Methodist Homes

Elmside

Inspection report

Elmside Walk
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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced inspection of this service on 13 July 2017.

The service provides accommodation and personal care for up to 66 adults, some of whom may be living with dementia.

The service did not have 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 the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were systems in place to safeguard people from harm and staff understood when and how to report any concerns they had. There were risk assessments in place that gave guidance to staff on how risks to people could be minimised, although these had not all been kept up to date. There were insufficient skilled staff to provide safe care to people and the service was relying heavily on agency staff. Poor management of the staffing rota meant that adequate numbers of staff were not always on shift. The provider had effective recruitment processes in place and were in the process of recruiting to vacant posts.

Staff had been trained to meet people's individual needs. They understood their roles and responsibilities to seek people's consent prior to care being provided. In recent months, staff had not received regular supervision to support them in their role, although some staff we spoke with told us that they had just had their first supervision meeting for a long time.

People were supported to have enough to eat and drink and to maintain a diet that was suited to their needs. They were also supported to access other health and social care services when required.

People's needs had been assessed, and care plans took account of people's individual needs, preferences, and choices. However, care plans had not always been kept up to date to ensure people's care was relevant to their current needs.

There was a wide range of events and activities provided which was based on people's interests and hobbies, and people were supported to maintain links with the local community.

The provider had a formal process for handling complaints and concerns but people, relatives and staff did not feel that the acting manager was approachable and did not have confidence that their views were used to make improvements to the service

There were systems in place to support the management of the home and to monitor the quality of the service, but these were not all used effectively.
We found there were breaches of regulations of the Health and Social Care Act (Regulated Activities)

Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report

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 always safe.

Risks to people were assessed and measures were in place to minimise harm although assessments had not consistently been reviewed in recent months.

There were not enough skilled and knowledgeable staff on duty at all times.

There were safe recruitment practices in place.

People felt safe and there were systems in place to safeguard them from harm.

People's medicines were managed safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not receive regular supervision to support them in their role.

People's consent was sought before any care or treatment was provided.

People were supported by staff that had been trained to meet their individual needs.

People had enough to eat and drink.

People were supported to access other health and social care services when required.

Is the service caring?

Good

The service was caring.

People were supported by staff that were kind, caring and friendly.

Staff understood people's individual needs, respected their choices and supported their independence.

Staff respected and protected people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's needs had been assessed and care plans were in place to meet their individual needs. However, these care plans were not consistently reviewed to ensure they were in line with people's current needs.

Care provided did not always meet people's needs or preferences.

People were supported to pursue their hobbies and interests.

The provider had an effective system to handle complaints.

Is the service well-led?

Requires Improvement

The service was not well-led.

The service did not have a registered manager. An area support manager was overseeing the running of the home until a new manager was in post.

Staff understood their roles and responsibilities when supporting people in meeting their needs, but did not feel supported by the management team.

People who used the service and their relatives felt able to share their views with staff and senior staff, but most people did not know who the current manager of the service was and therefore did not feel able to speak with them.

Quality monitoring audits were carried out regularly but had failed to identify issues found at this inspection.

Elmside

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider 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 unannounced inspection took place on 13 July 2017, and it was conducted by two inspectors 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.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed information we held about the service, including the notifications they had sent us. A notification is information about important events which the provider is required to send to us.

During the inspection, we spoke with 20 people who used the service, two relatives, the acting manager, who is also the area support manager, the regional director, the hospitality manager, six care staff, a member of kitchen staff, a music therapist employed by the service, and two domestic staff. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experiences of people who could not talk with us.

We looked at the care records for seven people who used the service, the recruitment and supervision records for five staff and the training records for all the staff employed by the service. We also reviewed information on how the provider handled complaints and how they managed, assessed and monitored the quality of the service.

Requires Improvement

Is the service safe?

Our findings

All of the people we spoke with told us there were not enough skilled and knowledgeable staff on duty. One person wanted to know how the home calculated their staffing numbers and said, "We are entitled to know - it's irritating - how do they rate each unit for staff? The staffing regulations need attention." Another person told us they had to wait too long for staff to respond when they called for assistance and that agency staff did not know their needs well. They went on to say, "We were one staff member down the other day which left just three agency staff on." Staff confirmed they were short staffed and that an over reliance on agency staff contributed to their work load as they were often working with colleagues who were not familiar with people's needs or the practices of the home. One member of staff said, "It's hard when you work with an unfamiliar agency nurse. We end up leading them."

Staff told us they tried hard to ensure that issues relating to staffing had as little impact on people as possible but told us that this had been made more difficult because they were not listened to by the management team. One member of staff said, "Everyone gets care, just late. It's not good enough and safety is compromised." We observed on the day of the inspection that people were waiting for assistance to get up. As a result we noted that some people were still eating breakfast at 11.30am and lunch was served to the same people an hour later. We saw one person refused their lunch because they were not hungry having only had breakfast an hour before. Staff confirmed some people preferred to get up later in the morning, but that other people, who otherwise would get up earlier, had to wait as staff did not have time to meet their needs or preferences.

Staff told us that cover for absent colleagues and vacant posts was often not addressed in a timely manner, which sometimes meant that shifts were left short, particularly at weekends. We looked at rotas for the current month and found that there were occasions when shifts had not been fully covered. There were other occasions when the shifts were covered using agency and relief staff with little or no permanent staff presence. The rota showed that on Thursday, shifts for the coming weekend were not fully covered. We also found that some staff who were scheduled to work were not available for the shifts they had been allocated. We asked the acting manager to address this urgently and to inform us what arrangements had been made to cover these shifts. Having received no response to our request by 2pm on the Friday after the inspection, we contacted the service to establish what action had been taken. We were told they were still waiting for confirmation that these shifts were covered. This lack of forward planning left people at risk of receiving unsafe care because there were not enough staff to meet their needs safely. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and their relatives told us they felt safe at the service. One person said, "There's no cruelty here." Another person said, "I feel safe here; the staff are wonderful." Relatives we spoke with also confirmed they were confident that people were safe at the home.

The provider had an up to date safeguarding policy that gave guidance to the staff on how to identify and report concerns they might have about people's safety. Information about safeguarding was on display throughout the home and it included contact details for the relevant agencies for staff to refer to when

needed. Staff had also received training in safeguarding people. One member of staff said, "I did my safeguarding training straight away when I started. I know what to do if I suspected abuse." Staff demonstrated good understanding of different types of abuse and the signs they should look for which may indicate that someone could be at risk of possible harm. Staff were able to tell us about external organisations they could report concerns to, although not all staff were confident that concerns they raised internally to managers within the service would be taken seriously or acted upon.

There were personalised risk assessments for each person to monitor and give guidance to staff on any specific areas where people were more at risk. The risk assessments included areas associated with people being supported with their mobility, risks of developing pressure area skin damage, falling, not eating or drinking enough. This maintained a balance between minimising risks to people and promoting their independence and choice. Risk assessments on the unit occupied by people living with dementia had been reviewed and updated regularly or when people's needs had changed so that they received the care they required. However, we noted on the residential unit that some risk assessments had not been reviewed as regularly and some had not been updated to reflect a change in the person's needs.

A record of accidents and incidents was kept, with evidence that appropriate actions had been taken to reduce the risk of recurrence. There were processes in place to manage risks associated with the day to day operation of the service so that care was provided in a safe environment. There was evidence of regular checks and testing of electrical appliances, gas appliances, and fire-fighting equipment. People's care records contained personal emergency evacuation plans (PEEPS) which gave staff guidance about how people could be evacuated safely in the event of an emergency.

The provider had recruitment processes and systems to complete all the relevant pre-employment checks, including references from previous employers, proof of their identity, confirmation of the right to work in this country and Disclosure and Barring Service (DBS) reports for all the staff. DBS helps employers make safer recruitment decisions and prevents unsuitable people from being employed.

People's medicines were managed and administered safely. People told us they received competent, sensitive assistance to take their medicines as prescribed. One relative said, "My [relative's] medication times for [medical condition] is very good and she needs medication four times a day." The medicines round was large with most people receiving support to take their prescribed medicines and senior staff told us it could take approximately two hours to administer all the necessary medicines. Medicines were stored securely in a dedicated medical room and we saw that adequate, but not excessive, stock of medicine was kept on the premises.

Medicine administration records (MAR) we looked at were completed accurately with no unexplained gaps. Each person had a clear medicine profile which included a photograph, GP details, date of birth, notes of any medical conditions, self- administration guidance (if applicable), preferences on how they wish to be supported with medicines and any known allergies. All MAR seen had been reviewed in July 2017. Where people were prescribed medicines on an 'as required' basis (PRN), protocols were in place to ensure people were assisted to take these as intended by the prescribing physician. We saw that senior staff completed regular weekly audits of boxed medicines and that records and stock levels were consistent with each other.

Requires Improvement

Is the service effective?

Our findings

People and their relatives were very positive about the skills of permanent staff, but were less complimentary about relief and agency staff. One person said, "Oh yes, the regular ones are great. It's the temporary ones that sometimes don't know how to do things." We observed that staff had the skills to support people well. For example, at lunch time we saw a member of staff assisting a person with visual loss to eat their meal. They clearly understood the support the person required to eat their meal safely and positioned the plate, utensils and drink within the person's reach. They told them what food was on their plate and gave physical guidance to support the person to locate their food. We saw that where people required assistance to mobilise, this was done safely and in line with the person's care plan.

The provider had a training programme and an induction process for all new staff which included a period of shadowing more experienced staff before taking up full duties on shift. One new member of staff told us, "I'm shadowing at the moment as I just started. I've done some training, now I'm getting to know people and how the shift works." There was a system in place to record all staff training so that the management team could monitor when updates were due. Staff we spoke with said that the training they had received was sufficient to enable them to carry out their roles. One member of staff said, "The training is good. We get enough so we know what we are doing." Another member of staff told us that they had a lot of opportunities to complete training and they were satisfied with the support offered by the provider with regard to their professional development.

Staff told us they used to receive regular supervision, but this was not the case in recent months. One member of staff said, "I haven't had a supervision in a while, but before the old manager left it was regular." Another member of staff said, "Supervision isn't always consistent, but we do have meetings." Without exception, the staff we spoke with were keen to emphasise the positive support they received from senior care workers and one member of staff told us, "I get the support I need from the seniors when I'm on shift. I can ask them for anything." We saw from records that formal supervision was starting to be addressed at the service but that many staff had not had regular meetings in recent months.

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

People were supported to give consent before any care or treatment was provided. Staff understood their roles and responsibilities to ensure that people consented to their care and treatment. There was evidence that where a person did not have capacity to make decisions about some aspects of their care, mental capacity assessments had been carried out and decisions made to provide care in the person's best interest. This was done in conjunction with people's relatives or other representatives, such as social workers. We saw that staff routinely asked people for their consent before providing care and that where people did not have capacity to consent, and they worked within the principles 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The service had assessed whether people were being deprived of their liberty under the Mental Capacity Act 2005 and made applications where it was felt to be appropriate.

People were supported to have enough to eat and drink and told us that they enjoyed the food provided. One person said, "The restaurant has spotlessly clean tables, laid nicely and food is served quickly. In fact we all eat too well here and staff always tempt us with something nice to eat if we don't like what's on the menu, there's too much food to eat." We saw that the food served for both breakfast and lunch was of good quality and that people were offered a choice of meal. People who did not want the meals stated on the menu were able to request something different to eat and we saw that their preference was accommodated. We observed that support offered to people who required assistance to eat was sensitive and appropriate to their needs. In addition to main meals, people were regularly offered snacks and hot or cold drinks. People were also able to access drinks and snacks from the coffee shop in the main communal dining area. There was evidence that people who were at risk of not eating and drinking enough were monitored and appropriate action had been taken to ensure that they maintained their health and wellbeing.

People told us that they were supported to access additional health and social care services, such as GPs, dietitians, chiropodist and dentists so that their health needs were appropriately met. Staff told us they had positive relationships with the various healthcare professionals that visited the service. One member of staff said, "We have a good relationship with the GP and the pharmacy. We can call the surgery when we have concerns and get a good response." Records also indicated that the staff responded quickly to people's changing health needs and where necessary, they sought advice from other health and social care professionals. One person told us that staff had been very quick to notice signs indicating a very serious medical condition and took action to ensure that they received timely medical intervention. They said, "I had an operation a week ago. I am thankful for their vigilance because no one else picked it up."

Good

Is the service caring?

Our findings

People and their relatives told us that regular staff were caring and respectful. One person said, "They are lovely here." We observed positive interactions between staff and people who used the service. Staff were kind and caring towards people and there was a warm atmosphere throughout the home. It was evident that respect for people's choices and preferences was embedded in the culture of the service and staff demonstrated a commitment to working in a manner which valued people as individuals.

People told us that staff provided care in a way that respected their dignity, privacy and choice. One person said, "They respect you, they treat me like a lady." People told us that assistance with personal care was carried out with sensitivity by staff who took care to ensure they were covered up as much as possible. Staff demonstrated that they understood the importance of respecting people's dignity and gave examples of how they would do so while providing personal care. However, one person told us they had received assistance that morning from a member of staff that was not of the gender of their choice. This had left them feeling uncomfortable. We discussed with staff how people's preferences were considered in relation to gender specific support. They told us that, where it was known that a person had a preference for support from either male or female staff, every effort was made to respect this choice. This had been overlooked on this occasion but when asked, the regional manager confirmed that this would not usually happen as it was the provider's policy to respect this choice wherever possible.

People confirmed that their friends and relatives could visit them whenever they wanted and that staff made them welcome. We found this enabled people to maintain their social networks and relationships with loved ones. One person said, "There's no fuss here; no rules or regulations."

People were supported to maintain their independence. One person said, "I like it here, I am independent and we can all do everything for ourselves. We are lucky, it's the best place - I wouldn't want to go back to my bungalow now." We saw people being supported in a way that enabled them to continue to do as much for themselves as they wanted or were able to do. For example, we saw staff prompting one person to eat and offering them assistance with the first few mouthfuls, but then leaving once the person started to manage to eat without support.

Information about the service was given to people when they came to live at the home to enable them to make informed choices and decisions. Some people's relatives acted as their advocates to ensure that they understood the information given to them and we saw that information was also available about an independent advocacy service that people could access if required.

Requires Improvement

Is the service responsive?

Our findings

People's needs had been assessed before they came to live at the service. Appropriate care plans were then put in place so that they could be supported effectively. People's preferences, wishes and choices had been taken into account in the planning of their care and had been recorded in their care plans. Although person centred, the provider's format used for care plans was long and led to information being potentially lost within multiple sections. In this service that was frequently supported by agency and relief staff, there was a risk that people would not receive appropriate care because the information within care plans was not easily accessible. The lack of a short profile identifying key issues for each person meant there was a risk that temporary staff were not always able to get know people's needs before they were expected to assist them.

Up until January 2017, we saw that care plans were reviewed regularly and when people's needs changed. However since this time, some care plans we looked at had not been reviewed or updated to reflect people's changing needs. For example, one person who had been assessed as being at high risk of falling on admission had fallen six times since January 2017. No review of the care plan had been completed as a result of any of these incidents. This person had been assessed as being at high risk of developing pressure ulcers, but this had not been reviewed since February 2017. Likewise, the care plan and risk assessment in relation to this person's nutritional needs had identified that weight loss of over a certain amount should have triggered a referral to the GP. However, there was no record of the person's weight since February 2017. We concluded from this that the person's needs, as identified on the original care plan had not been addressed and that information within the care plan was no longer current.

Staff told us they knew people well and that each person was treated as an individual. This was supported by our observations and in our conversations with staff who were able to tell us about the needs of individual people they supported. However, the lack of up to date care planning meant there was a risk that people would not be appropriately supported by new or temporary staff who were less familiar with their needs. At this time when the home was staffed using significant numbers of agency and relief staff, this risk was heightened.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home provided a wide variety of events and pastimes to support people to pursue their hobbies, interests and socialise with others within the home. People from both the residential unit and the unit for people living with dementia were free to participate in any of the activities provided. People who lived in the independent living flats that shared the same site, as well as people from the wider community, also took part in some activities; in particular those associated with peoples' spiritual wellbeing and events such as quizzes and film nights. On the day of the inspection there were opportunities for people to participate in a bible studies group which we saw was very well attended. A music therapist employed by the provider provided both group and individual sessions to people who showed an interest or those for whom it was felt may benefit from taking part. There was information on display throughout the home about other activities on offer such as, a crossword group, hymn singing, a film club, bingo, and carpet bowls.

The service was well situated on the edge of town close to shops and local amenities. People were supported to maintain links with the local community including local schools, churches, shops, cafes and businesses. Some people were able to access the local town independently. Those who required assistance to go out were supported to do so where possible, although this was dependent on staff availability.

The provider had an up to date complaints policy and people and their relatives were aware of how to complain should the need arise. However, people and relatives that we spoke with were uncertain who the manager was and did not all feel action would be taken if they were to raise any concerns. The management team kept a log of complaints made and we saw that those recorded had been managed and responded to in line with the provider's policy.

Requires Improvement

Is the service well-led?

Our findings

The service did not have a registered manager. The previous registered manager had left their post in December 2016. Since this time, a series of temporary management arrangements had been put in place. At the time of the inspection, an area support manager for the provider was acting into the management role and was in the process of applying to register with the Care Quality Commission. The regional director confirmed that a new permanent manager had been appointed who was due to take up their post imminently.

People and relatives we spoke with were not able to tell us with certainty who was the acting manager and many people commented on the sense of there not being clear leadership in the service over the last six months. It was clear from our conversations with staff that they felt unsupported by management and that morale was low. One member of staff said, "There is lots of unhappiness in the staff team. We don't get support from the manager. [They] are not approachable and we just get moaned at." Another member of staff said, "The managers can be rigid. I don't really know what [member of management team's] role is. The [acting] manager is a distant figure. We don't really know what the goal posts are."

Many staff told us that despite the lack of guidance and clear leadership, they felt they had been able to continue to provide a good service to people through their own commitment and the support of senior care staff. One member of staff said, "We have a good team. It's a tight unit and we manage well despite the lack of management. The Seniors are great." Another member of staff said, "If it wasn't for the seniors I don't know what would happen. Management is a bit non-existent at the moment." Many staff reported that the impact on staff was significant and that inevitably this would eventually impact on the care provided to people. One member of staff said, "I hope things improve soon. The past three months haven't been great and we need to know what's happening. People are unaffected at the moment but something has got to change. The staff can't carry on like this."

The provider had systems in place to assess and monitor the quality of the care provided. A number of quality audits had been carried out to assess the quality of the service. These included checking people's care records to ensure that they contained the information required to provide appropriate care. Other audits included checking how medicines were managed, health and safety and other environmental checks, staffing, and others. However, these audits had failed to identify and address issues identified at this inspection in relation to care planning, staffing and rostering.

The acting manager had not ensured that staff were adequately supported on a day to day basis by a visible manager who provided clear leadership. They had failed to ensure that adequate forward planning was carried out to ensure the service was staffed by sufficient numbers of appropriately skilled and knowledgeable staff. Due to this lack of forward planning, permanent staff had not always been available to support agency and relief staff and the home was left short of staff. We were further concerned that despite raising this issue at the inspection, action to address staffing for the forthcoming weekend was not completed until further prompting from us the next day. This put people at risk of receiving poor and unsafe care.

We saw that occasional staff meetings took place. However, we noted that in one instance the minutes indicated the meeting had been used as an opportunity to confront and name staff who were believed to have raised concerns outside of the immediate management team (Whistleblowers). This contravened the provider's whistleblowing policy which is intended to protect staff from any consequences of raising concerns at work. There was a risk that staff would no longer feel safe to raise concerns if they witnessed poor practice within the home. This placed people who used the service at risk of not being protected from harm.

These issues were a breach of Regulation 17 of the Health and Social Care Act 2008 (regulated Activities) regulations 2014.

The provider carried out annual surveys to seek the views of people, relatives and staff about the service. We also saw that meetings with residents and relatives had been held from time to time to share information and to seek people's views.

We observed the care provided to people on the day of the inspection demonstrated that staff were committed to providing a caring and person centred service to people. Despite the difficulties within the service and the low morale of staff, they were aware of and upheld the provider's values.

We spoke with the provider's regional manager about the concerns that were raised about the existing management arrangements at the service. They confirmed they were aware that the recent instability in the management team had been problematic but they felt optimistic that the newly appointed manager was due to take up post very soon. They confirmed that on- going support for the service would be provided by the senior management team whilst the new manager familiarised themselves with the service and the improvements that were required.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care People's care plans were not up to date and their individual needs were not met

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance There was poor management oversight of the service. Systems to support the provision of a safe service were not managed effectively. Staff were not provided with adequate support or leadership, and people did not feel they could share their views.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough skilled and knowledgeable staff on duty