Methodist Homes

Hillside

Inspection report

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Date of inspection visit: 22 July 2014
Date of publication: 02/02/2015

Ratings

Overall rating for this service	**Good**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
Is the service caring?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Good**

Overall summary

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 to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, and to pilot a new inspection process being introduced by the Care Quality Commission (CQC) which looks at the overall quality of the service.

Hillside is registered to provide accommodation and nursing care for up to 67 people. This includes people living with dementia. There are six units over two floors, including 'Lowry' unit which provides care and nursing to 17 adults with long term disabilities. At the time of our visit there were 65 people living in Hillside.

There was a registered manager in post. A registered manager is a person who has registered with the CQC to manage the service and has the legal responsibility for meeting the requirements of the law as does the provider.

People told us there had been times when there were not enough staff. They said there were too many different agency staff. This meant they didn't always know them

Summary of findings

and had to tell them each time how they liked their care provided. People and their relatives also said the majority of staff were very caring and that, despite being very busy, they were patient, kind and considerate. "I am well cared for" was what one person told us having also told us there were too many agency staff used.

A high turnover of staff meant training and supervision had become inconsistent across the staff team. Staff told us however, they felt supported by the management and thought they; "worked well as a team". One member of staff told us whilst they knew staff turnover had been high, this "Was a good thing if they kept the right staff for the home and the others left".

We observed relaxed and respectful interaction between staff and people. People told us they had no concerns over their safety. People who provided a range of health services into the home were mostly positive about both the standard of care they saw. They were also positive about the communication and co-operation they received from the manager and staff.

Staff had received training in how to identify and report abuse of any kind. The manager had reported any incidents of concern promptly and in line with good practice requirements.

People were offered choice about their care and could influence how it was provided. This process was supported by a system of assessment, review and care planning which ensured people's needs were met in a way which reflected their wishes and respected their individuality.

People knew who to speak to if they had any concerns or wished to make a complaint. People felt the staff and manager were approachable. We found there were systems in place to seek people's views about the quality of the service. Where issues or concerns were identified they were addressed wherever possible. For example, concerns about the decorative order of the home had resulted in a programme of redecoration and refurbishment which was already underway.

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?

Requires Improvement

The service was always not safe. There were not always the number of skilled and experienced staff available, required to meet people's needs in a timely way. Staff were not always familiar with how people preferred their care to be provided. People told us they felt safe.

The provider was meeting the requirements of the Deprivation of Liberty Safeguards (DoLS). Staff had received appropriate training in DoLS and the Mental Capacity Act 2005 (MCA) and had a good understanding of them.

Staff were trained and understood their responsibility to safeguard people. Staff were recruited safely to ensure they were suitable to work with vulnerable adults.

Is the service effective?

Good

The service was effective. People received effective care and support to meet their needs. Staff had the skills needed to meet people's needs.

Appropriate induction and training of staff was in place to ensure they could meet people's needs effectively.

People had their healthcare needs met. Other health and social care professionals were brought in to help meet people's needs as required.

Is the service caring?

Good

The service was caring. People who lived in Hillside, their relatives and visiting health professionals said the service was caring and that people received appropriate support in a sensitive and respectful manner.

Staff treated people with respect and understood the need to protect people's dignity whilst providing care.

People were involved in decisions about their care and support.

Is the service responsive?

Good

The service was responsive. People received care and support which took account of their individual needs and preferences and was responsive to them. Individualised care plans recorded how needs should be met. These were reviewed to make sure they were still responsive when people's needs changed.

There were a range of activities available for people, although these did not always extend into the weekend. People told us they had enjoyed different people coming into the home to provide entertainment, including animals for them to stroke and musical entertainers.

Summary of findings

People were informed of the home's formal complaints procedure but felt they could raise any concerns informally.

Is the service well-led?

Good

The home was well-led. People were asked for their views about the way the service was led and managed. Suggestions for change were acted on where possible.

Staff and people said the registered manager and their team were accessible and they were able to talk to them freely. Senior managers of the provider carried out regular visits and audits on the service to assess how it was performing. Action plans addressed any areas which required improvement.

Health and social care professionals received good levels of co-operation and communication from the home's management team.

Hillside

Detailed findings

Background to this inspection

Background to this inspection We previously carried out a inspection in June 2013 where we found breaches of legal requirements in respect of staff supervision and training. We carried out a follow-up inspection in October 2013 and found the provider had taken appropriate action.

This inspection was carried out by an inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this case they had experience of services for older people.

We reviewed the Provider Information Record (PIR) and previous inspection reports before the inspection. The PIR is information given to us by the provider. This enabled us to ensure we were addressing potential areas of concern and identifying areas of good practice. We also looked at the notifications sent to us by the provider. Notifications are information about specific important events the service is legally required to send us.

Before the inspection we contacted 19 health and social care professionals, including GPs, community opticians, dental and oral health specialists, wound management services, community occupational therapists, community physiotherapists, Multiple Sclerosis and Motor Neurone Disease specialist practitioners and commissioners of care. We received feedback from 12 of these. During the inspection we spoke with 16 people who lived in Hillside, 12 members of the care staff team, a member of the catering staff, activities staff and a senior manager for the provider. We looked at eight people's care records, reviewed medication practice, looked at three staff recruitment records as well as staff training and supervision summaries for all care staff. The registered manager was not present during the inspection. The inspection was facilitated by another Methodist Homes' manager and other members of Hillside's management team.

We observed people in different parts of the service, for example lounges and dining areas. In the part of the service for people who lived with dementia we used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.'

Requires Improvement

Is the service safe?

Our findings

People who lived in Hillside, relatives and staff, expressed concerns about staffing levels, especially at night. They also had concerns about the number of agency staff used. One person told us they could wait "Up to 30 minutes for the bell to be answered" and that sometimes they; "Threw things across the room to get attention". Another person told us; "Three weeks ago there was no nurse on the first floor at night, they would have had to come up from downstairs". They also said; "Too many agency staff, some of them couldn't care less". However, the same person also told us; "I am well looked after".

Relatives said there was a high turnover of staff which caused them concerns about the consistency of care provided. They also said this meant it was hard for their relatives to build a relationship with care staff as they changed so often. One person said it could be frustrating to have to keep telling new staff how their relative liked their care to be provided, although they also said they realised this was necessary. Staff told us the time taken to make sure new agency staff knew where things were and what they had to do, sometimes made it feel it was better to do it themselves. One staff member said the service; "Wasn't short staffed but too many agency staff which meant the quality of care was variable". Other staff said the service was; "Often short-staffed" and one member of staff said this was particularly the case with Lowry unit at weekends.

We were told staffing levels were determined according to the dependency levels of people who used the service. Staffing rotas showed staff levels reflected this. Staff were flexible and could work across different floors and units within the home. It was acknowledged by the area manager that occasionally the set staffing level had not always been met. This was the result of staff 'calling in' at short notice to say they were unable to work which made it difficult to get agency staff. We were told, for example, that one member of staff had only rung in that morning and wasn't able to work. We were informed wherever possible, agency staff who were familiar with the people who lived in the home were requested. This was not always possible therefore people were not always receiving support from staff who knew them and how they wanted their needs met.

Despite these concerns, each of the 16 people we spoke with told us they felt safe and did not have any concerns about their care. One friend and frequent visitor to the home told us; "They are well-looked after, staff are friendly and kind, they are safe here".

Whilst staff were busy, they told us they worked together as a team to ensure people were safe and their needs were met. We observed lunch time in two parts of the home and saw staff made sure people, who required additional support to maintain their safety, received it.

We looked at eight people's care records. These included detailed assessments which identified potential risks to them. Where risks were identified appropriate action was taken to reduce or eliminate them. For example, where people were at risk of developing pressure ulcers or at risk of falling, there was pressure relieving equipment in place or the number of care staff required for moving the person from one place to another was increased. There were risk assessments in place to enable people to take part in activities safely. Risk assessments were in place where people might be able to go out on their own. These were reviewed and updated to reflect any change in risk due to fluctuating health. Records reflected the care given to reduce risks, for example turning charts to record how people were turned regularly to reduce the pressure on any one part of their body. Assessments of risk had been kept under review and updated where necessary. This helped keep people safe if risks to them changed.

Records showed staff were trained in the Mental Capacity Act (2005). This provides the legal framework to assess people's capacity to make decisions. Where people are assessed as not having the capacity to make a decision, a 'best interest' process involves people who know the person well and other professionals where relevant to make a decision on their behalf. Where best interest decisions had been taken these were recorded in the person's care plan. One relative told us their family member did not have capacity to make decisions for themselves. They said they had been; "Fully consulted and involved" in decisions made on their relative's behalf and was; "Very happy with the way the process had worked".

CQC is required to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). DoLS provides a process by which a person can be deprived of their liberty when they do not have the capacity to make certain decisions and there is no other way to look after them safely. We found

Requires Improvement

Is the service safe?

the service was meeting the requirements of the DoLS. At the time of our visit we were told there was one DoLS in place. The management team were aware of recent changes in DoLS practice and were consulting with the local authority to keep people safe from being restricted unlawfully.

We looked at medicines records for three people in detail and spoke with one of the nursing staff who administered medicines. We found the records were accurate and the system for recording protected people who relied on staff to help them with their medicines.

The risks of abuse to people were recognised and steps were taken to eliminate or minimise them. There were clear policies and procedures in place, staff were provided with initial training on safeguarding during their induction, which was subsequently updated. Staff confirmed they had received this training. In our conversations with them, they showed a good understanding of what abuse was, how it could be recognised and what to do if they saw or suspected it had taken place. Details of who to contact in the event abuse had taken place were readily available to staff.

We looked at staff recruitment records for three recently employed staff. The necessary recruitment processes and checks were in place and being followed. Staff records included evidence of pre-employment checks including Disclosure and Barring Service (DBS) checks to ensure staff employed were suitable to provide care and support to people who used the service.

Good

Is the service effective?

Our findings

People said they received effective care. "They do all right by me" one person told us whilst another said "they really do work hard to make me comfortable and safe". Relatives told us they felt staff had the necessary skills to meet the needs of their relatives, although they also said staff were very busy and "overstretched" at times.

The service provided care and support for older people, people who lived with dementia and people with long term disabilities, such as Multiple Sclerosis. Care records included details of the involvement of a range of health professionals, appropriate for each of these groups of people. For example; tissue viability nurses, GPs, dental services, community physiotherapists, multiple sclerosis and motor neurone disease specialist practitioners and wheelchair services. Staff training reflected the different needs of people. For example, training and awareness sessions had been provided by a specialist motor neurone and multiple sclerosis nurses.

The comments we received from healthcare professionals were mostly very positive. One of the professionals contacted said they were "neutral" about the home but felt the standard of care was; "Acceptable". Others said: "The nurses, care assistants and administrative staff have always been helpful approachable and assisted in delivering quality care", "We always request that a member of the nursing team that knows the client is present throughout our whole visit. This has always been done. Some clients ask for a particular carer and again, this has always been honoured".

People had their physical and mental health needs monitored. Care records included details of reviews carried out to assess if people's needs had changed. Revised plans included evidence of specialist advice being sought and changes made to the way care was provided, for example if the incidence of falls had increased. This ensured people's changing needs were addressed and met appropriately and effectively.

People had a nutritional assessment on admission and specific dietary needs and preferences were recorded. Where people had been involved with speech and language services and recommendations had been made, for example, about the best consistency for their food and drinks, these were recorded and followed.

It was a hot day on the day we visited and staff encouraged people to drink regularly. "It's hot today and you need to take plenty of fluid". People were given a range of choices of what they could drink, for example, water or a selection of four squashes. We carried out an observation over lunch time to assess the experience for people. We saw those people who needed help were given it in a discrete and caring way. There was very good interaction between staff and people, with easy and relaxed conversations. Staff helped people understand the choices available to them. We found people were able to change their mind about the meals they had. The chef said people could always have; "Salad, omelettes or anything they asked for". However, one person told us they would really like some streaky bacon for breakfast and noted despite asking for it "repeatedly", they were always given back bacon. Other than that they told us the food was "very good".

Staff said they felt they had the support through training to help them provide effective and safe care. New staff received induction training which helped them know what was expected of them and gave them the necessary basic skills to carry out their particular role. More experienced staff confirmed they received a variety of training, including moving and handling, infection control, MCA and DoLS and safeguarding. They were able to discuss, in an informed way, some of the learning for them from this training. Training records confirmed training was undertaken and planned. Staff were at different stages in their training; some were awaiting updates whilst others were up to date.

Staff had different experiences in respect of supervision and appraisal. Whilst most agreed they had received this, changes in staff and supervisory arrangements had led to some disruption. The staff supervision planner indicated that; "Formal supervision must take place a minimum of six times a year with each staff member". We looked at seven supervisor's supervision records, covering 54 staff some of whom were new and some of whom had left. We found a range of frequencies. Some exceeded the target and some had received less formal supervision than six per year. There was no evidence this had impacted on the care people provided as those staff we spoke with told us they felt they received support and informal supervision at a satisfactory level overall. They also said they could approach their supervisor or the manager at any time to raise any issues.

Good

Is the service effective?

The PIR indicated individual staff had made suggestions for improvements to the service which had been implemented. Dining arrangements had been remodelled, for example, to provide additional capacity for those people who did not require any assistance from staff.

Good

Is the service caring?

Our findings

One person said: "Lovely caring staff", and another said "the girls talk to us with real warmth, I know they care about me".Relatives told us the staff were very caring even though they were often under pressure. One relative told us: "Nan is very happy here" Health and social care workers were positive about the care they observed: "I always find the staff well-informed and delivering care in a compassionate and respectful manner". "On the whole, I find the staff helpful and caring. Patients are always clean and well-cared for".

We saw staff talking with people in a polite and respectful way. They used people's preferred name, in some cases, for example, Mr and in others by the person's first name. We observed positive interaction between staff and people they supported and heard laughter and friendly exchanges even when staff were obviously busy and had tasks to complete. We saw one occasion when a member of staff reminded another to "close the door" when they were helping someone with personal care in the person's room, this showed staff were aware of the need to maintain people's dignity and respect whilst care was provided. People's dignity was also respected by making sure they were clean and appropriately dressed. Staff knocked before entering people's rooms whilst we were in the home and explained why they were there and what they were doing, for example bringing a drink or checking on their well-being.

People said they were as involved with their care and the daily activity of the home as they chose to be. Relatives said they felt they were usually involved appropriately in decisions about their relatives and were kept appropriately informed of any significant events or incidents. Details of advocacy services, to provide independent support to people and ensure their views were heard and taken account of, were readily available to those who wanted them.

We saw when people living with dementia became confused, anxious or disorientated, staff reacted appropriately. They were patient and gentle in their response and reassured the person and made sure they were comfortable. Staff confirmed they had received appropriate training to help them understand the implications of dementia for people and were able to respond appropriately from this increased understanding.

The decorative order of parts of the home did not always contribute to the dignity or respect of people who lived there. We discussed this with the person in charge on the day. We were told this had been recognised and the PIR included details of work due to start in September 2014, to include redecoration and refurbishment of some corridors, shower rooms, dining rooms and lounges. This work was scheduled to take at least five months.

Advanced decisions had been encouraged so people and their relatives could plan their end of life. People's choices at this time were noted. The provider had also ensured staff received training in end of life care. Staff training included the Methodist Homes; "Final Lap" training, which could be either face to face or online and included issues like dignity, respect and choices. The PIR indicated that in addition, one member of staff had completed a level three National Vocational Qualification in End of Life Care. The service had arrangements with one local surgery for recording people's wishes at their life's end. The service had access to a syringe driver with support from the palliative care team at a local hospice to provide advice and guidance. We were informed of 25 people who died during 2013, 22 were able to do so in their own rooms at Hillside with family, friends or staff with them.

The PIR indicated 39 people had made an advance decision to refuse treatment in certain specified circumstances and 44 people had a Do Not Attempt Resuscitation (DNAR) record in place to determine the action to be taken at the end of their life. These were recorded in the care records we saw. This showed where people had the capacity to do so, they were involved in decisions about their care, including what were their wishes at the end of their life.

There were a range of Methodist Homes and other organisations' information on display and readily available to help people and their relatives make informed decisions relating to care and well-being services available to them. This included, for example, information and advice about finances, advocacy, support organisations and other relevant local services.

Good

Is the service responsive?

Our findings

People said the service responded promptly when the situation required it. One person told us how recently, when they had a problem with a tooth, they had been taken to the dentist; "Very quickly so the problem could be dealt with" and they were; "not in pain anymore". One visitor told us about a dietician being involved with their relative's care when it was noticed they were losing weight. They said this had been done; "Very promptly" and they had been kept fully informed of the available dietary options and other action the home was going to take to address this weight loss.

We looked at eight people's care records. We found assessments had been undertaken when people were admitted to the home to identify their needs and set out how they were to be met. Care plans were individualised to reflect the person's life history. Preferences in respect of daily routines and any particular care or health issues were detailed in order they could be taken into account in the way care and support was provided. We were shown an outline of a staff training programme, called; "The person inside" which helped staff to provide 'person centred' dementia care. One GP told us "The computer system used to record notes is excellent as it allows legible and auditable notes to be accessible to those who need it without risk of it getting lost".

We monitored call bell response times in different parts of the home. The longest of these was six minutes. We did note however, in that instance, a member of staff walked past the room in question after only three minutes, but did not go in to see what the matter was. We discussed call bell response times with the senior person on duty. They said there had been some technical issues which had now been resolved and confirmed call bell response times were being monitored so action could be taken if there were unreasonable delays.

People said there were "lots" of activities. There was an activities programme displayed and we observed an activities session. This included reading the newspaper and discussion followed by music and exercise and then a quiz. The people at the session took part intermittently. Drinks and biscuits were served at one point with staff going round each person to see what they wanted. We spoke with an activity co-ordinator who provided us with details of past programmes. When we looked at the activities programme for two weeks in July there were similar newspaper and discussion sessions every weekday morning, with only one fete activity shown at a weekend. The afternoon programmes included arts and craft, knit and natter, internet sessions and bingo. In another part of the home we found four people were sitting watching the television on and off for three hours. However, they did tell us there had been activities recently, including a man with a dog, exotic pets like owls and a large spider, shopping trips and a singer.

We met visitors who confirmed they were able to visit without any undue restriction; One told us "I can come and go as I please" and another "I visit whenever I want". Visitors confirmed they could speak to people in their own rooms or in lounges for example. We noticed some relatives also took the time to chat to other people as well and this added to those people's involvement.

People said they were aware how to make a complaint. They said they were far more likely to approach either a carer or the manager with any concerns. "They are all round and about all the time so we can always get hold of them" one relative told us. The PIR showed seven complaints had been received during the previous 12 months, with 10 compliments received during the same period.

MHA's visions and values include a commitment to meeting people's spiritual needs. Whilst MHA is a Christian based organisation they have connections to all Christian denominations and other faiths.

Good

Is the service well-led?

Our findings

Hillside is run by MHA which is a large national provider of social care services.

The home had a management structure which included nursing and care staff as well as ancillary staff. The overall responsibility for the standard of operation rested with the registered manager. They were supported by a senior MHA management team, some of whom we met during this inspection. There were effective quality assurance systems in place to monitor care and other issues.

People confirmed they were asked for their views and we saw a very detailed document, displayed prominently in the reception area, which gave the results of an independent (Ipsos Mori) survey carried out in 2013. This included a bench-marking of the home against similar size services in a range of areas, for example, staff and care, home comforts, choice and having a say and quality of life. We were given a copy of an action plan drawn up to address any issues arising from this survey. Where people (20%) had, for example, said staff did not always have time to talk and deal with their complaints and concerns, additional monthly one to one key worker meetings had been planned to start from January 2014 in addition to quarterly 'residents' meetings.

People who lived in Hillside, staff and relatives said the management team were open and approachable. Relatives did note that where changes occurred to key staff, for example key workers for their relatives, they did not always get prior information this was to happen.

Health care professionals who provided us with feedback were generally very positive about the home's leadership as they experienced it. "The home appears to be very well run". Another oral health specialist noted that the management had responded very positively when they suggested some aspects of the recording of mouth care could be improved. This included arranging specific training for staff to achieve improvement.

Where concerns had been raised about the decorative order of the home this had been recognised. Whilst more major work on the home's infrastructure had been given priority, a programme of significant redecoration and refurbishment was already underway and was planned to continue throughout 2014/2015.

The values of MHA were clearly set out and displayed in the home. "To improve the quality of life for older people. Founded on love, compassion and respect for each individual." People told us the majority of staff put these into practice.

We saw that incidents and accidents were reviewed and analysed. This helped to ensure risks to people were looked at, any trends identified and the incidence of accidents reduced where that was possible. CQC had received notifications of significant events as required, including referrals made to statutory bodies outside the organisation in respect of safeguarding adults.

We found there were audits of key areas of the home's operation carried out regularly, for example of medicines and call bells. These audits were evaluated and, where required, action was taken to address any issues. For example, medicines errors were investigated and additional training provided where appropriate or procedures changed where that was found to be necessary. The PIR indicated overall monitoring, planning and communication had been identified as areas for improvement. This had led to the establishment of a new communications team and care planning format.

The system for monitoring supervisions was not sufficiently robust to pick up easily where individual supervisions were overdue. We discussed the supervision of staff with the senior manager present who was confident once the staff team and supervisory responsibility became more settled; the intended frequency would be achieved. We were informed that immediately after the inspection supervision records had been updated and a new recording system implemented to make it easier to track all staff supervisions.