

Methodist Homes Amathea

Inspection report

Newlands Lane
Workington
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Ratings

Overall rating for this service

Requires Improvement ●

Is the service safe?

Requires Improvement ●

Is the service effective?

Requires Improvement ●

Is the service caring?

Requires Improvement ●

Is the service responsive?

Requires Improvement ●

Is the service well-led?

Requires Improvement ●

Summary of findings

Overall summary

This comprehensive inspection took place on 27 and 28 February 2017 and the first visit day was unannounced. We last inspected Amatheia in December 2014 and we rated the service as good overall.

Amatheia is located a short distance from the town centre of Workington. It is a modern two story building set in its own grounds with parking to the front and a private secure garden to the rear. Accommodation and care is provided for up to 40 older people with disabilities or with chronic illness, the ground floor unit is designated to people living with dementia.

There was a registered manager in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

During this inspection we found breaches of Regulation 19 Fit and proper persons employed, Regulation 11 Need for consent and Regulation 9 Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not all of the appropriate suitability checks required by law to ensure that the persons being employed were of good character had been completed before people commenced employment. This was a breach of Regulation 19 Fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Medicines were being administered and were being kept safely but records relating to the application of topical medicines and creams had not been consistently completed.

We have made a recommendation that the records for the application of topical medicines and creams are reviewed to ensure that the correct application instruction is identified consistently.

On the days of the inspection there were deemed to be sufficient numbers of staff but we observed they were not always available at the time when people most needed them. The provider was in the process of recruiting more staff and developing the current staff team skills.

The processes used for identifying how best interest decisions were made for people who lacked the capacity to make complex decisions for themselves had not always been recorded. We also saw that consent to care and treatment had not always been obtained from the relevant persons with the legal authority to do so. This was a breach of Regulation 11 Need for consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us they had a good choice of foods made for them and that they enjoyed it. We saw that people

were not always sufficiently supported during the mealtime to ensure they had their needs met. People who were at risk of not having their nutritional needs met had been referred to the appropriate health professionals.

Staff had received a variety of training on commencing employment and on going training in specific topics to assist them in their roles. However we did not see that their knowledge and skills were consistently applied. Areas of development for staff had been identified by the registered and area support manager. One of these areas for development was the consistent demonstration by staff of dignity and respect.

We have made a recommendation that further staff development is provided to support staff in promoting dignity and respect of the people they are caring for.

Care records lacked some current information about peoples individual care needs. Care was not always being provided in a person centred way. We did not see that people had always been involved in their care planning or had consented to their care and treatment. This was a breach of Regulation 9 Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People living in the home were supported to access activities that were made available to them and pastimes of their choice.

The registered manager and provider had recognised areas of improvement required in the service and had already taken action to address these areas.

'You can see what action we told the provider to take at the back of the full version of the report.'

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement ●

The service was not always safe.

There were sufficient numbers of staff available but we were told they were not always deployed in the best way.

Checks of suitability had not always completed to ensure fit and proper persons had been recruited.

Where safeguarding had been identified it had been appropriately reported.

The management of medicines was safe but records for the instructions to apply topical medicines were not always accurate.

Is the service effective?

Requires Improvement ●

The service was not always effective.

Consents had not always been obtained from the relevant person.

People were happy with the food provided however people were not always sufficiently supported during the mealtime.

People had their nutritional needs assessed and referred to the appropriate health professionals

Is the service caring?

Requires Improvement ●

The service was not always caring.

We saw that staff did not always show they respected maintaining people's dignity.

People told us that they were being well cared for and we saw that the staff were friendly in their approaches.

People's preferences for care at their end of life had identified and recorded.

Is the service responsive?

The service was not always responsive.

Information in people's care records was not always reviewed and recorded accurately when a person's needs had changed.

There was a complaints system in place and people knew how to raise any concerns.

We saw there were a variety of activities which people took part in.

Requires Improvement ●

Is the service well-led?

The service was not always well led.

Not all processes in place to monitor the quality of the service were effective.

The registered manager and provider had already taken action to address the development of staff in order to improve the quality of the service.

The registered manager worked well with other agencies.

Requires Improvement ●

Amathea

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 was 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 unannounced inspection took place on 27 and 28 February 2017 and was carried out by two adult social care inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at the information we held about the service and including information from the general public, staff, community nurses and the local commissioners of the service.

We did not have a Provider Information Return (PIR) when we visited. 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 registered provider had not received the request for a Provider Information Return (PIR) before our inspection.

During the inspection we spoke with the registered manager, the area support manager, four members of staff, four people who used the service and seven relatives. We observed how care staff supported people who used the service and looked at the care records for six people.

We looked at the staff files for staff. These included details of recruitment, induction, training, supervisions and personal development. We looked at the overall training record for all staff. We also looked at records of maintenance and repair and other quality monitoring documents.

Is the service safe?

Our findings

People living at Amatheia that we spoke with told us, "It's alright here, I feel safe." Another person told us, "There seems to be enough staff but they are always busy, but I do feel safe here." A relative we spoke with said, "It's alright, there seems to be enough staff, it's okay, I am happy my relative is safe here." Another relative we spoke with raised some concerns about an event relating to a recent safeguarding incident. We immediately discussed this with the registered manager and the area support manager. The event was already known to them and it had been appropriately referred to the local safeguarding team. This demonstrated that the registered manager took appropriate actions to safeguard people living in the home.

Staff we spoke with during the inspection told us they understood their responsibilities to report any safeguarding concerns. One staff member told us, "I would say if there was anything safeguarding, well you've got to. We are sometimes the only ones who care what happens to them [people living in the home]." Another member of staff told us, "I would be happy to report anything wrong if I saw it." We saw from records that staff had been trained in identifying different types of abuse and how to report it. However from observations made and what inspectors were told during the inspection visit did not reflect that all of the staff understood their duty in keeping people safe. This area of staff development was already being addressed by the registered provider and management team with the support of the local authority adult social care team.

We looked at the staff files for recruitment and saw that not all the necessary checks of suitability on employment had been completed. Information about people's previous employment history and reasons for leaving employment had not always been noted. References had been sought however we noted that they were not always from the most recent or previous employer in accordance with the registered providers recruitment policy.

This was a breach of Regulation 19 Fit and proper persons employed of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because not all the records of the appropriate suitability checks required by law to ensure that the persons being employed were of good character.

We looked at records of the accidents and incidents that had occurred in the home. We saw that where necessary appropriate treatment had been sought and notifications to the appropriate authorities had been made.

We looked at the staffing rotas including the two weeks prior to the inspection and found that staffing levels through the day had been inconsistent in the numbers of staff on duty for each shift. Care staff numbers varied on different shifts. The registered provider did not use a dependency tool to calculate staffing levels required to meet people's needs. We were told by the registered manager that the numbers of staff on each shift varied based on the needs of the service for example on two days per week the community nurses spent time in the home. On these days the staffing numbers were increased by one to ensure that the visiting nurses had a member of staff to support them. We spoke with the visiting community nurse who told

us that the arrangement of having an identified member of staff to assist was very beneficial and worked well.

During the two days of the inspection we observed, at times, there was a delay by staff in responding to the sound of call bells for people requiring assistance and that staff appeared to be leisurely in answering them. We observed on both floors of the home that staff were not always present in sitting areas or the dining room where people were sitting on their own and left unattended for up to 30 minutes. We saw on the dementia unit that people were free to walk around and explore. However some people living there required a higher level of supervision and we did not see that this level of supervision was consistent. Staff we spoke with told us, "We could do with more staff but they tell us there are new ones starting so that will be good." A relative we spoke with said, "There seems enough staff." Another relative told us, "I have stopped coming at weekends because you can stand outside for ages waiting to be let in, my sister still comes and says she also waits for ages but during the week it's much better."

We discussed the level of staffing available with the area support manager and registered manager who told us that they felt there were sufficient numbers of staff but they could be better deployed at key times through the day. The registered provider was still in the process of recruiting and staff that had been recently recruited were due to commence working once all the checks of suitability had been completed.

We looked at how medicines were managed. The recording of medicine administration and stock control was being completed electronically via an online system. This had been recently introduced and had significantly reduced the risks of administration errors. Medicines were stored appropriately and administered by people who had received the appropriate training to do so. We looked also at the handling of medicines liable to misuse, called controlled drugs. These were stored, administered and recorded correctly. Regular checks on controlled drugs were carried out.

We saw that there were plans in place that outlined when to administer extra, or as required, medication. There were procedures in place for the ordering and safe disposal of medicines. We found that suitable care plans, risk assessments and records were in place in relation to the administration of medicines taken by mouth. However, the records for the administration of creams were not always in line with the actual prescription. Care plans for the use of creams did not always identify how to use them as in line with the original prescription.

We recommend that the records for the application of topical medicines and creams are reviewed to ensure that the correct application instruction is identified.

Is the service effective?

Our findings

People living at Amatheia all told us that they enjoyed the food. One person said, "The food is marvellous, I don't know how they do it, we get two meal choices and we have breakfast when we want and there is always a cup of tea." We observed the lunchtime meal served on the dementia unit and saw most people were sitting in their friendship groups. Where people chose to or were nursed in bed meal trays were taken to their rooms. A choice of main meal was offered and this was served on coloured plates and where necessary adaptive cutlery and plate guards were provided.

We observed that the dining experience on our second day of the inspection was very unsettled and not very person centred. Staff had been provided with cotton tabards as protective covers however we noted that most of these did not fit or could not be fastened and therefore did not always remain in place. This meant that cross contamination could happen. People who lived there were not offered aprons or prompted to use paper napkins. We saw that one person who required assistance to eat had a blue plastic apron tucked into their jumper to protect their clothing. This meant that people who struggled to eat independently were not offered the choice to have their clothing protected from food spillages. There was a radio playing a pop music channel and directly outside the open dining room doors a carpet was being deep cleaned. This made the dining room very noisy and not conducive for a relaxed atmosphere.

Staff were continually in and out of the dining room, supporting people in their rooms to eat. People had been into the room and staff assisted in seating them. However during the meal time people often got up from their seats and wandered out of the dining room without staff seeming to notice. For example we saw one person got up and walked out of the dining room carrying a knife and glass of juice unseen by staff. We immediately called attention to a member of staff who retrieved the knife and guided the person back to their seat to continue with their meal. We also noticed that two people nearly left the dining room without being offered a pudding. The cook who was serving the food highlighted this to the care staff in the dining room. This put people at risk of not receiving sufficient support when eating their meal. We have addressed this in the domain of caring.

We saw that people had nutritional assessments completed to identify their needs and any risks they may have when eating. There was also information on specific dietary needs such as diabetic diets and soft and pureed meals as well. However where one person had been identified as at risk of malnutrition and weight loss had occurred we did not see that actions taken had been recorded. We discussed this with the registered manager on the first day of our inspection and she took action to amend the records that had been referred to the dietician following a noticeable weight loss.

We looked at the staff training records which showed what training had been done and what was required. We saw that staff had completed induction training when they started working at the home. We saw that regular refreshing of training was arranged and the second day of our inspection in house training took place on the management of behaviours that might challenge the service.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of

people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called DoLS. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

We looked at care plans to see how decisions had been made and recorded around 'do not attempt cardio pulmonary resuscitation' (DNACPR). We saw that GPs had made clinical decisions as to whether or not attempts at resuscitation might be successful. We noted that some forms stated that they had been completed in the best interests of people who used the service.

Guidance on how to act in people's 'best interests' is outlined in the Mental Capacity Act 2005. The act states people's levels of capacity to make important medical decisions must be measured and documented. We found that the process for best interest decisions had not always been formally noted in the written records. We also noted that where two people lacked capacity to consent to care and treatment that the consent had been obtained from a relative who did not have the legal authority to do so.

This was a breach of Regulation 11 Need for Consent of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because care and treatment must only be provided with the consent of the relevant person.

Where people were living with dementia there was minimal signage and décor to show people what different areas were for. How the environment is decorated could improve in helping people with memory problems to be able to move around their home more easily and more independently. We discussed this with the area support manager and registered manager who were looking into some environment improvements. We saw that people had been able to bring some personal items into the home with them to help them feel more comfortable with familiar items and photographs around them. Bedrooms we saw had been personalised with people's own furniture and ornaments to help people to feel at home and people were able to spend time in private if they wished to.

Is the service caring?

Our findings

Our findings

People who lived in the home we spoke with told us, "The staff are very kind and friendly." Another person said, "It's very good, it's my home here now. The girls [care staff] are very nice. I do like the new ones, they are very kind." Relatives we spoke with gave mixed comments about how caring the home was. One relative said, "There are one or two really good carers, I wish they had more like them." Another said, "We have mixed feelings but our [relative] loves it and is very happy here." We were also told, "We are more or less happy, we just wish they would check on [relative] more often."

During the second day of our inspection we were told by two relatives they were unhappy with the standards of care their relatives were currently receiving. We immediately spoke with the area support manager and registered manager. The concerns raised were promptly responded to and resolved by the registered manager.

We spent time on the two floors in the home observing how staff supported and interacted with people living at Amatheia. We saw that staff appeared that were predominantly task orientated and the time made available for spending time with people who lived in the home seemed brief. Although when staff actually took time to interact with people they were caring for we observed some very positive and caring interactions between them with some friendly chatting and appropriate hugs.

Some of the situations that occurred in the home observed by the different members of the inspection team over the two days indicated that people's dignity and respect at times was compromised. For example the lunch time meal experience where staff appeared not to be aware of people's movements and needs. We also saw that where someone clearly wanted to use the bathroom staff had walked past without asking the individual about their needs. Attention to this person was raised to staff by one of the inspection team.

These examples of our observations plus others seen during the two days of the inspection were shared with the area support manager and registered manager. Both managers were very aware of the development needs of staff conduct in the home and actions had already been identified to improve this. We saw that this was appropriately being addressed by the registered provider with the support of the local adult social care team.

We recommend that further staff development is provided to support staff in promoting dignity and respect of the people they are caring for.

Information was available about support agencies such as advocacy services that people could use. An advocate is a person who is independent of the home and who can come into the home to support a person to share their views and wishes if they want support.

We saw that some people's treatment wishes had been made clear in their records about what their end of life preferences were. The care records contained information about the care people would like to receive at

the end of their lives and who they would like to be involved in their care. This was to ensure people who could be involved with planning their end of life care were cared for in line with their wishes and beliefs at the end of life.

Is the service responsive?

Our findings

We saw that a full assessment of people's individual needs had been completed prior to admission to the service to determine whether or not they could provide them with the right support that people required.

We saw that information recorded in people's care plans did not always provide staff with accurate and up to date information about how to support individuals. We noted from the regular reviews of care records that where some people's needs had changed the care plans had not been updated to reflect their current needs. For example where someone had developed an infection and where someone had fallen. This meant that the plans for caring and supporting people's needs were not always accurate.

Care plans were not always written in a person centred way. Person centred care planning is a way of helping someone to plan their care and support taking into account their individual preferences and what is important to them. Although care records were very accessible to people who lived at Amatheia and to their visitors some care records did not contain relevant and appropriate information relating to current health needs. For example weight loss management and dietary requirements. Where one person had been referred to professionals to support their individual dietary requirements there were no records to show what involvement or guidance had been shared with the staff team.

This was a breach of Regulation 9 Person centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the plans for the care and treatment of people did not always accurately reflect people's needs.

We could see in people's care records that the home worked with other health care professionals and support agencies such as local GPs, community nurses, mental health teams and social services in order to meet people's needs.

There was a complaints process in the home and people we spoke with were aware of who to speak with if they wanted to raise any concerns. We saw that complaints had been received and managed in line with the registered providers policies and procedures by the registered manager. One relative told us they had made a formal complaint and had been reassured by the way in which the registered manager had dealt with it.

On the day of the inspection there was a visiting hairdresser who regularly attended the home to provide her services. The home employed an activities coordinator and we spoke with them about their role in the home. We saw that there was a regular programme of activities available to people who chose to join in them. We also saw that individuals were supported with activities of their choice if people chose to stay in their rooms. We saw that adequate resources were available for specific activities such as crafts like knitting. People were also supported to access activities in the local community. People's religious needs were also catered for by the regular attendance of and the services of the chaplain.

On the ground floor dementia unit people could easily access a secure garden and patio area with raised floral beds and seating surrounded by decorated colourful walls.

Is the service well-led?

Our findings

The home had a registered manager in place as required by their registration with the Care Quality Commission (CQC). Staff we spoke with said that they really enjoyed working in the home. One member of staff said, "It's good to work here, we can talk to the manager about things and we get our training." Another staff member said, "It's good here, I used to work in another care home and this is so much better, we get a lot of training, a lot is done on line but it is good."

There were systems in place for reporting incidents and accidents in the home that affected the people living there. Where required CQC had been notified of any incidents and accidents and when safeguarding referrals had been made to the local authority.

Following some recent incidents in the home relating to the safety and quality of the service the registered manager was working closely with the local authority in improving the quality of the service. The registered provider had also taken action in providing extra managerial support in the home on an interim basis in order to allow the registered manager to develop the staff team in areas of practice and improve the quality.

At the visits made by the area support manager we saw they checked the quality and safety of the environment and spoke with staff and people who lived in the home. This meant that people were also given the opportunity to express their views about the service to a different senior person in the organisation. This helped the registered provider to maintain oversight of the home to ensure people received a good service. We also saw that the registered manager had an action plan in place to address areas for improvements in the home.

Although there were systems in place to assess the quality and safety of the service provided in the home these had not always been effective. The audits in place for care plans and care records had not always detected that some records were not accurate for example the records for prescribed creams and where changes in peoples care needs had occurred.

Regular staff supervisions took place. Staff had opportunities to contribute to the running of the service through regular staff meetings. We saw the minutes of these meetings and saw staff were involved in discussions about how the service could improve.

The provider worked in partnership with other professionals to ensure people received appropriate support to meet their needs. We saw records of how other professionals had been involved in reviewing people's care and levels of support required. One person at the home had regular support from community nurses and the home worked with the nursing team to meet this person's needs.

Maintenance checks were being done regularly and we could see that any repairs or faults had been highlighted and acted upon. There was a cleaning schedule and records relating to premises and equipment checks to make sure they were clean and fit for the people living there.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care This was because the plans for the care and treatment of people did not always accurately reflect their needs.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent This was because care and treatment must only be provided with the consent of the relevant person.
Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed This was because not all the records of the appropriate suitability checks required by law to ensure that the persons being employed were of good character.