Loomer Road Surgery

Wedgwood Unit

Inspection report

Greyhound Way
Stoke on Trent
Staffordshire
ST6 3LL
Tel: 0300 3650337

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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?	Good
Is the service well-led?	Good

Overall summary

We inspected this service on 14 January 2015. This was an unannounced inspection.

The service was registered to provide accommodation and personal care for up to 33 people. People who use the service remained patients at the University Hospitals of North Midlands NHS Trust, but are transferred to the unit because their health needs no longer require treatment within a hospital setting. Most people who use the service require a short period of rehabilitation before they are discharged to their own home or to a care home.

At the time of our inspection 32 people were using 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 the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

We identified that improvements were required to ensure people received their medicines safely.

Summary of findings

People's risks were assessed and there were sufficient numbers of staff to promote people's safety. However, care records did not always show that risks were reviewed when required to ensure people's safety was consistently promoted.

Some people were unable to make certain decisions about their care and one person had their movements restricted within the unit's environment to keep them safe. The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) set out requirements to ensure where appropriate, decisions are made in people's best interests when they are unable to do this for themselves. We found that the staff did not always apply their knowledge of the Act and the DoLS to manage the restrictions they placed on people. This meant that the staff did not always follow the legal requirements in place to ensure decisions were made in people's best interests.

People received sufficient amounts of food and drink. However, people's dietary care plans were not always followed. This meant people's risks of malnutrition and dehydration were not always being managed as planned.

The staff had received training that enabled them to meet people's needs. Care was provided with kindness and compassion and people's independence and dignity were promoted. Support and advice was also offered to people's relatives as required.

People's health and wellbeing were monitored and staff worked with other professionals to ensure people received medical, health and social care support when required.

People were involved in the assessment of their needs and care was provided in accordance with people's care preferences. People were encouraged to participate in their preferred activities to reduce the risk of isolation or boredom.

The provider listened to and acted upon feedback from people who used the service to improve care. As a result of feedback, plans were in place to improve people's involvement in the planning of their rehabilitation and discharge needs.

There was a positive and enabling culture within the unit and an effective management structure was in place to support the staff and improve the quality of care.

The registered manager had identified where improvements were required and was working on making the required improvements.

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. Systems were not in place to ensure people received their medicines safely or as prescribed. People's risks and care records were not always reviewed or updated in a timely manner to promote their safety.

There were sufficient numbers of suitable staff to keep people safe.

Staff knew how to report any safety concerns and showed a good understanding of how to manage the risk of preventable infections.

Requires Improvement

Is the service effective?

The service was not consistently effective. When people did not have the ability to make decisions about their own care the staff did not always follow the legal requirements to ensure decisions were made in people's best interests.

People received sufficient amounts of food and drink. However, when people needed their food intake to be monitored and recorded, this did not always happen. This meant that people's dietary care plans were not always followed.

The staff received training that enabled them to provide care and support. The staff monitored people's health and wellbeing and worked with other professionals to ensure people received medical, health and social care support when required.

Requires Improvement

Is the service caring?

The service was caring. Care was delivered with kindness and compassion and people were encouraged to make decisions about their care.

People were treated with dignity and respect and their independence was promoted.

Staff also supported people's relatives when required.

Good

Is the service responsive?

The service was responsive. People were involved in the assessment of their care and plans were in place to improve people's involvement in the planning of their rehabilitation and discharge needs.

People received care in accordance with their care preferences and people were protected from the risks of isolation and boredom because participation in activities was promoted.

The provider listened to and acted upon feedback from people who used the service to improve care.

Good

Summary of findings

Is the service well-led?

Good

The service was well led. The provider and staff shared common values and behaviours to promote a positive and enabling culture within the unit.

An effective management structure was in place and staff felt supported by the managers.

The registered manager had identified where improvements were required and was working on making the required improvements.

Wedgwood Unit

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 14 January 2015 and was unannounced. Our inspection team consisted of one inspector.

Before the inspection we checked the information we held about the service and provider. This included the notifications that the provider had sent to us about incidents at the service and information we had received from the public. We used this information to formulate our inspection plan. Some of the information we held alleged poor cleanliness so we included this in our inspection plan.

We spoke with nine people who used the service and three relatives. We did this to gain people's views about the care. We also spoke with four members of care staff, two nurses, the activity coordinator, two physiotherapists, an occupational therapist, the care lead, the unit manager, the registered manager and the business manager. This was to check that standards of care were being met.

We spent time observing care in communal areas and we observed how the staff interacted with people who used the service.

We looked at four people's care records to see if their records were accurate and up to date. We also looked at records relating to the management of the service. These included audits, staff rotas, training records and staff recruitment files.

Requires Improvement

Is the service safe?

Our findings

Medicines were not consistently managed safely. People's medicine administration records (MAR) were not always signed and completed correctly and the quantities of medicines listed on people's MAR did not always match the numbers of medicines stored at the home. We identified medicines discrepancies for three of the four people whose records and medicines we reviewed.

Effective systems were not in place to check that medicines were stored within the manufacturers recommended temperature range. We saw gaps on temperature monitoring forms where the provider could not show that temperature checks had been completed. Three of these gaps covered a three day period in December 2014 where the temperature of the medicines fridge had consistently not been monitored and recorded.

We saw that some bottles of liquid medicines with short shelf lives after opening were not labelled with the opening date. The staff we spoke with were unable to identify when these medicines should no longer be used to ensure they were effective.

People told us they felt safe. One person said, "The staff always keep a good eye on me". A relative said, "They do all they can to stop [The person who used the service] from falling". We saw that people's risks were assessed, managed and reviewed. However, reviews of people's risks did not always happen in a timely manner following incidents. For example, one person told us their en suite call bell had been broken for four days. This person said they would be unable to summon assistance in the event of a fall in their en suite. The call bell was fixed during our inspection. However, staff confirmed that the person's risks related to falling had not been reviewed during the four day period when the call bell had been out of action. This meant that improvements were required to show people's risks were reviewed and their safety was consistently promoted.

Improvements were required to ensure records relating to people's care and support were accurate and up to date. For example, we found that 20 people did not have an accurate or up to date personal emergency evacuation plan (PEEP) in place. PEEP's record how staff and emergency services should support people to evacuate the premises in the event of an emergency. When we informed the unit manager about this the PEEP's were immediately updated. We found that when people's care records contained inaccurate or out of date information the staff were able to demonstrate that they understood people's needs well.

People gave us mixed feedback about staffing numbers. One person said, "There's always staff on hand in case I fall". Another person said, "I fell recently and the staff came to me within a minute". However some people told us they occasionally had to wait for periods of up to 20 minutes before they received assistance to have their care needs met. One person said, "I can occasionally wait up to 20 minutes, but the staff will pop in and explain that they will help when they can". This showed that people were kept updated by the staff in the event of a delay in the provision of care and support.

Staff told us that they had time to support people and we saw there were sufficient numbers of staff to meet people's needs. Call bells were answered promptly and people were supported in an unrushed manner. We saw that the provider's staffing levels were flexible and were based on the needs of people. For example, additional staff were called in if people needed to be escorted to a hospital appointment. We also saw that staff absences were covered as required so that the provider's minimum staffing levels were consistently met.

Staff told us and we saw that recruitment checks were in place to ensure staff were suitable to work at the service. These checks included requesting and checking references of the staffs' characters and their suitability to work with the people who used the service. Regular checks were also made that ensured nurses were correctly registered with the Nursing and Midwifery Council.

Procedures were in place that ensured concerns about people's safety were appropriately reported. All of the staff we spoke with explained how they would recognise and report abuse and training records confirmed that staff received regular training that enabled them to do this. During our inspection the staff made a referral to the local safeguarding authority in regards to a medication error we identified. This showed that suspected neglect or abuse was reported in accordance with the local reporting procedures.

Requires Improvement

Is the service safe?

The unit manager and registered manager monitored incidents to identify patterns and themes. When themes had been identified, appropriate action was taken to reduce people's risks.

People told us the premises were clean and we saw that peoples were protected from the risk of infection. One person said, "It's always clean, my room is cleaned everyday". We saw that the premises and equipment were clean and the staff told us the procedures they followed to prevent and manage potential outbreaks of infection. Protective equipment such as, aprons and gloves were readily available and utilised by the staff.

Requires Improvement

Is the service effective?

Our findings

Some people who used the service were unable to make certain decisions about their care. The Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS) set out requirements to ensure that decisions are made in people's best interests when they lack sufficient capacity to be able to do this for themselves. Staff confidently told us about the basic principles of the Act and the DoLS. We also saw that mental capacity assessments were completed and recorded. However, we saw that the staff did not always apply their knowledge to ensure best interest decisions were made, in accordance with legislation when people were unable to make decisions about their care.

We asked the staff and registered manager if any people who used the service were being restricted within the unit's environment in their best interests under the deprivation of liberty safeguards (DoLS). We were informed that no one had or required a DoLS authorisation because no restrictions were in place. We observed one person who was seated on a low sofa unsuccessfully attempt to stand on numerous occasions. This person told us they wanted to stand so they could go home. Staff told us the person needed to sit on the low sofa to prevent them from standing and falling. The staff confirmed that the person did not have the capacity to agree to this decision, therefore this person was being restricted. We shared our concerns that this person's movements were being restricted. The staff agreed and a DoLS referral was immediately completed. This meant that the staff had failed to independently recognise that this person was being restricted and required a DoLS assessment.

People who had capacity to make decisions about their care told us that staff always sought consent before they provided care. One person said, "They [The staff] always ask me 'are you ready to get up?' and, 'are you ready for Physio?'". This showed that under these circumstances staff only provided care and support once people's consent had been gained.

People told us that they could access sufficient amounts of food and drink. One person said, "The food really is quite good. There's always a choice and always enough of it. They also bring us cake and biscuits for snacks". Another person said, "One of the reasons I came here was to get my appetite back. I'm eating better here than I ever have". We saw that people's risks of malnutrition and dehydration were assessed and regularly reviewed. However, when people had been identified as needing their dietary intake to be recorded and monitored, we saw that this did not always occur as planned. This meant that there were sufficient amounts of food and drink provided, but some people's dietary care plans were not always followed. We did not see that this had a negative impact on any of the people who were using the service.

People told us that the staff were suitably skilled to meet their needs. One person said, "The staff are very good, they know exactly what to do". Staff told us they had received training to provide them with the skills they needed to provide care and support. This included; an induction to the unit, moving and handling people, basic life support, infection control and safeguarding people. Training records confirmed that training had either been completed or booked for the staff. We saw that training had been effective because we observed the staff support people to move safely and we saw staff follow good infection control techniques. Staff also told us they were able to meet with a senior or manager to discuss their development needs and opportunities.

We saw there was a teaching and learning culture within the unit. Staff told us that they learned rehabilitation skills from the therapy team and a GP told us that they taught staff about medical conditions as they arose. For example, when a person developed symptoms of a stroke and medical care was required and given, this was used as a teaching experience for the staff to increase their knowledge of stroke.

People told us they had access to a variety of health and social care professionals. One person said, "I've had therapy here [Occupational therapy and physiotherapy] and a social worker has come to see me". Another person said, "I had a fall here and the doctor came straight to me". A multi-disciplinary team (MDT) approach was used by the provider. An MDT is group of different health and social care professionals. The MDT on the unit included; occupational therapy, physiotherapy, GP's, nurses and social workers. Weekly MDT meetings were held where people's progress and discharge were discussed. This showed that people's health and social care needs were monitored.

Good

Is the service caring?

Our findings

Without exception people told us that they were treated with kindness and compassion. One person said, "Nothing is too much trouble for them [The staff]". Another person said, "I haven't met anyone here who has shown any unkindness". We observed positive interactions between people and staff. For example, we saw a nurse sit and engage in conversation with one person for a ten minute period while they supported them to take their medicines.

People told us they could make decisions about their care. One person said, "The staff always ask me what I want". We saw that people were encouraged to make decisions about the food they ate and the activities they participated in. We also saw that staff respected people's decisions.

People told us that their independence was promoted. One person said, "I could hardly walk when I came here, but now I walk with a stick and I'm going home next week". A relative said, "I think it's a lovely place because the staff encourage [The person who used the service] to move about and do things for themselves". Staff told us how much they enjoyed helping people to regain and maintain their independence. One staff member said, "It's so good seeing people progress and go home. I like being able to think I've helped them to do that".

People told us they were treated with dignity and respect. One person said, "The staff make sure my door is shut and the curtains are closed when they come and help me. They always put something over me when they help me to wash". Another person said, "The staff are very friendly and treat us all with respect".

Relatives also told us the staff provided them with support. One relative said, "I've been upset today, but the staff have been brilliant with me and given me advice and support". This showed that the staff also considered the needs of people's relatives.

Good

Is the service responsive?

Our findings

People told us they were involved in the assessment process where their needs were identified and agreed. However, some people told us they were not aware of their rehabilitation or discharge plans. One person said, "I don't really know what's happening and it plays on my mind". Another person said, "I'm grateful for the care and I'm comfortable, but there is no clear plan on me going home". We shared this feedback with the registered manager who immediately requested that the therapy team designed and implemented some goal setting documentation that could be used with people to set and agree rehabilitation and discharge goals. A member of the therapy team told us, "We're going to write goals with people and keep them in their rooms". This meant the registered manager responded to people's needs to be more involved in the planning of their care.

People told us they received care in accordance with their preferences. One person said, "The staff help me how I want". Care records contained information to enable staff to meet people's needs safely and effectively. However, the unit manager and registered manager had identified that care records needed to contain more information about people's likes, dislikes and care preferences. We saw that new care records had been introduced to enable staff to record this essential information. This showed that the provider recognised the need to record people's care preferences so that staff had access to the information required to provide consistent care.

People were protected from social isolation and boredom because they could participate in their chosen social and leisure based activities. One person told us, "There are activities and exercises I can do, or I can sit in my room and read, watch TV or listen to the radio". Another person who chose to spend their time in their room said, "I don't feel isolated at all. The staff come to me and we do activities. I've had my nails done and I've made cards". We saw the activity coordinator; the therapy team and the care staff engage people in a variety of activities. This included; an exercise group, bingo, jigsaws and general conversation. People were encouraged to play an active role in these activities. For example, one person who used the service called the numbers out during the bingo game.

People told us they would not hesitate to share concerns or make a complaint. One person said, "I don't need to complain, but I would tell any of the staff". Another person said, "I would tell any of the staff if I needed to complain". Staff told us how they managed and escalated a complaint and we saw that this was in accordance with the provider's complaints policy.

We saw that written complaints were managed in accordance with the provider's complaints policy. One person told us they had verbally complained to staff about receiving their medicines very late at night. They said, "It's improved since I told the staff about it". This showed that this person's verbal complaint had been managed effectively.

Good

Is the service well-led?

Our findings

People and staff told us there was a positive and empowering culture at the unit. One person said, "It's really nice here, I can't find any fault. When I came here I couldn't walk at all, but I'm walking with a frame now. Everyone has been so good". A therapy team member said, "I feel like I am a finally a physio again. We're getting results which gives me joy and encouragement".

Staff told us they were involved in a team building session before the unit opened. One of the activities they completed identified how their behaviours could improve people's experiences during their admission. Behaviours the staff had listed included, 'help boost self-esteem' and, 'promote independence'. The agreed behaviours from this exercise were located on a wall in the staff room so staff could be constantly reminded of this. This showed the provider and staff shared common values and behaviours in their approach to care.

People and staff told us that the management team were approachable and supportive. One person said, "The person in charge appears to be very good". A staff member said, "I like the managers, they've always helped me when I've needed them".

There was an effective management and senior staff structure in place. This included the registered manager, the unit manager, a clinical lead (whose lead role was in nursing care), a care lead (whose lead role was in rehabilitation and care) and senior care staff. Staff told us this staffing structure enabled them to provide effective care. One member of care staff said, "The seniors make sure we are okay and allocate us tasks. It all helps with the running of the unit, its running well".

Staff told us about new initiatives that were being introduced within the unit. These included allocating a keyworker to each person and introducing link roles for care areas such as; nutrition, records, patient experience and wound care. Link roles promote information sharing and communication between specialist teams and other staff teams. The registered manager told us, "We will be arranging training for these roles and then the staff will cascade the training to the other staff. Staff will also complete audits within their specialist area which will give them more responsibility and ownership". All the staff we spoke with thought this was a positive improvement.

The provider registered this service with us in October 2014 and we saw that registered manager and provider had consistently made improvements to the service since it opened. Systems were in place to assess and monitor the quality of the care. The registered manager and unit manager had identified that these systems were not always effective so they were amending them to address this. For example, the provider's completed medicines audit had not identified the concerns with medicines management that we found. The managers were aware this audit required improvement and were in the process of addressing this.

We saw that people's feedback was sought and used to improve people's experiences. For example, people had told staff that it was difficult to know who all the staff were at the unit. In response to this a 'family tree' had been painted onto a wall in the corridor and staff photos and names had been placed on the branches. One person told us, "The family tree is such a good idea, it helps us identify the staff and learn their names". Coffee mornings were regularly planned to provide people and their relatives with a forum to share feedback about the quality of care.

Staff worked closely with their colleagues at the hospital to ensure any issues relating to the admission and transfer of patients were shared and resolved. For example, the provider's policy was to not accept admissions after an agreed time. When people did arrive after the agreed time this was reported to the hospital so it could be investigated to prevent further incidents from occurring.

The registered manager understood the requirements of their role. They had formulated and were following a service improvement plan to improve the care people received. They also informed us of significant events that were legally reportable to us.