Methodist Homes

Rowanberries

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Good

Summary of findings

Overall summary

We inspected Rowanberries Domiciliary Care Agency (DCA) on 18 July 2016 and our inspection was announced to ensure management was going to be available. The service was last inspected in October 2013 when it was found to be compliant in all areas inspected at that time.

Rowanberries DCA operates within the Rowanberries Housing with Care complex in the village of Clayton, about three miles from Bradford city centre and is part of the Methodist Homes (MHA) group. The agency is part of an integrated care scheme which aims to support older people to live as independently as possible within their own home. Out of 46 apartments, 43 people currently receive care and support from the DCA. Staffing is on-site, 24 hours a day which includes a chaplain, and there are extensive communal facilities including a restaurant/bistro, shop and lounges.

A registered manager was employed by the service. 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 off work due to illness on the day of inspection and the service was supported by the deputy manager and a registered manager from another similar MHA service.

People told us they felt safe when visited by the staff at the service and there were enough staff to support their needs. Some staff told us they would value an extra member of staff during busy morning periods, although the service deployed extra staff according to people's dependency needs.

Safeguarding procedures were in place and both people and staff were aware of what to do if there were any areas of concern. Risk assessments had mostly been completed where necessary although one bed rail assessment still required completion. We found accidents and incidents had been documented and appropriate risk assessments completed following these.

An effective medicines management system was in place. People received or were prompted to take medicines at the correct times.

A robust recruitment policy was in place with appropriate checks to ensure staff were suitable to work with vulnerable people. Staff had access to regular mandatory and service specific training and received regular supervisions and annual appraisals.

The service was adhering to the principles of the Mental Capacity Act 2005 and no-one was currently subject to Deprivation of Liberties Safeguarding (DoLS). We saw care was provided in the least restrictive way possible, people were asked for consent and independence was encouraged.

People had access to a range of health care professionals and were supported to access these if unable to

do so independently.

People praised the staff and told us they were kind, caring, compassionate and respectful of their privacy and dignity. They told us they were involved in the planning of their care, which was responsive to their changing needs.

Staff had a good understanding of people's likes, dislikes and care needs and enjoyed working at the service. Morale appeared good.

Detailed, person specific care records were in place which included assessments of people's care needs. People told us they had been involved in the planning of their care.

We saw the service promoted people's choice in all aspects of the service and we saw examples of the service respecting these choices.

The service employed a chaplain and an activities coordinator. A wide range of activities were on offer to promote social interaction, subject to people's choice.

Although only a small amount of complaints had been received, we saw these had been taken seriously and thoroughly investigated with outcomes and actions noted. People told us they had no complaints about the service.

People told us they felt able to approach the management with any concerns and had met the registered manager before they moved to the service.

Staff felt valued and supported by the management team, who in turn received effective support from the provider. Regular staff and management meetings were in place.

Regular tenant meetings were held to discuss a range of topics and to address any concerns.

A range of up to date audits and quality assurance tools were in place to ensure any issues were identified, remedial actions put in place and lessons learned.

Statutory notifications had been received by the Commission in a timely manner.

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.

Effective safeguarding procedures were in place and staff understood how to keep people safe.

Medicines were managed in a safe manner and people received or were prompted to take medicines at the correct times.

A robust staff recruitment procedure was in place which ensured people employed were suitable to work with vulnerable people.

Is the service effective?

Good

The service was effective.

People's choices were respected and consent was sought.

Staff benefitted from comprehensive training for key subjects and service specific courses. Staff supervisions and appraisals were regular and up to date.

People had access to a range of health and social care professionals and health care needs were addressed.

Is the service caring?

Good

People who lived at the service were treated with kindness and staff were praised for their care and attentiveness.

People's independence was encouraged and the service was responsive to people's changing needs.

Staff respected people who lived at the service and people told us the standard of care provided was good.

Is the service responsive?

Good

The service was responsive.

Care plans were detailed and person centred and care plan assessments were in place.

A comprehensive activities programme was offered to tenants in order to promote social interaction.

Complaints were treated seriously, documented, investigated and actions taken where necessary. Tenants told us concerns were listened to.

Is the service well-led?

Good

The service was well led.

Staff felt supported by management and able to discuss any concerns.

People were satisfied with the way the service was run.

Regular tenants and staff meeting were held.

A robust system of audit and quality control was in place.

Rowanberries

Detailed findings

Background to this inspection

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

The inspection took place on 18 July 2016 and we gave the service 48 hours' notice because the service provides a domiciliary care service and we needed to ensure the registered manager was available.

The inspection team consisted of two Adult Social Care Inspectors and an 'expert by experience' who spoke with people on the telephone. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience used on this occasion had experience of domiciliary care agencies.

Before the inspection we gathered information about the service from the local authority and commissioners, as well as information provided by the service in the form of notifications made to the Commission and the provider information return (PIR). The PIR which 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. We had also sent questionnaires to people that use the service to help inform the inspection and had received responses from 14 people that use the service, two staff members, one relative/friend of people that use the service and one community professional.

On the day of the inspection, we spoke with four people who use the service, one relative, three care staff, the assistant manager, the manager supporting the service on the day of the inspection, the activities co-ordinator and the service chaplain. The expert by experience spoke with four people that use the service and four relatives on the telephone. We reviewed four people's care records, some in detail and others to check specific information, four staff files, medicines records, staff training information as well as records relating to the management of the service.

Good

Is the service safe?

Our findings

People told us they felt safe at the service. One person said, "Yes. We've no complaints at all." Another person when asked if they felt safe told us, "Yes." 100% of people and relatives who returned the questionnaire agreed they felt safe from abuse or harm from their care and support workers.

A staff member told us, "People have said they felt safe with staff here 24/7," and another said, "I think tenants are kept safe."

Safeguarding procedures were in place. Appropriate safeguarding referrals had been made to the local authority and the Care Quality Commission. Staff had received safeguarding training and staff we spoke with had a good understanding of how to identify and respond to any suspected abuse or concerns they had about people's wellbeing.

Risks to people were assessed and managed appropriately. Risk assessments were in place covering areas such as moving and handling, falls prevention, and safety around people's homes. Mobility care records clearly detailed how to assist people with moving and handling and what equipment was used. One relative we spoke with told us they thought staff were competent in using hoists for transfers and that their relative was safely handled. Risk assessments were appropriate and subject to regular review. However we did identify that there was no bed rail risk assessment in place for one person. We raised this with the deputy manager who agreed to ensure this was put in place.

We found medicines were safely managed by the service. People told us they got their medicines in a timely way, for example one person said, "I get tablets at the time I need them." Medicine support was provided by senior care workers. This support was provided separate to people's personal care visits, which helped ensure a more person centred approach and allowed people to receive their medicines at the exact times they needed them. For example, arrangements were in place to ensure people who required medicines to be given before food received a call before their breakfast care call.

Risk assessments were in place detailing how to support people safely with medicines. We saw some people were supported to self-medicate and risk assessments were in place detailing how this could be done safely. During the inspection we saw staff ring one person to remind them to take their medicines as part of a programme to keep them as independent as possible.

We observed some people being supported with their medicines by the senior care worker. They adhered to good practice and wore gloves whilst handling medicines to reduce the risk of infection.

The service kept a complete record of the medicines they were supporting people with. This was kept within the care records for quick reference and also detailed on the Medicine Administration Records (MAR) present in people's rooms. We looked at MARs and saw they were appropriately completed and corresponded with the medicines people had in their homes. Where people were administered liquid medicines, the date of opening was written on the side of the bottle by staff to ensure it was clear when the medicine would expire.

The service undertook a weekly stock check of people's boxed medicines to ensure the correct number of tablets were in stock and ensure any discrepancies were identified in a prompt manner.

Where people were prescribed topical medicines, a topical medicine chart was kept detailing what they were prescribed and what area of the body staff were to apply it to. This helped ensure the safe administration of topical medicines.

Systems were in place to assist people to order medicines in a timely manner and dispose of medicines that were no longer needed.

We did identify where people were prescribed 'as required' medicines, there were no protocols in place detailing under what conditions people required these medicines. This could lead to inconsistent administration of these types of medicines. However, staff were able to tell us when these types of medicines would be administered, which showed us the risk of this occurring was minimal.

Accidents/incidents were recorded in line with the provider policy and using the provider forms. We noted the format of the forms was a narrative of the accident/incident and did not have a section for any analysis or action plan as a result, such as a comment to say, 'risk assessment completed', or 'care plan reviewed'. We spoke with the manager who was supporting the service on the day and they agreed this would be a useful addition. They told us the form was one generated by the provider, although the deputy manager confirmed risk assessments were completed as required following accidents/ incidents. Our review of people's care records confirmed this was the case.

We reviewed staffing levels and concluded there were enough staff deployed to meet the current care and support needs of people living at the service, although the assistant manager told us they deployed extra staff according to people's dependency needs. One staff member told us, "They have put extra people on when a poorly tenant needed extra support. There are enough staff. I don't feel rushed." However, some staff we spoke with said they felt particularly stretched and rushed during morning calls. They said, "With the residents who need more care, don't think we have enough staff. Could do with another member of staff during the mornings; we can be rushed off our feet."

People we spoke with told us they received care from regular staff who understood how to meet their individual needs. This was confirmed by the results of the Commission questionnaire which showed 100% of people who responded received care and support from regular staff. One person told us, "We get regular staff that we know and who know us." Another person said, "We've got regular staff that we know and they work shifts (so we know who is coming when). It's a regular routine." A third person commented, "We've got regular carers and they've got to know [person]." Another comment made by a person's relative was, "They're all very nice and we've developed a positive relationship with them. They know how to meet [person's name] needs."

We looked at staffing records and saw staff were recruited in line with the provider's policy. Safe recruitment procedures were in place to ensure staff were of suitable character to care for vulnerable people. We looked at four staff files and saw all staff completed an application form, attended an interview, had proof of identity and two positive references. The service also carried out a Disclosure and Barring Service (DBS) check on all candidates to confirm they were suitable to work with vulnerable people.

Good

Is the service effective?

Our findings

People and relatives spoke positively about the effectiveness of the care and support provided. For example one person told us, "They do things to a very high standard."

Some people looked after their own dietary needs and others told us staff assisted them appropriately to eat or drink or supported them to access the restaurant in the communal area of the complex. Where people required support with food and drink, care records were in place setting out the required support.

Some people received assistance with eating and drinking from various parties including relatives, the provider and other care agencies. Plans were in place to ensure a co-ordinated approach to this support. We spoke with one person's relative who told us their relative was party to such arrangements. They said there was good co-ordination between all parties and the arrangements worked well to ensure their relative had enough to eat and drink. One person told us when they had been ill, staff had 'stepped in' and supported them effectively. Some people were prescribed nutritional supplements and we saw plans were in place to help ensure people received these. Where dieticians had been involved in people's care and support their advice was documented within care files for staff to follow.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In the case of Domiciliary Care applications must be made to the Court of Protection. We found no people were currently subject to DoLS. We did not identify any concerns relating to people being deprived of their liberty by the service and concluded that care was provided in the least restrictive way possible.

We saw evidence in daily records of care that people were asked for their consent on a regular basis, for example about what they wanted to do and eat. We saw where people refused care and support or food/drink this was respected by staff and documented.

Where people lacked capacity to make decisions relating to their care and support, basic information was recorded within a dedicated section within their care record. In one case, we saw a person had a mental capacity assessment document in place which detailed how staff were to support the person to make decisions and ensure decisions were made in their best interests. However we identified another person who lacked mental capacity to consent to aspects of their care and support, had bedrails in situ. There was no assessment of their capacity to consent to bed rails or evidence that a best interest process had been followed to ensure the provision of bed rails were in their best interest. From our discussions with the deputy manager, we felt assured this would be addressed.

We reviewed the staff training records and saw a training matrix was in place. Staff training was up to date or booked and covered key topics such as moving and handling, emergency first aid, infection control, safeguarding and medicines management as well as other topics such as pressure ulcer prevention and general health conditions. The deputy manager told us they were also committed to sending staff to 'The Person Inside' three day dementia course run by Bradford University. Staff we spoke with said they felt they had really benefitted from this extended training.

People we spoke with told us they had confidence in their care worker's training and knowledge. One person told us, "Yes, they are skilled and know what they are doing as far as we can say," and another agreed staff knew what they were doing, saying, "Yes, I would say so."

We saw evidence of annual appraisals and regular supervision meetings designed to support staff and maintain a high quality of service delivery. Staff confirmed these took place, were an appreciated feature of working at the service and an opportunity to discuss concerns and plan their development.

People we spoke with told us staff would help them with their healthcare needs as and when required and they had access to a range of healthcare professionals. One person told us they felt staff responded well in a medical emergency situation, saying, "They stay calm and respond appropriately. They are trained to do so." We saw arrangements were in place to ensure people's healthcare needs were met. Information on people's medical conditions was present within their care records and how best to support them. Care records provided evidence staff supported people to access a range of health professionals including community matrons and district nursing teams and dieticians. We saw meetings took place with these professionals to co-ordinate care, for example around pressure sores.

Good

Is the service caring?

Our findings

People we spoke with indicated staff were kind, caring, attentive and responsive to their changing needs. For example, we saw the senior care worker supported people with their medicines in a caring and supportive manner. Six people we spoke with commented on the service. These comments included, "We've no issues with any of the staff. They are kind, caring and understanding," "They really care for people and involve them," "We've no complaints. They are very understanding," "They are very good, no problems at all, only need to ask and they will help, very happy," "Staff are very helpful," and, "I class it as a five star hotel."

One relative told us "It's the individualised care and support here, the small things, they understand [person] and [person's] routine."

When asked about the standard of care provided, the response was overwhelmingly positive from the people we spoke with and the majority of responses to the questionnaire. People told us, "Yes, it's very good," and, "It's some of the best."

Staff had a good knowledge of people who lived at the service and were able to tell us about their likes, dislikes and care needs. People confirmed staff knew them well and they had built up good relationships with their care workers. One person told us, "They're all very nice and we've developed a positive relationship with them." A member of staff commented, "I think staff know the residents really well. They treat them as they need to be treated."

We saw evidence of encouragement around independence and goal planning. Care plans focused on ensuring people remained as independent as possible. People told us the service helped them maintain their independence. Two people we spoke with praised how staff offered appropriate support but encouraged and supported them to do as much as they could for themselves, for example, in the preparation of their own meals. When we asked one person if staff encouraged their independence, they answered, "Yes. As best they can. We couldn't live 'at home' without their support." 86% of people who commented in the questionnaire agreed the support and care they received helped them to be as independent as possible. A staff member told us, "We are promoting independence here. We try to get them to keep their independence for as long as possible."

We asked people if they were offered choices and were involved in making decisions about how their care was provided. One person told us, "Yes they do," and another person's relative told us, "Yes, they do. They ask [person's name] questions and respect [person's name] decisions." People told us they had seen their care records and had been involved in developing it. One person and their relative commented when asked about their involvement, "Yes. We have been involved. We're always discussing things."

Care records contained information on people's likes, dislikes and personal preferences. For example, these included what they liked to eat/drink and what leisure activities they liked to get involved in. Information was present which detailed people's life histories and backgrounds. This information helped staff to understand people and provide a person centred approach to care and support. Care plans focused on

people's goals and aspirations to help people achieve things such as going on holidays.

We saw where appropriate, future wishes and end of life arrangements were documented within people's care records.

When people started using the service they were 'inducted' to the service. This helped them to adjust to the service and find out about its aims, objectives and the services offered. For example, the service user guide and statement of purpose were explained to people. This helped ensure a seamless transition into the service.

People living at the service had access to advocates where necessary. Advocates support individuals, particularly those most vulnerable in society, to ensure their voice is heard on issues that are important to them and correct procedures are followed by the registered provider and other health professionals.

Everyone who responded to the questionnaire agreed staff respected their privacy and dignity, as did the majority of people we spoke with. One person said, "We've had no issues," and another commented, "They never intrude but will help if needed or asked." However, one relative commented they had noticed their relative wasn't always covered up when receiving personal care, although they hadn't reported this. This showed us sometimes people's dignity was not fully respected.

We spoke with a senior staff member who told us, "I watch them (staff). They always ring the bell and say who it is. They go and introduce themselves and watch their face. They make sure towels are over them, ask what clothes they want to wear, ask what they want to eat. It's their home. We ask them everything." Another member of staff said, "Staff treat people as individuals. They will sit and talk to people if they're upset and take them somewhere private."

Good

Is the service responsive?

Our findings

One relative told us, "Superb, there isn't any one of them I would fault at all, carers and seniors are both superb. [Person's name] wouldn't be here now if it wasn't for the staff here."

The service delivered care solely to residents of the Rowanberries complex. Eligible people who moved into the complex were subject to an admissions assessment should they require personal care from the service. Following this, a plan of care and support was put in place which covered areas such as continence, moving and handling, eating and drinking and washing/dressing. These provided clear information to support staff in providing personal care. Staff we spoke with demonstrated a good understanding of the people they were caring for, providing us with assurance that care records were followed.

Care records were subject to regular review by senior care staff to ensure they were relevant and reflected people's current needs. Periodic reviews also took place with people and/or their relatives to evaluate the success of care and support plans. The care reviews we looked at were all positive, demonstrating people and their relatives were happy with the care and support provided.

People had call bells which they could use to summon assistance in the event of an emergency. We spoke with one person who told us they had once rung for assistance after a fall and staff were very quick and responsive. Another person told us, "If we pull the cord they'll be here in minutes." We saw examples in daily records of staff being responsive to people's needs and personal circumstances, for example scheduling extra care visits or coming back a bit later in the day if people weren't quite ready for personal care.

Daily records of care provided evidence of the care and support provided at each visit. These were largely well completed and provided evidence people received care at appropriate times each day with a reasonable level of consistency.

Some people were at risk of developing pressure sores. We saw they had appropriate care records in place and staff provided care visits at consistent times in line with the care records to ensure timely pressure relief.

Some people required two carers for safe moving and handling. In most cases daily records provided evidence that two staff had attended these calls. However in two people's records we identified that on a number of occasions only one staff had signed the record during overnight pressure relief calls. We therefore could not confirm whether two staff had attended, in line with the plan of care. We raised this with the manager who told us they would investigate this discrepancy.

Care and support was planned to help meet people's social needs. For example we saw staff had identified that one person with complex needs was becoming isolated, so had worked with health professionals to develop an appropriate plan of care which allowed them to spend a number of hours within the communal area of the building complex to help meet their social needs.

The service employed an activities coordinator 35 hours per week who worked with the service chaplain with some activities. We saw good evidence of social activities during our inspection with weekly activities displayed in three separate areas on the ground floor. Activities included parties for various occasions, making up hanging baskets, take-away evenings, pub lunches, theatre visits and trips out. We saw the service had held a Spring Fair in June 2016 which some tenants had helped organise. One activity the activities organiser and the chaplain told us they were particularly proud of was the 'Cameo' (Come and Meet Everyone) afternoon which was held every Monday and had proved a big success. This included a variety of activities designed to bring the tenants together, such as sing-a-long (including a selection of hymns), reminiscence, knitting, intricate colouring and 'rag rugging', where a group of tenants would work on the same piece. The activities organiser explained the intention of the activity was to get people who wouldn't normally mix interacting with each other.

We saw the service catered to people's individual wishes wherever possible. For instance, a local scout group had come to visit the service after one of the tenants who used to be a scout leader had asked if this was possible.

Equipment such as hoists were used for those people where necessary and staff were trained in moving and handling techniques. However, where possible, people were encouraged to be more independent with their mobility and alternatives were considered. For instance, one person's relative told us, "They use the hoist now and then but we are now looking at a rotating stand as [person's name] isn't keen on the hoist."

We saw the service encouraged involvement with the local community. For instance, the old local hospital had been turned into a Muslim boarding school. One of the teachers regularly visited with pupils to reminisce about the changes in the building and interact with tenants with crafts and board games. The activities organiser was also planning to invite children from the local nursery school to spend time with tenants.

Complaints were brought to the attention of people via the service user guide which detailed how to raise a concern. We saw complaints were appropriately documented and actions clearly seen. People told us they knew who the manager was and how to complain, saying, "Yes, I do," and, "I'd just pick up the phone." They told us any issues had been dealt with immediately and effectively. For instance, an outside manager had come to the service to investigate concerns raised by a member of staff and a thorough, documented investigation had taken place. This indicated the service took complaints seriously, listened to people and took the appropriate actions. A small number of complaints had been received in the last year and we saw these had been appropriately responded to in a timely way. A significant number of compliments had also been received by the service, detailing areas where the service exceeded expectations.

Good

Is the service well-led?

Our findings

Tenants and staff praised the approachable nature of the management team and the way the service was run. For example, one person's relative told us they had contacted the registered manager about one of the carers and had been happy with the response. Another relative told us where they had raised a concern, the matter had been immediately resolved, "Without fuss or any residual problems."

People told us they felt comfortable raising concerns and these were dealt with effectively. One person told us, "Manager is very nice. I feel I can go to [manager's name] with a problem." Another commented, "Nothing needs improving, you can't improve on perfection." A relative told us, "Can go to the registered manger with issues, and seniors. [Manager's name] is very knowledgeable, friendly and approachable." 86% of people who responded to the questionnaire told us they knew who to contact in the service and had been asked their opinions about the running of the service.

Staff told us they enjoyed working at the service and felt supported. One staff member told us, "I feel supported. If I had a problem I'd go and tell them (manager)." We saw the service fostered teamwork amongst staff who told us, "It's a very good team, can depend on them. They ask, "Do you need any help". They're all really good." Another staff member commented, "We all support each other and look after each other."

We saw the manager had an 'open door' policy and also held regular surgeries in their office when people could speak to them in private about any concerns. The management had an open and honest approach to running the service. For instance, when a recent concern had been raised by an employee, a manager from a different service came to investigate the issues raised, to allow an impartial view.

During our inspection, we observed morale was good amongst staff and there was a relaxed atmosphere at the service. This was confirmed by speaking with staff members and by reviewing staff records and noting a low staff turnover. The deputy manager told us a couple of members of staff had recently left to go to work elsewhere but had now returned to work at the service. This showed us staff felt the service was a good place to work.

The assistant manager told us they had good communication and support from the provider and the area manager visited the service on a regular basis. Management support and sharing of 'best practice' was also provided with regular manager meetings, held at different service locations throughout the year.

We reviewed minutes from the tenants meetings and saw these were held every six to eight weeks and discussed a wide range of topics from activities and events to staffing and any concerns.

Staff meetings were held monthly and were an opportunity for staff to raise any concerns as well as to discuss documentation and communicate service and provider updates. Staff saw these as a good opportunity to discuss matters as a team.

We reviewed the service quality assurance processes and saw these were robust and up to date. A wide range of audits were carried out including health and safety and medicines and we saw where actions were taken as required as a result of these.

Tenant surveys were carried out annually and feedback analysed. An annual activities survey also helped inform the activities coordinator about future plans.

Statutory notifications had been made appropriately to the Commission.