Methodist Homes

Churchfields

Inspection report

Millers Court
Hartley Road, Radford
Nottingham
Nottinghamshire
NG7 3DP

Tel: 01159424051

Date of inspection visit:
27 January 2016

Date of publication:
08 March 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an unannounced comprehensive inspection at Churchfields on 3 March 2015. After that inspection we received information that raised concerns from the local safeguarding team in relation to a number of areas following a safeguarding investigation. As result of this we undertook a focussed inspection. This report only covers the areas focussed on during this inspection. You can read the report from out last comprehensive inspection by selecting the 'all reports' link for Churchfields on our website at www.cqc.org.uk.

This focused inspection took place on 27 January 2016. Churchfields is run and managed by Methodist Homes. The service provides accommodation and nursing care for up to 70 people. On the day of our inspection 50 people were using the service. The service is provided across two buildings. People requiring nursing care were accommodated in one building over two floors with a passenger lift connecting the two floors. People requiring residential care were accommodated in a separate building over three floors with a lift connecting all floors.

The service had a registered manager in place 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 and associated Regulations about how the service is run. People were protected from the risk of abuse. Staff were aware of the types of abuse people who lived in the home may be exposed to and they understood their responsibilities in relation to protecting people in their care.

Although individual risks to people were assessed and recorded in their care plans the provider could not demonstrate people were fully protected from the use of faulty equipment as processes for monitoring cleaning and checking of equipment in use were not robust. People were not always protected from preventable risks as the provider did not always respond to safeguarding incidents in a timely way. Staff recruitment was safe and the distribution of appropriately trained staff to each area was appropriate. Although staff had received training to develop their knowledge and skills in relation to their job role there was a lack of assessment of their competency to check their learning.

People were protected under the Mental Capacity Act 2005 [MCA]. Individual mental capacity assessments and appropriate Deprivation of Liberty Safeguarding [DoLS] applications had been made.

People received personalised care from staff who knew their needs. People felt they could report any concerns to the management team and felt they would be taken seriously.

People could not be assured that internal company processes were fully effective as the provider's response to a serious incident had been slow. In addition to this, feedback to staff about the outcome of this incident and any changes required was not robust. This resulted in lessons learned being slow and communication

between the different units not always being effective.

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.

People were not fully protected from the risk of using equipment that had been maintained appropriately as the processes for managing the maintenance of equipment were not robust.

There were enough staff to meet people's needs and staff were able to respond to people's needs in a timely manner.

The provider had systems in place to recognise and respond to allegations of abuse and had individual risk assessments in place.

Is the service effective?

Requires Improvement

The service was not always effective.

People could not be assured that they were supported by staff who had been assessed as competent in their job role and supported in their personal development.

Procedures were in place to protect people who lacked capacity to make decisions.

Is the service responsive?

Good

The service was responsive.

People residing at the home, or those acting on their behalf, were involved in the planning of their care when able and staff had the necessary information to promote people's well-being.

People were supported to make complaints and concerns to the management team.

Is the service well-led?

Requires Improvement

The service was not always well led.

The systems in place to monitor the quality of the service were

not always robust.

People felt the management team were approachable and their opinions were taken into consideration.

Churchfields

Detailed findings

Background to this inspection

We carried out this unannounced inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned in response to a number of concerns that had been raised in respect of people's safety and the management of untoward incidents. We did not follow up on the breach identified in our last report. This will be undertaken at a later date with a comprehensive inspection when we will check to establish whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008. At that point we will look at the overall quality of the service, and provide a rating for the service under the Care Act 2014.

This inspection took place on 27 January 2016. The inspection team consisted of two inspectors. Prior to our inspection we reviewed information we held about the service. This included previous inspection reports, information received and statutory notifications. A notification is information about important events and the provider is required to send us this by law. We used information provided by the local safeguarding team about recent events.

During the inspection we spoke with five people who were living at the service and two people who were visiting their relations. We spoke with six members of staff and the registered manager. We also looked at the care records of four people who used the service, five staff files, as well as a range of records relating to the running of the service, which included audits carried out by the registered manager.

Requires Improvement

Is the service safe?

Our findings

The management of faulty equipment was not always robust and this placed people at risk of using equipment that may be faulty which could then result in injury to the person or a member of staff. The registered manager told us that all equipment such as wheelchairs, hoists and walking frames were cleaned and underwent a visual safety check by the night staff on a regular basis. However there were no schedules in place to show what equipment had been cleaned and checked and when the checks had taken place. Approximately ten walking frames and five wheel chairs viewed by us had visible signs of dirt on them which indicated that the regular checks were not effective and staff continued to use the equipment although it had not been adequately cleaned.
This was a breach of regulation 15 (1) (a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During our inspection we saw that some faulty equipment was labelled and stored appropriately. We asked day staff if they understood the process for taking equipment out of service and they were aware of the procedure. One staff member told us they had taken two pieces of equipment out of service on a previous shift. Staff we spoke with were aware of the need to protect people when using equipment during their care through checking for faults prior to use. Another member of staff told us, "It is our responsibility to check all equipment before use. It is extra work but we realise it is important for peoples safety." Despite this we found that staff were still using equipment that had not been cleaned and therefore we could not be assured that the essential checks to the equipment had in fact taken place.
Risks to people were assessed when they were admitted to the home and reviewed regularly to ensure their safety. We found that risk assessments were in place which detailed the support people required with all aspects of their care. This included instructions to staff to check equipment prior to use. We saw information in the risk assessments for one person detailed what support was needed to assist the person to mobilise. We observed staff assisting the person in the way the assessment had outlined. We spoke to the person's relative who told us staff worked hard with the person to improve their mobility in a safe way.

Although the provider reported incidents to the local safeguarding authority and us, people were not always protected from preventable risks as the provider did not always respond to safeguarding incidents in a timely way. Records showed that an investigation into a serious safeguarding incident had been protracted and took approximately four months to complete. Several issues that arose from the incident had not been fully addressed by the provider. For example, one issue was staff response to emergency situations. The registered manager told us there were no clear protocols in place to assist staff in responding to particular situations.

Relatives we spoke with told us they felt their relations were safe. One relative told us, "Yes we have no worries about [name] they (staff) do everything they can for them." Another relative said "I feel that [name] is safe here. They are moved safely by staff, I have no reservations." Relatives told us they had confidence in the staff who cared for their relations to keep them safe. They told us they knew who to speak with if they were concerned about their relation's safety. One relative said, "I would speak to a senior care worker or the manager, they would be responsive."

Staff we spoke with had a good understanding of the different types of abuse and how to recognise and respond to any possible abuse. The staff we spoke with understood their responsibilities in ensuring the safety of the people who lived in the home. They had received training on protecting people from the risk of abuse and understood the process for reporting concerns and escalating them to external agencies if needed. One member of staff told us, "I would go to the nurse and document everything. I could go to social services if I needed to."

Staffing levels were regularly assessed and monitored to make sure there were sufficient numbers of staff on duty to meet people's individual needs. Each floor that had people who received nursing care had a registered nurse on duty. Staff rotas were well organised with senior care staff and registered nurses in charge in appropriate areas. The registered manager told us until recently there had been some reliance on agency nurses as the home had struggled to recruit. However this had stabilised in the last month with the employment of registered nurses to match the needs of the service.

People could be assured they were cared for by staff who had undergone the necessary pre-employment checks. We examined five staff files and saw the provider had taken steps to protect people from staff who may not be fit and safe to support them. Before staff were employed the provider requested criminal records checks, through the Disclosure and Barring Service (DBS) as part of the recruitment process. These checks are to assist employers in maker safer recruitment decisions.

Requires Improvement

Is the service effective?

Our findings

People could not be assured that they were supported by staff who had been assessed as competent in their job role and supported in their personal development. We found staff had not always received appropriate supervision to assist them in their role. The staff supervision records we viewed only had written entries up to the middle of 2014 followed by a gap of approximately 16 months.

Staff who had been involved in an investigation following a significant incident in 2015 had not received any supervision until after the investigation had been completed. The investigation took four months to complete and during that time the members of staff had not received any documented assessments of their competencies. This meant there was a risk that poor work practice could have been repeated placing other service users at risk. Furthermore two new members of staff we spoke with who had been with the company for approximately four months had not had any supervision meetings since commencing their employment. The lack of documented supervisions for staff meant there was a risk that people who lived in the home were supported by staff who had not been supported in their professional development.
We spoke to the registered manager about the lack of supervision records and they told us some supervisions had been taking place but the previous system for recording was not working so they had now introduced a new system to rectify this.

We saw that people were cared for by staff who received regular training relevant for their role. Relatives we spoke with felt staff were competent in their roles, one relative told us, "Staff have the right knowledge to do the job."

Staff we spoke with also felt the regular training updates, the majority of which were via e-learning packages, they received assisted them in their roles. The registered manager told us new staff were given an induction booklet and a buddy to work with during the first three months and they had a minimum of a week supervised working dependant on their experience. A member of staff who had been in post for four month told they had been satisfied with the induction process We viewed the training matrix and saw that the majority of staff were up to date with training in areas such as moving and handling, safeguarding and health and safety.

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

People 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).We checked whether the service was working within the principles of the MCA and DoLS, and found the conditions on authorisations to deprive a person of their liberty were being met.

The majority of staff we spoke with had an understanding of the Mental Capacity Act (MCA) and how the use of the Act protected people in their care. One member of staff who had recently been recruited was not very knowledgeable but told us they had not yet completed their mental capacity training. People could be assured the registered manager was working to ensure that staff knowledge of the MCA was up to date. They had checked when all staff had last had MCA training and had requested that all staff who had not accessed the training for over a year undertook the e-learning module on the company's training site. The registered manager had also requested the provider arranged some face to face training sessions for staff within the next few months.

A recent safeguarding investigation questioned if people who lived in the home had been appropriately assessed to establish their mental capacity. As a result the registered manager had undertaken a systematic review of the mental capacity of the people in her care. We viewed mental capacity assessments in people's care plans and the registered manager supplied us with records of assessments that they kept. These showed that appropriate mental capacity assessments and best interests meetings were taking place for people who lived in the home.

Good

Is the service responsive?

Our findings

People received personalised care and staff were responsive to their needs. Care records had been updated and contained detailed information about people's needs. We saw care plans that had been signed by relatives to show their involvement in their relations' care.

Plans reflected how people would like to receive their care and included details of their personal histories, individual interests and preferences. The plans described how people should receive care centred upon them as individuals. For example, a person with particular behaviour patterns had refused certain aspects of personal care. Staff discussed previous routines with the person's family and changes were made to the person's personal care routine. As a result, with the family's support, the person was happy to receive these aspects of personal care

A relative told us, "I have been more than happy with the care for my relative. I visit several times each week. Staff always keep me informed and don't do anything without letting me know." They told us some medicines had been changed and they had been involved in the decision and was happy with the outcome. They said, "I am invited to all reviews and look at the care plan."

The complaints procedure was on display in the home. One relative we spoke with told us they had spoken to the registered manager a number of months previously about some concerns they had regarding their relation. They told us the registered manager had responded to their concerns and dealt with the issues they raised appropriately and to their satisfaction. We viewed records of complaints made during the last year all had been responded to appropriately including the concerns mentioned by the relative we had spoken with.

The staff we spoke with were able to describe the process for handling a complaint. They said they would listen and try and rectify the issue if they could and would document it. Staff felt confident that, should a concern be raised with them, they could discuss it with the management team who would respond appropriately to this.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had responded in respect of a serious safeguarding incident by starting to raise awareness of issues with the staff, such as safe moving and handling processes and equipment monitoring.

However the provider's response had been slow resulting in the manager receiving little support and direction leading to a un-co-ordinated approach. Despite the need for ensuring equipment was well maintained having been identified previously following a safeguarding investigation there was a lack of monitoring in place for equipment which would allow the management team to identify when, and if, regular cleaning and maintenance checks were undertaken.
We found that there was a need for additional training and information for staff on dealing with specific incidents and this had not been implemented by the management team. Staff supervision records were not maintained to show what support had been available to staff. The provider had failed to thoroughly assess the issues raised and use effective systems and processes in a timely and thorough manner to identify and respond to shortfalls and risk to people using the service. This placed people at risk of this type of incident reoccurring and at the risk of sustaining serious injuries and was a breach of Regulation 17(1) (2) (a) and (d) (ii) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives we spoke with told us the registered manager was visible and approachable and relatives of people on the residential unit told us they saw the registered manager regularly undertaking walk rounds of the service. Staff we spoke with who worked on the residential unit told us they felt communication between the nursing unit and themselves was not always consistent.

The registered manager also acknowledged the need to improve communication and support between the nursing and residential unit and had plans in place to address this. One initiative they had instigated two months ago was a daily meeting for the people in charge in each area of the home, which had been well received. Staff we spoke with told us it was useful but further improvements were required as senior care staff on the residential unit had been seeking advice and support from one another rather than the deputy and registered manager.

We spoke to some visiting health professionals who had attended the home over a period of time. They told us that they had previously had issues with communication and how staff responded. They said that when they had discussed a treatment plan with a member of staff and documented things in the care plan this had not always known about by other staff and the required actions implemented. Visiting health professionals told us that with the employment of new nurses there had been some recent improvement with treatments they had instigated. On the day of our inspection we saw a health professional working with the nurse in charge on one unit to ensure particular equipment was in place to assist in a person's treatment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 15 HSCA RA Regulations 2014 Premises and equipment Equipment used by the service provider was not always clean

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The registered manager had not protected people who lived in the service against the risks of inappropriate or unsafe care by regularly assessing and monitoring the quality of services or maintaining records relating to staff development.