Methodist Homes

Connell Court

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 unannounced inspection of Connell Court took place on 5 July 2017.

Situated within walking distance of Birkdale Village and close to public transport links, Connell Court provides accommodation and personal care for up to 37 people. It is a three storey purpose built property which is fitted with a passenger lift providing access to all floors. All the bedrooms are for single occupancy and have en-suite facilities. There is a lounge, dining room and conservatory on the ground floor. At the last inspection in March 2015, the service was rated 'Good'. We found during this inspection that the service remained 'Good.'

Risks were well assessed and information was updated as and when required. We were able to view these procedures and how they worked. Staff were able to describe the course of action they would take if they felt anyone was at risk of harm or abuse this included 'whistleblowing' to external organisations. People were supported to manage their medication by staff who were trained to do so. The registered manager had systems and processes in place to ensure that staff who worked at the service were recruited safely. Rotas showed there was on-going recruitment to ensure staff numbers were at the level they should be; this was still on-going at the time of our inspection.

There was a supervision schedule in place, and all staff had received up to date supervisions and most had undergone an annual appraisal, any due were booked in to take place. All newly appointed staff were enrolled on the Care Certificate. Records showed that all staff training was in date.

We saw that where people could consent to decisions regarding their care and support this had been well documented, and where people lacked capacity, the appropriate best interest processes had been followed. The service was working in accordance with the Mental Capacity and DoLS (Deprivation of Liberty) and associated principles.

Staff were able to give us examples of how they preserved dignity and privacy when providing care. People we spoke with were complimentary about the staff, the registered manager and the service in general. People told us they liked the staff who supported them.

The complaints policy contained contact details for the local authorities and commissioning groups. Complaints were well managed and documented in accordance with the provider's complaints policy.

Staff we spoke with demonstrated that they knew the people they supported well, and enjoyed the relationships they had built with people. Care plans contained information about people's likes, dislikes, preferences, backgrounds and personalities.

Action plans were drawn up when areas of improvement were identified. Staff meetings and resident meetings took place. Quality assurance systems were effective and measured service provision. Regular

audits were taking place for different aspects of service delivery.

Further information is in the detailed findings below.

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 remains Good.	**Good**
Is the service effective? The service remains Good.	**Good**
Is the service caring? The service remains Good.	**Good**
Is the service responsive? The service remains Good.	**Good**
Is the service well-led? The service remains Good.	**Good**

Connell Court

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 checked 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.

The inspection took place on 5 July 2017 and was unannounced.

The inspection team consisted of two adult social care inspectors and an expert by experience. An expert by experience is a person who has expertise in a particular area, in this case, care of older people and people living with dementia.

Before our inspection visit we reviewed the information we held about Connell Court. This included notifications we had received from the provider, about incidents that affect the health, safety and welfare of people who used the service. We also accessed the Provider Information Record (PIR) we received prior to our inspection. 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. This provided us with information and numerical data about the operation of the service.

We carried out a Short Observational Framework for Inspection (SOFI). SOFI is a methodology we use to support us in understanding the experiences of people who are unable to provide feedback due to their cognitive or communication impairments.

We spoke to 11 people using the service, three relatives, one medical professional who was visiting the home at the time of our inspection, the chef, the senior carer, the registered manager and three staff. We looked at the care plans for four people and other related records. We checked the recruitment files for two staff. We also looked at other documentation associated to the running of the service.

Good

Is the service safe?

Our findings

People told us they felt safe living at the home. One person told us, "There is always someone about day and night, they are very good". Also, "I only have to press the buzzer and staff respond". One relative told us, "The residents are very safe here".

We received mixed responses with regards to staffing levels at the home. People spoke positively about the staff however a few people told us that there were sometimes not always enough staff to meet their needs. We observed people were waiting longer than 20 minutes to be escorted back to their rooms after lunch. The PIR indicated that the staff turnover had been high over the last twelve months, so we discussed this, along with our observations with the registered manager. We saw there was a procedure in place for recruiting staff along with KPIs (key performance indicators) set by the provider to ensure targets for staffing were met. The only negative comments we received were from people were, "Very short of staff at the moment", "A bit short of staff with the holidays", "New staff arriving a little more". Also "Short staffed but I think they are getting their quota now". We saw that staffing had improved in the last few weeks, and the registered manager was transparent about the ongoing recruitment, more new staff were due to start work at the home.

Staff were able to explain the course of action that they would take if they felt someone was being harmed or abused, this was reflected in the organisations safeguarding policy. Staff we spoke with also said they would 'whistle blow' to external organisations such as CQC if they felt they needed to. Staff had received training in safeguarding, and there was information displayed around the communal areas of the home such as the phone number for the local authorities safeguarding team.

Medication was well managed. All staff had received training by a competent person in the administration of medication and additionally received annual updates and competency refreshers. We viewed a sample of MAR (Medication Administration Records) which were completed accurately by staff, and had been audited by the service. We counted a sample of loose medications and found that all stock balances corresponded to what was recorded on the MAR.

The home was clean and tidy. Procedures were in place to ensure the safe removal of hazardous waste, and bins and toilets were regularly cleaned and checked. PPE (personal protective equipment) was available for all staff, such as gloves and aprons. There were hand sanitizers fitted to the walls in various areas of the home, and these were full. Repairs and maintenance were carried out in a timely way, and there were regular checks on equipment such as the lifts, PAT (portable appliance testing) electric and gas. Fire procedures in the event of an evacuation were clearly marked out, and equipment for safely evacuating people was stored securely and safely in the home. PEEPs were in place for each person which were personalised and contained a breakdown of what equipment that person needed to evacuate the home safely.

Risks to people's health and wellbeing were appropriately assessed and measures were put in place for staff to follow to support people to remain safe. We saw risk assessments in relation to nutrition, medication, falls

and the environment. There was a process in place to record, monitor and analyse incidents and accidents, which included an explanation of why the incident occurred and any remedial measures put in place as a result of this.

Staff were recruited safely and satisfactory checks were made on staff before they started at the home. These checks included two references and a DBS check [disclosure and barring service.] This is a check that new employers request for potential new staff members as part of their assessment for suitability for working with vulnerable people.

Good

Is the service effective?

Our findings

A staff member told us their induction had been 'thorough'. Staff reported feeling well supported in their role and felt that they had the skills and knowledge they needed to carry out their roles effectively. They received regular supervision and appraisals.

Staff told us they had completed training in areas such as moving and handling, fire safety, mental capacity and infection control and training records reflected this. The training matrix confirmed that all staff had training in the Mental Capacity Act and the majority of staff (97.6%) had trained in 'Equality and Diversity'. The training programme helped to ensure the staff had the skills and knowledge to support people safely. We spoke to staff members who provided examples of how they would ensure they respected people's privacy and how they promoted dignity which included ensuring that they knocked before entering people's rooms.

We checked to see if the service was working within the legal framework of the Mental Capacity Act (2005) (MCA). People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). This legislation protects and empowers people who may not be able to make their own decisions. The care files included mental capacity assessments and demonstrated that people were encouraged to make decisions around their daily life and that consent was sought from people and their relatives were consulted with were appropriate. The registered manager had applied to the relevant Local Authority for four authorisations to deprive people of their liberty. The rationale for this decision was clearly documented following a mental capacity assessment and best interest process. DNAR's (Do not attempt resuscitation) were clearly visible within files.

The majority of people we spoke to were happy with the food served at the home. People had a choice of meals and in sufficient quantities. Comments included "Wonderful" and there "Was too much, if anything". A fruit bowl and refreshment station was available and people had access to their own kitchen to make drinks. The weekly menu was on display and an all-day snacks menu was available. There was flexibility around breakfast times. People had a choice of using a small plate or large plate and there was evidence of consultation with people about menu changes. People's allergies were catered for. For example we saw that two people had milk allergies and required specific support around this. People also had support plans around nutrition contained within their care files. Staff supported people with their nutritional intake when necessary and completed this in a discreet way. For example one person had their food cut in small pieces- this was done in the kitchen then brought out to the person to promote dignity.

The care files we looked at showed people attended medical appointments in accordance with their individual needs. People told us that staff responded promptly to health needs and ensured quick access to appointments. The care files we examined showed people received advice, care and treatment from relevant health and social care professionals, such as the GP, physiotherapist, and optician and that referrals were made in a timely manner. A visiting health professional told us that the staff were very

receptive to advice and competent in delivering this care.

The layout and the décor of the home met the needs of people. Small refreshment bays allowed people to help themselves to refreshments. There was a room for hairdressing and reflexology.

Good

Is the service caring?

Our findings

We received positive comments about the caring nature of the staff. Comments included "They (the staff) are really good to me". Also, "Couldn't get a more caring place" and, "If you want anything you only have to ask". Someone else said, "I've been really happy all the time I have been here". A relative told us "The care is very good here". We observed interactions between people who lived at the home and staff were cheerful and relaxed. A relative survey completed described the staff as 'excellent- go way above their duty, they are truly exceptional'.

Staff we spoke to demonstrated a good understanding of how to protect and promote people's dignity. The management had introduced 'value cards' to remind staff of the principles of this. We observed staff asking for consent before providing care to people. We spoke to staff members who provided examples of how they would ensure they respected people's s privacy and how they promoted dignity which included ensuring that they knocked before entering people's rooms.

Care plans were either signed by the person themselves, if they had the capacity to do so, or via a best interest process which involved their family members. Some people we spoke with could not remember whether they had been involved in reviewing their care plans, however, care plans had been signed and dated when they had been subject to review.

People's records and personal information was securely stored in a lockable room which was occupied throughout the duration of our inspection.

The advertisement of local advocacy services in the communal area of the home ensured people could access support if required. There was no one accessing this type of support at the time of our inspection.

Good

Is the service responsive?

Our findings

Support plans were in place that covered a wide variety of care needs ranging from spirituality to mental well-being.

Support plans provided detailed information about people's health, behaviours, communication and the way in which they wanted their support delivered. This information was personalised and an individual personal profile was available which contained Information around people's life history, likes, dislikes and personal preferences. Each care file we saw contained a document as to how the person preferred to celebrate their birthday and what music they enjoyed. Their individual needs were catered to and the plans contained preferences such as whether the person preferred a bath or a shower and whether they wore perfume or aftershave. People's views were sought and recorded as to whether they preferred a male or female carer.

Support plans were signed by people (if they had capacity to do so) to support their inclusion in the planning and delivery of their care. As outlined in the Provider Information Return, we saw evidence that management had (quote from PIR) 'asked people about their end of life wishes.' This was documented in a separate document in people's care plans. Some people had chosen not to complete this document. This was respected and the document was not in their care plan.

People told us they enjoyed taking part in the activities and had recently been on a trip to Wales. This followed a new 'seize the day' initiative where people living at the home were consulted with regarding what activities they would like to do in the future. Care files contained an 'Individual Activity Record'. A computer was available for people to use within the home with a specially adapted keyboard to encourage use. During our inspection visit, there was evidence of activities taking place including hymn time and crossword searches that people enjoyed. The service ensured respect and the promotion of people's individual spiritual needs through the provision of the chaplaincy and communion service. At times, the shortage of staff had an impact on the provision of activities within the home, which we saw when looking at the 'resident survey'. The registered manager and provider had already taken steps to action this.

There was a complaints process in place for people to express their concerns. Records demonstrated that the management had responded to concerns in a timely manner. One person told us, "There is nothing I can complain about".

A recent 'resident survey' confirmed that all respondents felt that there was sufficient choice within the home. People had choice as to how they spent their time, whether to partake in activities and when they had their breakfast. 'Residents meetings' gathered people's views, for example, one person requested more sauces with their meals. There was evidence that this had been actioned to help improve the service. If the service were not able to comply with requests, they explained their reasons for this. For example, one person had requested that chips be available on a more regular basis. They were advised that chips were available twice a week to ensure a balanced diet and the offer of a 'fish and chip shop' meal was given.

Good

Is the service well-led?

Our findings

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.

Everyone we spoke with was complimentary about the registered manager. All of the staff we spoke with said that the registered manager was approachable. One person told us, "I don't know about other homes but they can't be any better."

We saw that team meetings were taking place every month, the last one had taken place in June 2017 and we viewed the minutes of these, as well the previous months. We saw topics such as safeguarding, training and health and safety were discussed.

There were audits for the safety of the building, finances, care plans, medication and more regular checks like the water temperatures. We saw any recommendations were being followed up with a plan of action by the registered manager. For example, we saw that one audit had identified the need for more staff, and a plan to advertise was put into action using additional methods rather than the online job websites.

There were polices and procedure in place for staff to follow, the staff were aware of these and their roles with regards to these polices.

The registered manager was aware of their roles and responsibilities and had reported all notifiable incidents to the Care Quality Commission as required. The ratings from the last inspection were clearly displayed in the main part of the building.