Accord Housing Association Limited

Meadowyrthe

Inspection report

Comberford Road
Tamworth
Staffordshire
B79 8PD

Tel: 0182766606
Website: www.accordha.org.uk

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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?	Requires Improvement
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We inspected Meadowyrthe on 3 February 2016 and it was an unannounced inspection. This was the first inspection for the new provider. The home provides residential accommodation for people who were living with dementia. There were 29 people living there at the time of our inspection, and four people were receiving respite care.

The home had a registered manager in place. 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.

Some risks to people's health and wellbeing had not been effectively assessed, monitored or actioned to reduce them. Some of the care that we observed was not in line with the recommended support agreed and put people at potential risk of harm. Staff we spoke with told us that they did not think that they received the training and support that they needed to assist them to do their jobs effectively. For example the staff we spoke with had an inconsistent understanding of the Mental capacity Act (2005) and people's ability to consent to care. However, we saw that assessments had been completed for people and best interest meetings had taken place withsenior care staff to support important decisions. Some people were legally deprived of their liberty, but care staff were unclear who had a DoLS in place and what this meant to the care they received.

We saw that there were not always enough staff to meet people's needs safely. Staff told us that they found it difficult to provide personalised care within the current staffing levels. We observed that staff were often task focussed and sometimes used language which was not about people but referred to them in terms of tasks. People also had their privacy and dignity compromised when staff spoke about them in communal areas and did not always ask for their consent before providing care and support.

The mealtime experience was inconsistent and in one dining area people had limited choice and the assistance they received was rushed and inconsistent. People and their relatives said that the food was of a good quality and anyone who was nutritionally at risk was monitored and provided with specialist diets.

Some of the care staff told us that they did not feel supported by the provider and did not think that they

would be listened to if they wanted to raise concerns or suggestions. Supervision and appraisal had not happened regularly and staff did not feel that they were up to date with developments within the service. The provider recognised that there had been a period of uncertainty and transition and that systems were being developed to address this. Some audits had recently been introduced to monitor the quality of the service and although they identified some areas for improvement they had not been in place long enough to make a significant difference.

Medicines and the risks associated with them were effectively managed to keep people free from harm. Staff knew people well and care plans contained enough detail to support them. Staff were aware of how to protect people from abuse and knew how to report any concerns. Recruitment procedures had been followed to ensure that staff were safe to work with people. People were monitored and referrals were made to relevant healthcare professionals when needed to ensure they maintained good health. They had monthly reviews and relatives told us that they felt well informed of people's changing support needs. When concerns or complaints had been raised they had been responded to in a timely manner and actions put in place to avoid repetition.

We saw that people were encouraged to pursue their interests and they were supported by volunteers and a programme of activities to do this.

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 consistently safe
Risks to people's health and wellbeing were not always assessed or actions taken to reduce the risk. There were not always enough staff to meet people's needs. Safe recruitment procedures had been followed to recruit the staff. Staff were aware of how to keep people safe from abuse. Medicines were administered and managed effectively.

Is the service effective?

Requires Improvement

The service was not consistently effective
Staff we spoke with did not feel that they had all of the training and support that they required to support people effectively. They had an inconsistent understanding of MCA and DoLS and how to care for people under it. Mealtimes could be rushed and people were not assisted consistently. Peoples healthcare needs were met and referrals were made to relevant professionals when required.

Is the service caring?

Requires Improvement

The service was not consistently caring
People were not always spoken about in a caring person focussed manner. Their dignity and privacy was not always respected when they were being supported and they were not always asked for their consent. They were able to make choices about their care and people's families and visitors were welcomed.

Is the service responsive?

Good

The service was responsive
Staff knew people well and care plans contained information about people's preferences and life histories. People were encouraged to pursue interests and activities and supported to do this by a volunteer. Feedback was encouraged and any complaints or concerns were responded to in a timely manner.

Is the service well-led?

Requires Improvement

The service was not consistently well led
Staff told us that they did not think there was an open culture and they did not always feel listened to. Supervisions and appraisals were irregular and staff did not feel that they were well informed of developments. Audits and quality systems were being introduced and had resulted in some improvements being made, but they needed to be fully embedded to be effective.

Meadowyrthe

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.

The inspection was unannounced and completed on 3rd February 2016 by one inspector, an expert by experience and a specialist adviser.The expert by experience had personal experience of using or caring for someone who used a health and social care service. The specialist adviser had professional expertise as a nurse with older people living with dementia.

On this occasion the provider was not asked to complete 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. However, we gave the provider the opportunity at the inspection to provide us with any relevant information. We looked at information received from the public and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We spoke with one commissioner about their experience of working with the provider. Commissioners find care and support services which are paid for by the local authority.

We spoke with ten people who used the service and three relatives about their experience of the support they received. Some people were unable to speak with us about the care and support they received. We used observation to help us understand their experience of care. We also reviewed the care plans for six people to consider whether the information in the records assisted staff to meet peoples' needs safely.

We spoke with eleven members of staff, six care staff, the registered manager, the deputy manager, the catering manager, the facilities manager and the operations manager. We reviewed four staff files to see how staff were supported to fulfil their role and to check that recruitment procedures were followed to make

sure that staff were suitable to work with people.

We also looked at the systems the provider had in place to ensure the quality of the service was continuously monitored and reviewed to drive improvement.

Requires Improvement

Our findings

We saw that people did not always have risks to their wellbeing managed safely and that staff did not always know what actions to take to reduce the risks. We saw that when one person became upset several members of staff tried to support them, we saw that some of this interaction increased the person's distress. One member of staff we spoke with said, "There is not a set way of supporting the person, they are used to me being here and they let me help". This means that the person received inconsistent support some of which made them more distressed and put them at further risk of harm. When we reviewed the plan that was in place to guide staff on how to reduce the risk of harm we saw that it did not have enough information to consistently support someone who may become upset. For example, the record said 'use distraction techniques if they become frustrated'. The record did not provide any further information on the types of distractions which could be effective.

We saw that people were not supported consistently when mobilising. For example one person was supported by one member of staff to go to the dining table, but we saw the person leave independently without support. We looked at the risk assessment for this person which had been reviewed after a serious accident. It said they should always be supported by two members of staff. One member of staff we spoke with said, "I know the risk assessment for them changed but I have not read it". We saw that not all the plans were in place to respond to emergencies. Not everyone had a personal emergency evacuation plan and others that we reviewed did not contain up to date information about the person's mobility needs. This meant that staff were providing inconsistent support to people which did not minimise the risks to their wellbeing associated with their mobility.

We saw that protective clothing and equipment was not always used. For example, we saw that a member of staff wiped somebody's nose with a tissue and then continued to serve food. They were not wearing gloves or an apron and did not wash their hands. This meant that they did not minimise the risk to people's health from acquired infections.

We saw that there were not always enough staff to meet peoples needs. The staff were deployed across two communal areas and in one of these people we saw that people had to wait to receive support and on occasion there were no staff in communal areas.. The staff we spoke with said that there were not always enough staff and one said, "Sometimes residents have to wait for assistance because they need two staff to help them". Another member of staff we spoke with said, "There are not always enough staff because people need more support and it is more physically demanding. It means you don't get to spend one to one time with people". In the other communal area we saw that there were enough staff and we observed that

they provided support to people when they required it.

The provider ensured that staff were safe to work with people by following recruitment procedures. A new member of staff we spoke with said, "I applied through the website and had an interview quite quickly afterwards. I didn't start for a while because there was a delay in sorting out my DBS and I couldn't start without the checks being done". A DBS is a check by the Disclosure and Barring Service, the national agency that keeps records of criminal convictions. Records that we reviewed confirmed that checks were in place, including for volunteers.

People we spoke with told us that they felt safe. One person said, "I definitely feel safe, they help me with everything". Another person said, "I am quite happy and safe here". Staff knew what abuse was and how to spot the signs and report any concerns. One member of staff we spoke with said, "I did safeguarding training not long ago and I would be confident to report any concerns". There was a procedure in place that had been followed when required to report and investigate concerns. The registered manager had informed us of any investigations as required.

People told us that they received the medicines that they needed. One person we spoke with said, "My medicine is always there first thing in the morning". We saw that medicines were administered to people in a patient manner in order to meet people's needs. For example, we heard a member of staff explaining what a medicine was for and what flavour it was to encourage someone to take it. We saw that medicines were stored safely in a locked separate room. Records that we reviewed confirmed that there were systems in place to monitor and manage the risks associated with medicines.

Requires Improvement

Our findings

Four staff we spoke with said that they did not have the all of the training that they needed to be able to do their role well. They said that they had not completed training in behaviours that challenge or working with people living with dementia for several years and they felt that this was necessary in order to be able to support people effectively. The registered manager told us that the management team had completed training in developing a new person centred approach to supporting people. They told us there were plans to cascade it to the staff, but that this hadn't happened yet. One member of staff said, "I know there is a new project but I haven't done any training and don't know what it's about". The registered manager told us that the project was a new way of providing personalised care to people living with dementia.

New staff we spoke with told us they had received induction training before they worked unsupported. One member of staff said, "I had a two week induction which included shadowing other members of staff. I am completing my care certificate and I also have observations in work as well." The care certificate sets out common induction standards for social care staff. It has been introduced to help new care workers develop and demonstrate key skills, knowledge, values and behaviours which should enable them to provide people with safe, effective, compassionate and high quality care

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 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).

Staff we spoke with had an inconsistent understanding of MCA and DoLS. One member of staff said, "I am not sure, I think it means whether someone can make a decision. I don't know about DoLS". Another member of staff could explain what DoLS was but said that they did not know if anyone they supported had one. Three staff we spoke with told us that they had not had training and that they thought this was needed to help them to support people.

When we reviewed records we saw that where people did not have capacity to make a decision then a

capacity assessment had been completed to record this and some best interest meetings had been held to support the decision. For example, we saw that a best interest meeting had been held with a person and their family to discuss a change in their accommodation. We saw that five people had their liberty lawfully restricted as there were DoLS in place.

We saw that the mealtime experience was inconsistent across two different dining areas. We saw that in one people were offered a choice of meal but that in the second dining area the meals arrived already plated. The catering manager said, "They choose their meal the day before and I do realise that some people might forget. I know personal choice has gone by plating the meals up". We saw that in one dining area when people needed assistance it was rushed and disjointed which meant that people were not supported in a person centred way. For example, one person had three different staff support them with their meal and there were times when they were left without any help. In the other dining area we saw when people needed support to eat it was given in a patient manner maintaining conversation throughout.

People told us that they enjoyed the food and that it was of good quality. One person said, "I enjoyed my breakfast, the food is always good". A relative we spoke with said, "The food is really nice". People who were nutritionally at risk had their intake monitored and the catering manager was knowledgeable about specific dietary requirements. We saw that some people who were being monitored were provided with a snack plate in the afternoon.

People told us that they had their healthcare needs met. One person said, "I have only got to mention it to them and they bring me a doctor or a nurse". Another person said, "I see chiropodist and nurses from outside when I need them". A relative also said, "They always let me know when my relative is getting a visiting doctor". We saw that referrals were made to provide specialist support when required; for example a referral had been made to the falls team to investigate the deterioration in someone's mobility.

Requires Improvement

Our findings

We saw that staff did not always focus on people and we heard people referred to in terms of tasks. For example, we heard people who required two staff to support them referred to as 'doubles'. We also heard one member of staff say to another in the communal area, "That's it then; we will do the rest after lunch". This meant that potentially not everyone had their needs met before their meal. One member of staff we spoke with said, "The move from task based care to more person centred will be difficult with the current staffing levels, we would need at least one more to have time to spend with people doing activities ".

We also saw that people were not always spokenwith, or about, in a way that respected their dignity and their privacy. During lunch one member of staff said to another (who was supporting someone with their meal), "They won't let you feed them will they?" Another member of staff said to a room of people, "Do we want to go to the toilet before your dinner my ladies and gentlemen?" We saw that sometimes when staff used equipment to assist people to move they did not always consider their dignity by ensuring that they were fully covered or always ask their permission and provide an explanation for their actions. For example, we saw people had clothes protectors put on them without staff asking if it was okay. On another occasion a member of staff discussed someone's illness in front of them saying, "It's sad, they don't remember before".

We saw that people made some choices about their care. We saw some people choose to spend time in their room and we heard staff asking if the television programme was okay or if they liked the music. One person we spoke with said, "I have a choice on what time I get out of bed and also going to bed". We also saw that some people were encouraged to maintain their independence, for example, we saw that people assisted in some of the tasks around mealtime.

People we spoke with told us that their relatives were welcomed at any time. One person said, "My relative visits every Wednesday and they are always welcomed". A relative we spoke with told us, "They have nothing to hide you can come at any time you like". We saw and staff and the registered manager confirmed that relatives and friends visited throughout the day.

Good

Our findings

People told us that they were supported to follow their interests. One person said, "I go to church and celebrate Christmas, and like to see the garden Another person said, "We have some schools and choirs come in and do some singing". Another person showed us a newsletter which contained photographs of activities from Christmas. We saw a volunteer visited and offered activities with people, such as dominoes and cards. They said, "We organise bingo and special days like family day". We also saw some staff spend time with people reading the newspaper and supporting someone with a domestic task. Some staff we spoke with said that they did not always have time to provide more individualised care. One member of staff said, "We do as much as we can, but I would like to be able to them out more".

Staff we spoke with knew people well and could describe their likes and dislikes. One member of staff we spoke with told us, "I find out about people through their care plans by asking the residents and in hand over and the handover bulletin. The families and the seniors tell us about any changes". Records that we looked at showed that people had been included in planning their care when they could and that families were involved. We saw that there was a review in place each month which clearly demonstrated any changes in the persons support needs. A family member we spoke with said, "I have monthly meetings with staff and they tell us what is going on. I was concerned about something and they got straight onto the doctor. If I have any queries I will go to the office".

We saw that the provider welcomed feedback and responded to any complaints in a timely fashion. We saw that information was displayed in reception with photographs of the staff and details of how to complain. One person we spoke with said, "I have never had to say that things are not good but I could talk to them". A relative we spoke with said, "I am always welcome and have never had a reason to complain. If I had any concerns I would speak to the senior". We looked at records of complaints and saw that they were responded to and actions which could prevent them occurring again were put in place.

Requires Improvement

Our findings

Some staff we spoke with did not feel that there was a supportive culture where they would be listened to. One member of staff said, "They don't always listen and promises aren't kept, like we keep getting told we are getting more staff but we don't". Another said, "The managers are not helpful and sometimes there are situations that they could help but they don't". One member of staff told us that they had raised a concern with the provider because they didn't think someone's needs were being met and they didn't think the management team would listen. However, they said that the provider had not responded to them. One member of staff said, "We asked for a meeting with the new provider and they got involved but nothing much changed".

Staff we spoke with said that they did not always receive regular supervisions and appraisals. Some staff said that they had not had a supervision for over ayear and one member of staff said, "I have never had an appraisal". Other staff said that they had recently had group supervisions. Records that we looked at showed that supervisions had not always been regular for all staff. We saw that one member of staff had recently signed a supervision contract which stated that they would take place three monthly and we saw that a new rota had been devised. The registered manager recognised that this had slipped. They said, "We have had to do a lot of work on policies and procedures since we moved over".

The registered manager was implementing systems to audit the quality of the service and ensure that improvements were made. These focused on our quality indicators and regulations and recognised where some improvements were needed. For example, they audited care plans and set a target for them all to be changed to a new person centred system in the next two months.

The provider also completed a quality audit to ensure that actions were being taken and to give feedback to the registered manager and the staff team. They had recognised that although staff understood how to raise safeguarding concerns they were not always doing so in a timely fashion. This had improved since the team had received the feedback showing that the audits were becoming effective. The registered manager had completed some staff observations, which including the night time staff. These were used to monitor staff competence. The completed audits were used to develop an improvement plan. The registered manager said, "They help me to focus on what we need to get done". However, they were not fully embedded and had not highlighted all of the issues that we had observed. The provider told us the systems were new and they recognised that there were improvements needed and there had been in managing change in the last year.

The registered manager understood the responsibility of registration with us and notified us of important events that occurred in the service which meant we could check that appropriate action had been taken.