Methodist Homes

Edina Court

Inspection report

55 Harecroft Road
Wisbech
Cambridgeshire
PE13 1 RL
Tel: 01945 463419
Website: www.mha.org.uk/hs24.aspx

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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

This unannounced inspection took place on the 16 June 2015. At our previous inspection in June 2014 we found the provider was not meeting two of the standards we assessed. This was in relation to the care and welfare of people and support to staff. The provider told us they would make the necessary improvements by 30 September 2014. At this inspection of 16 June 2015 we found that some, but not all, necessary improvements had been made.

Edina Court is a domiciliary care agency that provides personal care to people who live at Edina Court extra care scheme. At the time of this inspection the service provided 18 people with care.

The scheme had a registered manager in post but at the time of our inspection they were on leave. They had been registered since 2012. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the scheme. Like registered providers,

Summary of findings

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 scheme is run.

The provider's recruitment process ensured that only staff deemed suitable to work with people were offered employment. Records viewed showed us that staff were only employed after all essential safety checks had been satisfactorily completed.

Staff had a good understanding of how to protect people from harm. They were knowledge about the safeguarding adults recording and reporting procedures. Staff had been trained in medicines administration and had their competency regularly assessed.

The CQC is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) Deprivation of Liberty Safeguards (DoLS) and to report on what we find. We found that people who used the service had their capacity to make day-to-day decisions formally assessed. At the time of our inspection no one in receipt of care had been deprived of their liberty.

People's needs were assessed and this information was used when compiling each person's care plan. This enabled staff to support people in a consistent way. However, not all risks had been identified. This meant that there was a risk that people's care needs would not be managed safely.

People's privacy and dignity was consistently respected by all staff. Staff had obtained a valid consent from each person before any care or support was provided.

The provider had a complaints procedure in place which people had access to including advocacy support if this was required.

The provider had arrangements and systems in place to assess the quality of care it provided. However, these were not always effective in identifying the issues we found.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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?
The scheme was not always safe.

Risks to people's safety were not always managed effectively.

Staff were knowledgeable about how to protect people from the risk of harm. Reporting and recording information was provided so that people, staff and relatives could report any concerns to the appropriate authorities.

Staff were only employed after all the required and essential pre-employment checks had been satisfactorily completed.

Requires Improvement

Is the service effective?
The scheme was effective.

Training was provided so that staff were provided with the right skills to support people receiving a service.

Staff confirmed that their induction, supervision and appraisals had been thorough and had enabled them to perform their roles effectively.

People were supported to live as independently as possible. People were able to choose when they wanted to eat and had sufficient quantities of nutrition and refreshments available.

Good

Is the service caring?
The scheme was caring.

People were treated with kindness and compassion and in a caring way.

Staff responded to people's requests for assistance and support in a meaningful manner. People were treated with dignity and respect

Staff had a clear understanding of how consent and agreement to provide people's care was obtained. People were involved in the decision making process in planning their own care.

Good

Is the service responsive?
The scheme was responsive.

People were supported to actively take part in their hobbies and interests.

People's concerns, complaints and compliments were responded to and were used as a way of recognising what worked well and where improvements were required.

Good

Is the service well-led?
The scheme was well led.

Good

Summary of findings

The provider and registered manager had quality assurance procedures and processes in place to monitor the safety and effectiveness of the scheme. However, we found that these were not always effective in identifying the issues we found.

The views of people and staff were actively sought in running the service with a range of meetings, surveys, residents' forums and face to face meetings.

The registered manager provided leadership to ensure a high standard of care was maintained.

Edina Court

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the registered manager is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the scheme, and to provide a rating for the scheme under the Care Act 2014.

This unannounced inspection took place on 16 June 2015 and was completed by one inspector and a specialist advisor from the National Palliative Care Council.

Before the inspection we looked at records in the provider information pack. This is information we hold about the service such as previous inspection records, notifications and if a registered manager is in post. A notification is information about important events which the registered manager is required to tell us about by law.

During our inspection we observed how staff interacted with people. We spoke with seven people and two of their relatives. We also spoke with five care staff. We spoke with two visiting healthcare professionals. We contacted commissioners of the service for their views.

We looked at five people's care and medicine administration records. We looked at records in relation to the management of the scheme such as quality monitoring records and staff meeting minutes. We looked at records for the maintenance of the equipment that people used. We also looked at staff recruitment documents, supervision and appraisal processes, training records and complaints records.

Requires Improvement

Is the service safe?

Our findings

Risk assessments had been completed for risks such as people accessing the local community, travel and transport arrangements, falls, and moving and handling. However, we found that in one person's care records there had been at least four instances since February 2014 where the person had behaviours which challenged others. Staff had failed to record this risk in a formal assessment. They had also not identified what the triggers or appropriate calming measures were to ensure this person's safety. In one situation the record just showed that the staff had left the person's flat. However, the care plan did not identify if this was the correct response. This put people and staff at risk of harm. In another person's care records staff had been identified as being at risk of falls and that the risk was low. However, we saw that this person had recently experienced several falls and no update to their risk assessment had been completed. Staff told us that this should have been reviewed in May 2015 but this had not happened. This meant that people at an increased risk did not have their risks effectively or safely managed. This lack of adequate management of risk had also been identified at our previous inspection in June 2014.

We also noted that staff have not identified the risks involved with using equipment that had not been inspected as frequently as required. This meant that for the previous 29 days prior to our inspection people who had used the baths were put at serious risk of being hoisted in equipment that had not been inspected under Lifting Operations and Lifting Equipment Regulations 1998.

This was a breach of Regulation 12(1) and (2) (a) and (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were safe when they received a service from the scheme. One person told us, "I feel safe because as I am treated well." Another person said, "I have hospital appointments and staff accompany me to make sure I am safe." Another person said, "If I need staff I just call and someone comes to see if I am alright or if I need any assistance."

Healthcare professionals we spoke with told us that any identified risks to people's health were acted upon quickly. For example, if people required support with their health conditions including skin care, diabetes or eating.

Staff we spoke with had a good knowledge of how to protect people from harm. This included an understanding of who, and how, to report any safeguarding concerns. The same staff were knowledgeable about ensuring people were not discriminated against in any way. For example, by following the provider's safeguarding and medicines administration policies. Staff were aware of the provider's whistle-blowing policy and procedure. They told us they would feel confident in raising any concerns as they would be protected from recrimination.

We found that staff recruitment records provided assurance that appropriate pre-employment checks had been satisfactorily completed. The checks included employment references, evidence of staff's physical fitness and ability to do their job safely and completion of an unacceptable criminal records check. Staff told us about their recruitment and the documents they had to supply. This meant that the scheme only employed staff after all the required and essential safety checks had been satisfactorily completed.

We saw there was a sufficient number of staff to ensure the safety of the people receiving personal care. Where people's needs required additional staff support we saw that this was provided. For example where people required two staff to assist with their moving and handling during the day time. One person told us, "Whenever you call [the office] there is always someone there." Staff told us that if they were going to be delayed they let other people know and the reason for this. The provider had a lone working policy in place and measures to support staff included an hourly telephone call to ensure people and staff remained safe. If staff required assistance with unplanned events an on call system was in place to provide additional resource.

Medicines were held securely in people's flats and they were encouraged to manage their own medicines as far as practicable. People's medicines were found to be clearly identified for the person they related to. Staff told us they had regular medicines administration training. They added that their competency to safely administer medicines was checked at least annually. Our observations of staff administering people's medicines showed that they followed relevant guidance and best practice. Checks were completed to ensure people were only administered medicines they had been prescribed.

The staff training records we looked at showed us that staff had completed training on various subjects including

Requires Improvement

Is the service safe?

safeguarding adults and medicines administration. Staff had access to the Medicines and Healthcare Products Regulatory Agency guidance (MHRA) on, and alerts regarding the recall of people's medicines. Staff were knowledgeable about these subjects. One care staff said, "We get updates and then ensure all staff are aware."

Good

Is the service effective?

Our findings

People told us, and we found, that they were supported by experienced care staff who knew them and their care needs well. One person said, "A new staff member started recently and they are really good and know what they are doing." Another person said, "I like my own space but if I need support I just ask and staff help me." And "It doesn't matter what I need help with, they do exactly as I request."

We were told and saw that care staff ensured they always obtained consent from each person before providing any care or support. Staff did not enter people's flats until they had obtained permission. For example, knocking and waiting until the person acknowledged staff's presence. This enabled staff to support people in a way which respected people's wishes. Care staff confirmed that wherever possible people's care was provided by staff who knew what mattered to the person and what their preferences were. Examples of this were where staff had supported people to do take part in their daily life activities. One person said, "I can have the support when I need it but staff respect what I can do independently."

Staff told us that their training was mainly e-learning but face to face training was available for those subjects such as moving and handling. The records of staff training and qualifications we looked at showed us that training was planned to fit in with staff's shift patterns. Some staff had been nominated as 'champions' for various subjects and they had an enhanced level of learning. Staff were made aware of changes in care practice such as MHRA and the Social Care Institute for Excellence. Staff confirmed that they were supported to gain additional health care related qualifications such as NVQ's.

Training which was considered by the provider to be mandatory for all care staff included subjects such as medicines administration, safeguarding people from harm, and fire and health and safety. However, we found that staff had not received training in some specialist areas of care that they provided. For example, staff told us and we found that they had never had any training to work with people with behaviours which challenge others. This put people and staff at risk of not responding appropriately for people with these behaviours. All staff we spoke with told us they would also benefit from some end of life care training.

Staff told us about their induction which lasted several weeks including a probationary period. They said, "I found the induction very good, especially the shadowing of various shifts to get to know people's needs throughout the day." And, "Once I felt confident I was then allowed more freedom working on my own." Another staff member said, "I had an induction booklet to complete and this recorded when I had satisfactorily completed each stage of the training."

Staff told us and we found that that they had regular supervision and annual appraisal where required and that these were an opportunity for them to raise any issues or concerns related to, or about, work. One care staff said, "We now get regular support from the senior carers. It is an opportunity for us to have a moan but also to be reminded of what good care should look like." One person said, "The staff definitely know what they are doing. I am [an] easy going person but they support me no matter what my needs are." One care staff said, "It isn't just about meeting people's needs. We do have some fun which people really find helpful."

We found that the senior care staff had a sound knowledge and thorough understanding of how people were supported. This was with people's decision making and also what action to take if a person's capacity to make certain decisions changed. There were no restrictions on people's freedom who used the service and people were able to leave their home at will. Staff knew when to respect people's wishes and when a person needed prompting with their care needs. Staff told us they had a useful MCA guide 'Living the values' to aid their decisions about people's capacity. This showed us that staff, appropriate to their role, had a good understanding about what the implications of the MCA and DoLS meant, or could mean, for each person.

People's preferred meal and drink options and the time of day they preferred these were respected by staff who knew people well. We saw that as well as having a choice of their meals, people could purchase from the on site caterers. We found and saw that people were encouraged and reminded to eat and drink sufficient quantities in their flats. One person said, "The food here is pretty good. If you don't want your original choice you can gave something else." Another person said, "They [staff] know my portion size make sure it is right." One relative said, "My [family member] has been here a while and they always look like,

Good

Is the service effective?

and tell me, they are well fed." People told us that if they were feeling a bit under the weather then staff often offered some soup or other food. Records showed that people were supported with appropriate food and drink, especially if they were at risk of weight loss or choking. We saw and people told us that they were supported to eat healthy food options especially for those people living with diabetes whose blood sugar levels, as a result of certain foods, needed careful monitoring.

We saw that people were supported to eat at a relaxed pace. This included in their own flat, in the scheme's dining room or a place of their choosing. One relative said, "My [family member] has their meals cut up for them as this is what they need." We also saw that staff respected people's abilities to be independent with their eating and drinking. One person told us they had to avoid certain foods and that the food provided met their needs. They said, "It can be a bit boring not having what I used to eat but it's for my own good."

People told us, and we saw, that they were supported to access health care professionals including community nurses or a GP when needed. A visiting community nurse told us that the staff followed their advice and guidance. They said that where specialist health care support was needed this was always requested in good time. One person said, "I recently needed a lot of regular health checks and the staff made sure these were done."

People were kept informed about their health care needs and information was passed to relatives if people wanted this. A care staff member told us, "As soon as there is an incident or a person needs health care support we let the family know. The same staff added, "If a GP visits and the person's health changes we also make sure the person knows the reason for the visit and any changes to their medicines. People were assured that requests and referrals for health care would be made in a timely manner.

Good

Is the service caring?

Our findings

We observed care staff offering and providing care sensitively. People were consistently offered choice based on what was important to them. Examples included, attending religious services appropriate to the person's wishes. We saw staff supporting people in a way that people wanted whilst respecting their independence. For example, we observed staff giving people time to complete their conversations, listening to what they had to say and responding with empathy and concern. One person said, "I have only compliments in the way we are all treated." Staff explained how they ensured people's privacy and dignity was respected. This was by locking doors, using towels and leaving people dressed as much as possible.

We saw that staff entered people's flats in the way people wanted. This was by knocking and announcing their arrival or waiting for permission to enter. At other times if the person was out staff did not go into the person's flat. One care staff said, "It is amazing the things people tell you about their lives. It can be new things or historical events they had experienced throughout their lives." We saw in records viewed that people's life histories were used to form the basis upon which their care plans were based. For example, if a person liked gardening or indoor activities such as knitting, then this was what they were supported with. People confirmed that staff always respected their dignity and never discussed other people or their individual circumstances. One person said, "I never hear them say anything about other people."

People had individual care plans which included guidance and information about what their preferences and wishes were. Most people we spoke with knew they had a care plan. We saw that people had confirmed their agreement to the care plan when they started using the scheme. We found that staff were knowledgeable about people's preferences. For example, when people liked to be woken up or when they needed help to attend their preferred hobbies. Where a person's relative was involved with the care this was clearly identified. This meant that staff were able to use the information in people's care plans to meet people's needs in the way the person wanted.

Independent advocacy arrangements were available if this was required. Staff told us that people using the scheme generally had a relative or friend but the information on advocacy was always available if needed.

Good

Is the service responsive?

Our findings

The scheme considered the local authority's Single Assessment Process (SAP). This was then used as part of people's assessment of their needs. In addition to the SAP the registered manager or senior care staff completed a full assessment of the person's care needs before they received care. This was to ensure that the service and staff were able to meet their needs. Relatives told us that they were always involved with their family member's care, either when they visited the person or by telephone. People were supported with hobbies, pastimes and interests that were important to them. For example, sessions with poetry, gentle exercise classes, knitting or reading a book or the scheme's own monthly newspaper. This was to help ensure people had as much choice as possible.

Staff respected people's chosen religious preferences whilst also respecting those of people who did not have any particular wishes. Staff told us they used this information to inform people's care plans and gain an individual understanding of what was really important to each person. Examples included, supporting people with audio recordings, art classes, sing-alongs and trips out to the seaside. One person said, "[Name of staff] regularly calls in to see me as well as receiving a morning call to make sure I am okay." Other activities included a visiting mobile library and visits from a selection of high-street retailers which people had requested.

Senior care staff told us that people's care plans were kept up to date by their appointed care staff (key worker). This was done at least annually or more frequently if there were more urgent changes needed. However, we found in some people's care plans that these had not always been reliably completed. This meant that some people's care was not based upon their most up-to-date care information. Although staff knew people's needs there was a risk that some out of date information in people's care plans could be used.

Meeting minutes showed us people were able to highlight areas they found needing improvement. Items covered included future trips out and new equipment people receiving personal care had requested. This proactive approach helped ensure that actions were taken to address any concerns or suggestions as swiftly as practicable. One person told us, "If I ever had concerns, which I don't, I would speak with [Name of registered manager] who is around most days." Complaints we viewed showed us that they were of a general nature and that there were no trends.

People were provided with information about how to raise a concern. This included details about the local authorities, people could access if their concerns were not responded to, to their satisfaction. Responses to people's complaints and concerns were acted upon within the timescales determined by the provider. We found that the daily contact with people in their flats or around the scheme enabled staff to identify and act on any issues quickly.

Staff meetings were also used to remind staff of their responsibilities. For example, ensuring medicines and care records were completed accurately and ensuring staff discussed people's care needs in private.

One person said, "I have never needed to complain as such. I just go down to the office and speak with [name of registered manager]. They sort things out as soon as they are able." People were supported to raise more general concerns during their regular visits by care and domestic staff from the scheme. This was to help ensure that any concerns were effectively addressed.

Good

Is the service well-led?

Our findings

We found that the provider and registered manager had quality assurance survey and audit programmes in place. These had identified several areas for improvement including ensuring that staff completed people's falls diaries and skin examination records. However, we found that these audits had not identified the issues we found. These included out of date inspections of equipment, the failure to identify and record risks to people's health and update these. Where maintenance was due on equipment, appropriate steps and measures were not in place to alert staff, that this was due. In addition, staff had not completed training on managing people's behaviours which could challenge others.

Staff confirmed that they were supported with supervision, annual appraisals and also on-going development opportunities such as gaining additional qualifications. One senior care staff said, "I really appreciated training on managing staff absence and the MCA." Staff showed us the matrix for their supervision and appraisals throughout the year. We saw that these were now regular and in line with the providers' policy.

People's views were sought daily, but more formal reviews took place including the option to take part in residents' meetings run by the agency staff. This was to obtain people's views and satisfaction of the quality of care they had received. People knew the registered manager's name or where they worked from. One person said, "The [registered] manager has a lot on her plate but she seems to get things done." This was by a variety of methods including visits to people in their flat on a one to one basis. The provider produced a newspaper with pictures and articles about what was planned in the scheme, events that had taken place including various trips, adopting a donkey and people's birthdays. We saw the May 2015 edition on a notice board and people could have copies. In addition, we saw that dates for residents' meetings were advertised and people were asked to share their views about the service. These meetings included those people who did not receive a service. However, this helped the registered manager prioritise any issues which affected people's care. We saw that actions, including times people preferred to be woken up, were acted upon wherever practicable.

We found from our review of accidents and incidents that the registered person's had notified the CQC of events they are, by law, required to tell us about. This included incidents involving, or investigated by, the police. We also saw that any trends in people's accidents and incidents were monitored. Action was then taken such as referrals to the falls team or obtaining equipment to support people with their independence. This information was then used to put measures in place. For example, to help prevent the potential for any recurrence such as changes to people's medicines or the format of medication that was provided.

One person said, "I have absolutely nothing to complain about it is wonderful here." And "The staff do their level best to meet all our needs." A visiting health care professional told us that, "If I ever needed a care service for my mum this is where I would choose."

We saw and staff told us that they supported people to maintain links with the local community which included going out on trips, going shopping and accessing a visiting chaplain.

All staff told us they really liked working at the scheme and that it was a good team. One care staff said, "If one of us is struggling then we all pitch in." All staff said that the registered manager was an approachable person, that their door was open and that they were keen to develop staff's skills.

Staff were not just aware of the values of the scheme but were able to recite these to us and explain what this meant for each person they supported. One care staff said, "It's not just about people's personal care, it is like treating people like I would like to be treated and respecting all their wishes." Another care staff said, "One of the good things about working here is that any concerns are addressed quickly." We saw that staff put these values into action.

The scheme had recently been awarded a rating of five (the highest) by the Food Standards Agency for a second time. Part of this assessment included management in maintaining high food hygiene standards. For example, having the right processes in place to ensure that a high standard of food hygiene and preparation was consistently achieved. This enabled those people who chose to use this facility to have a high standard of food service provision within the scheme.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: Risks to people's health and well-being were not always identified or acted upon. Regulation 12 (1) and (2) (a) (b)