Methodist Homes

Claybourne

Inspection report

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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 21 December 2016 and was unannounced. Claybourne is a care service for people who have a variety of support needs, such as older people and people with dementia. There were 44 people receiving a service at the time of the inspection.

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

People told us they felt safe and we saw risk assessments and plans had been put in place to keep people safe. When an incident had occurred, action had been taken to protect the person and to reduce the likelihood of another incident occurring. Appropriate moving and handling techniques were being used to help people mobilise.

Medicines were stored and managed safely. There was clear guidance available for staff to follow and checks were made to ensure people were receiving their medicine as prescribed. PRN protocols were also in place for people that needed their medicine 'as and when required'.

There were appropriate amounts of staff to care for people and people did not have to wait for support. Staff were aware of their responsibilities to safeguard people from abuse and referrals had been made if there had been an incident.

Safe recruitment practices were in place and staff had appropriate checks prior to starting work to ensure they were suitable to work with people who use the service.

Checks were made on the building itself to ensure it remained safe for people to live there.

The principles of the Mental Capacity Act 2005 were being followed. Mental capacity assessments were being carried out and when people did not have capacity decisions were made and recorded in their best interest. Evidence had been sought to verify that representatives had Lasting Power of Attorney.

Appropriate Deprivation of Liberty Safeguarding referrals had been made to ensure people were not being unlawfully deprived.

Staff had sufficient training to support people effectively and staff were able to refresh this training when required.

People had access to other health professionals in order to maintain their health and wellbeing.

People were supported to have food and drinks of their choice that were appropriate for their needs.

People felt staff were caring and that they were treated with dignity and respect, and people were encouraged to maintain as much independence as possible. People were offered choices and these choices were respected. Visitors were able to visit at a time convenient for them and people could decorate their rooms so they could have personalised space.

Care plans contained good personal detail so that staff could get to know the people they supported and people had their preferences documented and catered for where possible. People and family were involved in reviews and when people's needs had changed plans had been updated.

People were encouraged to partake in activities that interested them and staff were able to support people with this. People's spiritual needs were taken into consideration and people were able to access spiritual support.

People and relatives were encouraged to provide feedback or complain if they needed to and it was recorded that this feedback was acted upon. We saw that complaints were recorded, investigated and responded to.

Effective quality monitoring systems were in place. Care files and associated documentation was audited and action was taken when omissions had been identified.

Staff all felt they could approach the registered manager and management team. There was an open door policy and staff all said they could raise things if necessary.

The registered manager felt supported by the provider and had submitted notifications about the service, which they are required to do by law.

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.

Risk assessments were detailed and action had been taken if an accident or incident occurred.

Medicines were managed safely.

People were protected by staff that knew how to report abuse.

Safe recruitment practices were followed to ensure appropriate staff were working with people who used the service.

Is the service effective?

Good

The service was effective.

The principles of the Mental Capacity Act 2005 were being followed. Capacity assessments were carried out and Lasting Power of Attorney's were checked.

Staff had been trained sufficiently to support people effectively.

People had adequate amounts of food and their preferences and needs were catered for.

People accessed health care services and advice from professionals was followed.

Is the service caring?

Good

The service was caring.

Privacy and dignity was respected.

People found the staff kind and caring.

Staff offered choices and encouraged people to be independent.

Is the service responsive?

Good

The service was responsive.

People had personalised care plans which included life histories and their preferences were catered for.

People were asked for their opinion about their care.

The service recorded and responded to complaints.

Is the service well-led?

Good

The service was well-led.

Quality monitoring systems were in place and action taken when issues identified.

People and relatives knew who the registered manager was and staff were supported by the registered manager.

The registered manager was supported in their role by the provider.

Claybourne

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.

The inspection took place on 21 December 2016. The inspection was unannounced and was carried out by two inspectors. The service had not been previously inspected under our new way of inspecting services and did not have a previous rating.

We looked at information we held about the service including statutory notifications that we had received from the provider. Statutory notifications include information about important events, which the provider is required to send us by law. We also asked commissioners and Healthwatch if they had any information they wanted to share with us about the service. Healthwatch is an organisation that gathers information from people and relatives who use services and provides feedback to commissioners and regulators (like the CQC) about those services.

We spoke with two people who use the service, seven relatives, five members of staff that supported people and the registered manager. We also spoke to four health professionals. We reviewed the care plans and other care records for seven people who use the service. We also looked at management records such as quality audits. We looked at recruitment files and training records for four members of staff.

Good

Is the service safe?

Our findings

People told us they felt safe. One person we spoke with said, "I feel safe, I just like living here." A relative with spoke with told us, "I have no concerns" and went on to say, "I don't feel the need to check things when I visit." Another relative we spoke with said, "My relative is always safe, they know when they are up as there are alarms to let the staff know."

Risk assessments were in place and we observed staff following these. Some people needed equipment to help keep them safe. For example, some people needed a padded mat by their bed in case they fell out of bed or a hoist to help them move. These were detailed in their risk assessments and photos were included so staff knew what the equipment looked like and how it should be arranged. If the equipment had a particular setting it needed to be on for the person, this was also recorded in their risk assessment so staff knew what was safe for the person. Some people needed support to help maintain their skin integrity and we saw plans in place for staff to follow which included the details of the equipment, how often each person needed repositioning and any other interventions people needed. Regular checks were made about people's skin to check it had not deteriorated and that the support was appropriate. This meant people were being protected from risk and being supported to maintain their safety.

If people had fallen, we saw that action had been taken to ensure the person was safe and reduce the likelihood of another fall occurring. A relative we spoke with said, "My relative fell out of bed and they got them a crash mat straight away." One person had fallen from a chair and a plan was put in place to support the person, such as staff checking on them. Another person had fallen and the service took action to reduce this happening again and to find out why the person fell. Hearing and sight checks were arranged, equipment was checked and checks were made to see whether they had been wearing the correct footwear. Action taken had been documented and trends were identified in order to reduce the likelihood of them occurring again. It was noticed that some people had lost weight and action had been taken to try and determine why and to try to prevent people from losing more weight. This meant that people were protected when incidents had occurred and the likelihood of incidents happening again was reduced.

People were supported to mobilise in a safe way. One relative we spoke with said, "They're very good, they help move my relative safely." We observed staff using correct moving and handling techniques. For example, one person was supported from a sitting to a standing position, staff were encouraging them and no inappropriate techniques were used. We also observed a person being hoisted and staff used the correct techniques. People sitting in a wheelchair had their feet on foot plates so they would not be injured whilst moving.

Medicines were managed safely. There was clear guidance for staff to follow on the Medication Administration Records (MARs) alerting staff to whether people had an allergy or if medicine had to be given in a certain way. The recording of the administering of medicines was clear and accurate and stock counts of medicines were documented so it was clear to see whether any errors had been made. If an error had been made, appropriate action had been taken to protect the person and prevent a reoccurrence. If people

had topical medicines that were applied to their skin, there was clear guidance for the staff about where and when to apply it which included body maps and written instructions. Staff were also consistently recording when they had applied topical medicine in line with the prescription. Some people had medicine that was administered 'when required', this is called PRN medicine. There were PRN protocols in place to help staff determine when people did or did not need their medicine. Medicines were also stored safely in line with guidance. This meant people were kept safe as they were receiving their medicine as prescribed and it was stored correctly.

People and staff told us there was enough staff. A relative we spoke with said, "There is a good balance of staff, I don't think the safety of my relative is neglected." One member of staff told us, "I feel there is enough staff." Another member of staff said, "Yes there's enough staff, it's really busy but there are enough. Afternoons are quieter." We observed that people did not have to wait for support and staff were able to spend meaningful time with individuals. This meant people were having their health, safety and well-being maintained by appropriate amounts of staff.

People were protected against the risks of potential abuse. Staff we spoke with were able to tell us about the different types of abuse and the action they would take if they suspected someone was being abused. Staff told us they had received training to extend their knowledge about safeguarding. If an allegation had been made or an incident had occurred it had been referred to the local safeguarding authority. Staff also told us they knew about the whistleblowing policy and knew they could report concerns if they felt something was wrong. This meant people were protected as people were supported by staff who knew and understood their responsibilities regarding safeguarding people.

The service followed safe recruitment practices. Staff files we viewed included application forms, records of interview and appropriate references. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with people who used the service.

We observed that infection control measured were in place and used. For example we saw a member of staff pick up a person's used tissue, throw it away and they immediately washed their hands. Staff were asked to sign an agreement that they would inform the service if they became unwell, in order to try and prevent any illness passing onto the people living in the service and other staff. Staff also received hand wash training in order to ensure infection control was maximised. There were also checks in place in relation to fire safety, water hygiene and equipment checks. There was also a risk assessment and plans in place in the event of an emergency such as a fire, and people had personal plans to help them evacuate the building if it was necessary.

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 in their best interests and as least restrictive as possible. A person who has Lasting Power Of Attorney (LPOA) for health and welfare has the legal right to make decisions and sign agreement on behalf of someone who has lost their capacity to make their own decisions.

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

We checked whether the service was working within the principles of the MCA. Staff were able to tell us about the MCA, and we saw that staff supported people to make their own choices and staff explained to us how they helped people. We saw that the service had evidence when relatives or representatives had LPOA and the appropriate people were contributing to making decisions in people's best interest about people's care, if people were unable to. Mental capacity assessments were carried out which clearly recorded how it had been determined if people no longer had capacity and plans were in place to support people. DoLS referrals had been made to ensure that any restrictions on people had been considered. This meant people were being protected and the principles of the MCA were being followed.

Staff had training to ensure they were effective within their role. People and relatives told us they felt the staff were well trained. Staff told us and we saw records to confirm that they undertook an induction when they first started working in the service. One member of staff told us, "The induction prepared me, it was in depth" and they went on to say, "The training has been changed so it is face to face and online. I feel I learn more by doing." Staff were also supported to refresh their training, and told us they received regular supervisions and support

People were supported to maintain their nutritional intake. People told us they were offered choices. One person said, "I get to choose. The food is nice" and they went on to say, "I've had a big breakfast, so I only want a sandwich for lunch." We observed staff offering choices at lunch time and staff showed people the different foods available so they could make a more informed choice. If people did not want the main menu options available, they were offered alternatives. We also saw staff encouraging people to eat and drink more and people were able to ask for drinks when they wanted one, both hot and cold. This meant people were able to have food and drinks of their choice which helped support their health and well-being.

People had access to health professionals. One relative we spoke with told us, "My relative became unwell, they called the GP who treated them and the staff monitored them, it was dealt with." We saw documented that referrals had been made such as to the GP, District Nurses, optician, hearing specialist and podiatrist. If

people were having difficulty swallowing, the service had made referrals to a Speech and Language Therapist (SaLT) and we saw the guidance was recorded and being followed by staff. We also saw that when people had fallen, referrals were made to the external Falls Prevention Team so people were supported to avoid falling again. One professional we spoke with said, "The staff are very receptive to information and they are able to give us information about people" and they went on to say, "Staff act on guidance we give." Another professional we spoke with said, "They are approachable, polite and at all times professional." This meant people were able to maintain their health as they were able to consult with other health professionals and guidance was being followed.

Good

Is the service caring?

Our findings

People and relatives told us they felt the service was caring. One person we spoke with said, "Yes, they are very respectful and caring." A relative we spoke with said, "The staff are so nice. They're brilliant with my relative and so patient." Another relative we spoke with said, "The staff are loving towards my relative, they're lovely to them." Another relative told us, "The staff are lovely." We saw that when people asked staff for things, that staff responded straight away. For example, a person told a member of staff that they had itchy eyes, the member of staff supported the person to their room and gave them their eye drops and they explained what they were doing with the medicine to the person. The person responded saying, "Thank you very much, my eyes feel so much better." One person commented that they did not know where their shawl was, and the staff member went and got it for them to keep them warm. We also saw staff getting drinks for people when required. Some people were not well with flu. A staff member went to buy some softer tissues for people so their noses would not get sore. We observed staff checking that people were comfortable when being supported. This meant people were supported by staff who were caring and catered for their needs.

People were treated with dignity and respect and were able to have privacy. One relative we spoke with said, "Staff totally treat my relative with dignity." We saw examples of health professionals visiting, such as a GP or a podiatrist, and people were encouraged and supported to go into a private area, such as their bedroom, so they could have a consultation in private. One professional we spoke with said, "staff I met when visiting the home all appeared to work to high standards and strove to maintain the residents' privacy and dignity at all times." At meal times, people were offered material napkins to wear to protect their clothing. People who chose to eat their meals in their room had it brought to them on a tray which was laid out in the same way as the tables in the main dining area, so people in their rooms would have the same dining experience as those who chose to eat in a communal area. We saw examples of staff kneeling down so they were at the same level as the people they were speaking to, so they could have a conversation and people could see the staff member clearly. Staff were observed being patient with people and did not rush them. We also saw staff knocking on doors before entering. Staff were also able to tell us about how they supported people to retain their dignity, such as ensuring people were covered whilst supporting them with personal care and knocking on doors prior to entering a room.

People were offered choices and encouraged to retain their independence .We observed one person asked for a drink and we saw the staff member kindly encourage them to get it themselves. We also saw staff encouraged people to try and eat their meals independently and offered support when people needed extra help. We also saw staff support a person to wipe up after dishes had been washed. Another person was also able to make themselves a drink, wash up and wipe up after themselves so they were treating the service as their home.

People were able to decorate their rooms how they chose and visitors could visit at a time that suited them. Visitors were acknowledged by staff and staff knew their names and offered them drinks. This meant people could maintain personal relationships at a time convenient to them and visitors had built up positive

relationships with staff who knew them.

Good

Is the service responsive?

Our findings

We saw that staff knew people well and staff were able to tell us how they supported people, which matched what was documented in people's care plans and we observed staff following the plans. We observed staff talking to people, and staff knew personal details so they were able to have a conversation with people about it, such as their family. One relative we spoke with said, "If my relative doesn't want to do something they don't force them" and they went on to say "I like the staff approach. They don't give up and my relative responds" and, "They tailor the care to my relative." Plans were personalised and contained good detail on how people liked to be supported and also details of their life history. We saw that assessments had been made prior to people coming to live in the service to ensure the service could meet their needs. A relative we spoke with told us, "I was involved in the writing of the care plan." Another relative said, "I felt included about decisions about my relative's care." We saw that if a person's needs had changed this had been discussed in staff meetings and this matched the care we observed being delivered. Care plans were reviewed regularly and had been updated when required, and we saw that family members were also included in these reviews. Additional plans were also put in place, sometimes temporarily, if a person's needs had changed for a short period of time. For example, one person had changing needs regarding how they were supported to eat and a temporary plan was put in place until the SALT professional could visit. Once the SALT professional had visited, the care plan had been updated to reflect their changed needs. This meant there were personalised plans available for staff and staff were following these plans to support people safety, health and well-being.

We observed an incident between two people in which they became aggressive with each other. Staff immediately intervened to take preventative action to stop the situation escalating and to distract the people involved. Staff explained to each person what they were doing and the situation was resolved quickly. We also saw that plans were in place for staff to follow for people who experienced periods of agitation, with clear guidance on what helped the person become less agitated. This meant people were kept safe by staff who knew how to support people to diffuse a situation, and knew how to support people when they were experiencing periods of agitation.

People were supported to partake in hobbies and interests with the help of an activities coordinator, and a music therapist visited weekly. We saw plans in place to support people to partake in activities and encouraging hobbies and interests was included in care plans to support people's mental health. We observed staff spending time with people, for example some people sat around a table and were colouring in whilst other people were sitting alone colouring in. We also saw photographs of people participating in activities and it was recorded in people's notes when they had been out in the community or when an event had taken place in the service and they had attended. For example, one person was supported to access the local market and listen to a visiting gospel choir. A relative we spoke with said, "If my relative wants to stay in bed, the staff don't just leave them there, they go into my relative's room to tempt them to get up." One person we spoke with said, "I don't like to go out. I prefer watching TV." There was also a cat at the service which people enjoyed spending time with and we saw people stroking it. This meant people were able to choose how they spent their time.

Care plans were in place to support people with their spiritual needs and there was a visiting chaplain who supported people. We saw the chaplain on the day of our inspection and they spent time talking with people on an individual basis. The care plans were reviewed monthly where people were asked if their spiritual support needs had changed.

There was a complaints policy in place and relatives confirmed they knew how to complain. One relative we spoke with said, "I've complained before, staff were able to give advice about what I had to do." We saw that complaints were recorded and a written response was sent to the complainant which they were satisfied with. Compliments had also been submitted to the service and recorded. This meant the service dealt with complaints and would act upon feedback.

Good

Is the service well-led?

Our findings

There were effective quality assurance systems in place, with regular reviews. We saw that when people had fallen the registered manager had looked for any patterns to see if future falls could be prevented. When no pattern could be found, they asked the provider to do an audit and also the external Falls Prevention Team to look at the information to ensure nothing had been missed. Care plan audits had also been carried out. We saw that when a person's care file had been reviewed, an action plan had been put in place to rectify any omissions and we saw that the omissions had been remedied. There were monthly audits carried out to check if people had lost weight or if anyone had developed a pressure sore, for example. Medicines were also audited, with MAR charts and stock levels being checked. The manager also made visits to the service during the night to check the competency of the night staff. This meant that the checks were being made to ensure systems in place were effective and that people were being appropriately supported.

People, relatives and staff were asked for their opinion about the care. There had been both a staff survey and resident survey, both of which had positive overall results. We saw recorded that there were regular meetings and questionnaires about activities and the food and people were asked for their feedback. One person said in a questionnaire, "I like going out and everything that we do." The registered manager knew people well. We also saw that relative's meetings had taken place. Some feedback had been received about the entrance doors and action had been taken to make changes to these to improve them. Other feedback from relatives had suggested displaying photographs of staff and re-decorating one of the communal rooms, whilst although they had not yet been completed, action had been taken to start these processes. This meant that feedback was encouraged and the service used this feedback to make improvements.

People and relatives told us they knew who the registered manager was and felt able to speak to them. One person we spoke with said, "I can chat to the registered manager if I need to." One relative we spoke with said, "The registered manager know what's going on and we always see them when we visit. They are approachable and have given us lots of support." The relative also said, "I can approach the registered manager or the staff about anything." A relative we spoke with said, "I can speak to the registered manager, the deputy and other staff, they are approachable." This meant people and relatives felt able to speak to the registered manager and the staff team if they needed to.

Staff also felt supported by the registered manager. One member of staff said, "The registered manager has an open door policy, I can always go to them" and went on to say, "The registered manager is supportive." Another member of staff told us, "The registered manager always has their door open if you've got a problem" and went on to say, "The registered manager is very approachable, they help me." Staff also felt supported by other staff. One member of staff told us, "Morale is high. The staff are all focussed." There were regular staff meetings held; we saw that staff competency was discussed as well as the company newsletter. We also saw that during a meeting staff had been encouraged during a meeting to sit and eat with people to encourage people to eat and we saw this happening. This meant that staff felt supported to effectively care for people.

The registered manager felt supported by the provider. They attended network meetings with other services owned by the same provider and had support from an area manager, quality manager and HR support. The registered manager had also notified CQC about significant events that they are required to notify us of by law.