Methodist Homes

Chapelfields

Inspection report

Chapelfields
Frodsham
Cheshire
WA6 7BB

Tel: 01928734743

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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

We carried out an unannounced inspection of Chapelfields on 2nd August 2016. We carried out a further announced visit on the 4th of August 2016. For this second visit, the registered provider was aware that we were visiting.

Chapelfields is a purpose built care home with separate units providing nursing and residential care for 40 frail older people and 30 people who are living with dementia. The home has two storeys and all bedrooms are single rooms with en suite facilities. There are a choice of lounges as well as a communal dining room on the ground floor of the unit for older people. There are lounges and separate dining facilities on both floors of the unit for people living with dementia. At the time of our visit, 65 people were living at Chapelfields.

A registered manager was in post. 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. The registered manager was not present during our visit.

Our last visit to the service on the 7th of July 2014 found that the registered provider had complied with all the regulations that we used to assess the service at that time.

People told us that they felt safe living at Chapelfields. Staff demonstrated a good understanding of how to protect vulnerable adults from harm. The premises were well maintained, clean and hygienic. People were further protected by the way the registered provider recruited new staff. People's health was promoted through the safe management of medication.

The registered provider demonstrated that staff received up to date training on topics which related to the needs of people living at the service.

Staff demonstrated a good understanding of the Mental Capacity Act 2005 and associated safeguards. The registered provider demonstrated that the capacity of individuals was taken into account in their daily lives.

The nutritional needs of people were taken into account. This included the risks faced by people of malnutrition and dehydration. People were offered a choice of meals and regular drinks throughout the day.

People told us that they felt cared for and observations of staff practice confirmed that people were treated in a supportive, patient and respectful manner at all times.

People were able to take part in meaningful activities which included in house activities and trips out to the local community. Activities met the spiritual needs of people.

Care plans were accessible to people, were personal to their health and social needs. Care plans were reviewed and updated as appropriate.

People knew how to make a complaint and any complaints received were investigated in a timely and robust manner.

People told us that they considered the management team to be supportive, approachable and maintained a presence in the service. They stated that the service was well led as a result. The registered provider had a number of ways to measure the quality of the service provided and sought the views of all concerned.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People told us that they felt safe living at Chapelfields.

Staff demonstrated a good understanding of abuse and how to report any concerns.

The premises were well maintained and clean.

Medication management was safe.

Is the service effective?

Good

The service was effective.

The staff team received training relevant to their role.

The capacity of individuals was considered by the registered provider and safeguards were applied when assessed as appropriate.

Is the service caring?

Good

The service was caring.

People told us that they felt cared for. about.

People were observed being supported in a patient and respectful manner at all times.

The health needs of people were met.

Is the service responsive?

Good

The service was responsive.

Care plans were accessible to people, outlined their personal needs and were reviewed regularly.

People could participate in meaningful activities both within the service and in the wider community.

People knew how to make a complaint and a robust complaints procedure was adopted by the registered provider.

Is the service well-led?

Good

The service was well led.

People considered the service to be well led with the management team being approachable, supportive and visible within the service.

The views of all involved in the support of people were sought.

The registered provider demonstrated a robust system for measuring quality within the service.

Chapelfields

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.

This inspection took place on 2nd of August and was unannounced. We carried out a further visit on the 4th of August 2016 and the registered provider was aware that we were to visit that day.

The inspection was carried out by a team of one Adult Social Care Inspector.

Before the visit we looked at our records to assess the quality of care within the service. We looked at our records relating to notifications, safeguarding referrals and any areas of concern that we had received.

Before the inspection, the provider completed 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. The PIR was returned to us when we asked and the information recorded was used as part of our inspection process.

We contacted the Local Authority safeguarding team as well as the Local Authority commissioning team. They had no concerns about the service.

We checked to see if a Healthwatch visit had taken place. Healthwatch is an independent consumer champion created to gather and represent the views of the public. They have powers to enter registered services and comment on the quality of care provided. Healthwatch visited in May 2016 and found that the quality of care was satisfactory.

We spoke with 3 people who used the service, 3 relatives and 4 members of staff.. We observed care practice within the service and the interactions between service users. We provided the registered manager with a

poster to display informing people of our visit and to encourage them to share their views. We reviewed records relating to the service. These included five care plans, risk assessments, medicines records, five staff personnel files and audits relating to quality assurance.

We were taken around the premises. This was done to ensure that standards of hygiene and decoration were being maintained.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Good

Is the service safe?

Our findings

People told us that they felt safe living at Chapelfields. Observation of interactions between people and the staff team indicated that they felt comfortable and were willing to approach people for reassurance or information. Relatives told us "My relation is absolutely safe living here" and "I can leave knowing they are safe". People told us that there was always enough staff on duty "There is always someone there" and "The building is so clean and I am happy with my relations room-it is very nice"

Staff demonstrated a thorough understanding of the types of abuse that could occur as well as how to report concerns on poor practice if the need arose. Staff were able to identify the action they would take in reporting any abuse and which agencies referrals would be made to. The service identifies any low level concerns and reports them to the Local Authority safeguarding team. Low level concerns are those which fall below the safeguarding thresholds and are therefore recorded as such. In turn these incidents are reported monthly to the services Area Manager for analysis. Staff told us they had received training in protecting vulnerable adults and this was confirmed through training records. Information was on display within the service about the process for reporting concerns or any abuse. In addition to this, the registered provider had published a leaflet on how anyone could report any concerns they had. Our records confirmed that twelve alleged incidents of abuse had been reported since our last visit with appropriate action taken by the registered provider.

Personnel files suggested a robust approach by the registered provider to ensure that suitable staff supported people. Checks on staff within the records included a disclosure and barring check (known as a DBS check). This was made to ensure that staff had not been convicted of offences that would put vulnerable people at risk. Other checks were in place such as references from previous employers and a medical questionnaire confirming the physical fitness of people to perform their role. Photographs confirmed the identity of staff that applied to work at Chapelfields and application forms gave the registered provider the opportunity to assess their experience and skills. Where applicants were registered nurses, checks to ensure that their registration as nurses was current were made.

Sufficient staff were available to meet the needs of people who used the service. Staff rotas demonstrated that a mix of staff was employed with the skills to deliver care. These included registered nurses as well as senior care staff and care assistants. In addition to this, ancillary staff that included domestic, laundry and kitchen staff were employed to enable care staff to concentrate on their caring role. The registered provider had also recruited a number of volunteers to assist with the provision of activities. A chaplain and wellbeing co-ordinator were employed to meet the pastoral and spiritual needs of people. Maintenance staff ensured the premises were well maintained and kept safe for people who lived at the service.

Each person living at Chapelfields had a personal emergency evacuation plan (PEEP). This was colour coded as red, amber or green indicating at a glance the support each person would need in the event of an evacuation of the premises. These had been reviewed and took the physical needs of people into account as well as the need to reassure those people who may not readily appreciate the need to leave the building in an emergency. Fire drills were carried out monthly and included an assessment of how effective the staff

team had been in response to an unexpected fire alarm test. The registered provider had devised a fire risk assessment and a visit from the local fire officer earlier this year confirmed their satisfaction with systems in place. Checks to fire doors, fire extinguishers, fire alarms and emergency lighting were checked on a regular basis. All doors that required locking when not in use were locked.

All areas of the premises were clean and hygienic. Ancillary staff undertook cleaning of the building. During our visit, ancillary staff were seen making their way through the building attending to cleaning tasks. A cleaning schedule was available to support their work. Infection control audits had been put into place. Personal protective equipment was used by domestic and care staff at all times. There were sufficient stocks of this equipment available.

All equipment in the building had been checked for safety and had been serviced. This included equipment used by staff and people who used the service such as hoists, assisted baths and the passenger lift. Portable appliances had been tested for their safety this year. Further documentation confirmed checks had been undertaken on the safety of gas and electrical wiring.

Accidents experienced by people were recorded. These records included a full account of the nature of the accident, any injuries sustained and action taken to deal with any injuries. These were reported on a monthly basis to the Area Manager who looked for any patterns or trends in accidents.

Risks faced by people in their daily lives were taken into account and evaluated regularly. Risk assessments in place related to the likelihood people faced from falls, malnutrition and the development of pressure sores. These assessments gave staff a clear indication of each risk with details of how the wellbeing of people in respect of these could be promoted. Where there was a risk of malnutrition, there was evidence that people were weighed more frequently. In respect of pressure sores, people were provided with pressure relief mattresses to prevent further deterioration and to assist with their comfort. Any wounds or pressure sores encountered were regularly monitored and attended to.

Medicines were appropriately stored in lockable cabinets which were also located in locked clinic rooms when not in use. Controlled medicines had been prescribed to individuals. These are prescription medicines which are controlled under the Misuse of Drugs Act 1971. These were separately stored with an accompanying register which was countersigned by staff to confirm stocks of medication. We found the register tallied with controlled medicines in stock.

Clinic rooms were available for each of the four living areas. Records showed all these had their temperature monitored daily to ensure maximum effectiveness of medication storage. Where temperatures did exceed 25 degrees, action was recorded in order to remedy this. Some medicines required storing in cooler temperatures. Refrigerators were available for these medicines and again temperatures were monitored and recorded.

Medication records (known as MARS) were appropriately signed with codes in place confirming the circumstances under which medicines had not been administered. Records confirmed details of how much medication had been received and by whom. A system was in place to ensure that when new medication stocks were received, the process of changing medications was smooth. Photographs were in place confirming the identity of the person as well as information on allergies to ensure that their health was not at risk. Records outlined whether people were able to manage their own medication and at the time of our visit, no-one did.

Staff who administered medication confirmed that they had received training in handling medicines and

this was confirmed through training records. In addition to this, staff had their competency to undertake this task checking periodically.

Good

Is the service effective?

Our findings

People told us that they felt that the staff team were good at what they did and were knowledgeable. They told us "Staff know what they are doing" and "staff are good". People commented that the food was good and that a choice of meals was always offered.

A training matrix was available indicating what training staff had received. It included a mix of mandatory training. This training included fire awareness, health and safety, infection control and food hygiene. Other training included topics relating to the needs of people such as dementia awareness. Training was specific to the role of each member of staff and registered nurses confirmed that they had received more clinical based training such as venepuncture (taking blood) and catheter care. Training had been provided for them in relation to end of life care. Registered Nurses were also able to outline that their continued registration as nurses had been supported by the registered provider. This was through the revalidation process and workbooks were available to enable them to provide the necessary evidence that they had maintained their practice. The training matrix enabled the registered provider to see at a glance which staff needed refresher training.

Supervision of staff took place. This involved one to one supervision sessions with staff's respective line manager as well as group supervision through staff meetings. Staff had information on clinical issues and forthcoming training available to them. Staff viewed supervision as a positive process and were mindful that supervision could be requested at any time if they felt the need for this. Staff confirmed that they had had their performance appraised on an annual basis enabling them to know areas of strength in care practice and areas for development.

New staff were subject to a structured induction process. This led to them gaining the Care Certificate. The Care Certificate is provided by the Skills for Care organisation and is the start of the career journey for staff and is only one element of the training and education that will make them ready to practice.

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 so that they can received care and treatment when this is in their best interests and legally authorised under the MCA 2005. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

The Care Quality Commission (CQC) is required by law to monitor the operation of Deprivation of Liberty Safeguards. We discussed the requirements of the MCA 2005 and the associated DoLS, with the staff and management team.

Staff demonstrated a good understanding of the Mental Capacity Act and associated safeguards. They were able to outline the principles of the act and how people should be assumed to have capacity in the first

instance. They were aware that people had already been the subject of safeguards to ensure their safety. Staff had received training in this and this was verified through training records.

Documentation was available where applicable, to demonstrate deprivation of liberty orders had been applied for. During our visit, the registered provider was in the process of applying for an urgent deprivation of liberty order for one person to ensure their safe care. Orders had been granted in relation to other individuals to ensure their wellbeing and these were kept under review.

There was effective communication between the registered provider and the staff team as well as between staff members at key times. Information on training, clinical issues, policies and procedures and other issues were available to staff within the staff room. Observations noted that at key times, such as lunch, staff informed each other on who they were going to support to eat, which people had been asked what their meal preferences were and the reasons if they had to leave each unit. Information following medical appointments that had occurred was passed to each member of the team verbally.

During lunch, people were given the choice where to eat their meals. Some people preferred to eat in the dining room, others in their rooms and others in the lounge. One person had initially wanted to eat in the dining room but then eventually wanted to have their meal in the lounge. Staff accompanied this person and allowed them the time to make this decision. People were given a choice of the meals on offer and staff ensured that people were comfortable, received the meal they had requested and that they quality of food was to their liking. Assistance was given to those who required their food cutting up but this was only done once people were asked if they wanted this and had consented. Some people required assistance with eating. This was done on a one to one basis and involved staff sitting at the same height as people with explanations given as to what the meal consisted of. Drinks were available during lunch and at times during the day.

During the initial part of our visit, breakfast was being served. Breakfast times were flexible and people were still finishing breakfast as the morning progressed. Tables were then set for lunch. Menus were available indicating what meals were being served for lunch. Menus followed a three week cycle. The premises had a well equipped kitchen facility. Records were available indicating that food temperatures had been checked before meals were served as well as records indicating the food provided. Once prepared, meals were placed in a trolley which kept food hot as it was distributed to each living area.

Good

Is the service caring?

Our findings

People told us that the staff team cared about them. They told us "staff are good" and "staff really care". Relatives told us that they had confidence in the staff team and that their relations would be cared for with dignity and respect. People told us that if they needed to, they could have access to medical professionals such as doctors when needed.

Observations of care practice noted that people were treated with patience and kindness at all times. People who used the service felt comfortable with the staff team to make their needs known and thanked staff for their help. Where people took time to make a decision about what they wanted to do or where they wanted to sit, staff took the time to enable people to make decisions and would only leave the individual once they considered the person was happy. Staff interactions with people were respectful and dignified at all times.

When people wished to stay in their own bedrooms, this was respected with staff seen knocking on bedroom doors and only entering once they had been invited to. Staff were observed taking the time to give explanations to people in a patient manner. During times when people were being supported with bathing and other personal care tasks, they were discreetly supported by the staff team.

No one received advocacy at the time of our visit although one person had recently received support from an advocate. Information on advocacy groups was available for people who used the service and their families so that access to this service could be made if required. Part of the chaplains and wellbeing co-ordinators role was to provide a listening ear as independent from the care staff as possible if people so required.

The registered provider had a religious ethos which reflected a religious faith. Care plans and discussions with the management team noted that it was not a requirement for people living at Chapelfields to belong to any particular faith. The spiritual needs of all were taken into account regardless of their beliefs or otherwise.

The independence of people was taken into account. People who relied on mobility aids to access all parts of the building were able to do so. Those individuals who required support with eating lunch were always asked first if they needed assistance and staff adopted a supervisory role and encouraged people to maintain the skills they still had.

Information was provided to people either verbally or through written information. Information to meet the needs of those people with communication needs was done verbally and staff were witnessed throughout our visit communicating with people on how they were to be supported. Written information was also available for others such as the activities on offer.

No one during the time of our visit was receiving end of life care. Documentation was in place gaining the future wishes of people and care plans included records to be used when a person reached this stage of life.

The physical wellbeing of people was taken into account. Records suggested that people had received support from other health professionals such as doctors, opticians, dieticians and chiropodists. Such involvement had occurred in response to an acute illness that people had experienced to more ongoing appointments with hospitals and other agencies. All people were registered with a doctor with appointments made when necessary.

Good

Is the service responsive?

Our findings

People told us that the staff team responded to their needs. They told us "I have seen my care plan and I can look at it anytime". Relatives also confirmed that they were aware that their relation had a plan of care. People told us that there were activities on offer throughout the day. While no one had made a complaint, people knew who to speak to and felt confident that any concerns would be listened to.

Care plans contained assessment information relating to the main health and social needs of people living at Chapelfields. These assessments suggested that at the time of our visit, no one had been admitted with needs that could not be met by the staff team. This information was then transferred to a plan of care. Care plans were individual and personal to the needs of each person. Care plans had been discreetly stored in each person's bedroom enabling people to access them whenever they wished. All care plans were supplemented by daily records which provided an account of significant events for people and their progress. All documentation had been reviewed monthly and was up to date and accurate.
Care plans were clearly documented and provided an indication of the steps required for each person to be supported. Care plans covered all aspects of daily activities such as nutrition, social needs and preferences. Our visit coincided with the admission of one individual. Steps had been taken to obtain an assessment and this had been translated into a plan of care.

An activities co-ordinator was employed by the registered provider. This role was supplemented by a number of volunteers who assisted in the provision of activities. Activities programmes were tailored to the needs of people in each individual unit. Activities for people with general needs associated with old age differed from those for people living with dementia. These involved in house activities as well as those in the local community. During our visit, people were seen being supported to attend a local market in the local town. Others were listening to a pianist playing in one lounge area and a quiz was held in another area. Activities on offer in units where people are living with dementia were more individual and designed to maintain a relaxed atmosphere for people. People's views on activities had been specifically sought in quality assurance questionnaires.

Our observations noted the amount of choice that was given to people. People were always asked first whether they needed support and this was provided once the person had agreed. Other choices included alternatives' at mealtimes and whether people wished to join in with activities.

We had not received any complaints about the service since our last visit. A complaints procedure was available and was on prominent display. The procedure contained details of how a complaint could be made as well as the timescales involved in investigation. The registered provider had received one complaint since our last visit. This related to missing items of clothing. Records demonstrated that a response had been made to the complainant and that an outcome had been reached. The complainant had not yet confirmed their satisfaction with the outcome. The registered provider retained compliments received from relatives. These took the form of cards and letters and all indicated satisfaction and gratitude for the support provided. Compliments were put on display for the staff team to see.

Good

Is the service well-led?

Our findings

People told us that they thought the service was well managed. They said "I know who the manager is and they are always around and available" and "The home is well run and well organised". Staff told us that the registered manager and area manager were approachable and supportive.

The registered provider had a number of ways in which to measure the quality of care provided. People who used the service and their families were invited to participate in meetings from time to time to enable their wishes and preferences to be gained. The last meeting had been held in June 2016. Questionnaires had also been sent to people who used the service and their families. This had last been done in 2015. Results of surveys were made available and were linked to the five questions we ask of the service. Results suggested that people were very satisfied with the support they received. Quality assurance questionnaires could also be sent in by people and their families in between annual surveys. These were available to people and their families in communal and hallway areas. In addition to this, a staff survey had been completed in 2015. The results of this were made available to staff and an action plan had been drawn up highlighting areas of development, such as team work and communication.
Staff meetings were held with each designation of staff. These were held periodically to discuss issues that were relevant to each staff group. Staff confirmed that meetings took place and records were available.

The registered manager reported monthly to the registered provider in respect of weight loss, falls and other incidents relating to the health of people. The registered provider analysed the result of these incidents with a view to taking action to promote health needs. The registered provider employed a quality assurance team whose role was to monitor the quality of care within the service based on the information received by the registered manager. Information on staffing levels, health and safety, concerns and other clinical issues were analysed and fedback to the registered manager for action when needed. These processes demonstrated that the registered provider was able to monitor closely the quality of the support provided in Chapelfields.

Other audits were in place in respect of medication, health and safety and infection control. Where checks had been made, for example, on equipment used, there was evidence that these had been audited to ensure that all appropriate checks had been made and that equipment used by people remained safe. Where action needed to be taken, there were robust processes in place including action plans to ensure that issues were dealt with in a timely manner.
Policies and procedures were available. These had all been reviewed and covered key areas such as health and safety, codes of conduct and safeguarding. The availability of policies and procedures formed part of the induction process. Staff had signed to acknowledge when policies had been reviewed.

The registered manager was not available during our visit. In their absence, the Area Manager, a representative of the registered provider, was based within the service to provide support to the staff team. They were present on both days of our visit, In addition to this, the registered manager was shortly to leave the service and the registered provider had informed us in advance on arrangements they were making to ensure a smooth transition.

Our records showed that the registered provider always informed us of any adverse incidents that affected the wellbeing of people. The registered provider had returned their provider information return to us when asked. The certificate of registration was on display for people to refer to.