were available, but staff we spoke with were unsure of what to record and who was responsible. One staff member told us: "We've had to hold [person's name] this morning and we do this quite often." We could find no records of this person having being held. The staff member told us they thought it was the nurse's role to record the incidents. Records of restraint we looked at lacked detail of who had been involved in the incident and for how long it had taken place. An expectations report was submitted to the provider on a monthly basis. The report documented all areas of concern and any action taken. For example, the number of falls, any pressure area and any sudden weight loss, however as the use of restraint was not always recorded appropriately this meant that the registered manager and provider could not be sure that it was proportionate and safe.

The registered manager had sent us some (CQC) notifications as they are required to, however they were unaware of all the notifications they were required to send us and assured us that all the relevant notifications would be sent in the future.

Systems were in place to monitor staff performance, through regular support and a comprehensive training schedule, however we observed that some staff required additional support and training in treating people with dignity. Regular team meetings took place and staff had individual support and supervision with a nurse or manager. Nurses were being supported to complete their revalidation to ensure they remained competent in their role.

Staff told us that they felt supported and the registered manager was approachable. All the staff we spoke with told us that they enjoyed working at 'Queensway' and that they worked well as a team. One staff member told us: "If we have had a stressful incident and need time out, the nurse or management will tell you to go and have five minutes".

Annual quality surveys were sent to everyone who used the service and their representatives. The registered manager told us that they arranged for someone impartial to support people who needed help in completing the survey so that a true reflection of their views would be sourced. Information from the survey was analysed and an action plan drawn up with any identified improvements.

The provider had systems in place to monitor the quality of the service. An annual standard assessment of the service took place. We saw the last report and saw that there was a clear timeline for improvement if any issues had been identified.