Methodist Homes

Trembaths

Inspection report

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Date of inspection visit:
07 February 2018

Date of publication:
19 April 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This unannounced inspection was carried out on 07 February 2018. During our last inspection in July 2017 we rated the service as requires improvement. Following this inspection the rating remains requires improvement. This was because, although we saw improvements had been made following the last inspection, these improvements have not yet been fully embedded within the culture of the service. We also found some additional aspects of the service which required action before the service could be rated as good.

Trembaths is a 'care home with nursing'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Trembaths accommodates up to 51 people in one adapted building across two separate units, each of which have separate adapted facilities. One unit is for people with nursing needs and the second is for people with residential needs including people who live with dementia. At the time of the inspection there were 41 people living at the home.

Since the last inspection the registered manager had left the service and one of the provider's area support managers was acting into the role until such time as a permanent manager was recruited. The area support manager (acting manager) had commenced the process to register. 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.

Following the last inspection, we met with the provider to confirm what they would do and by when to improve the key questions Safe, and Well led to at least good. A condition was placed on the provider's registration requiring them to provide monthly reports on their progress towards meeting the required standards. The provider also submitted an action plan showing what action they would take and by when to address the concerns identified at the inspection.

This inspection was done to check that improvements to meet legal requirements planned by the provider after our July 2017 inspection had been made. The team inspected the service against two of the five questions we ask about services: Is the service well led, and is the service safe? This is because the service was not meeting some legal requirements within these two questions.

No risks or concerns were identified in the remaining key questions through our ongoing monitoring or during our inspection activity, so we did not inspect them. The ratings from the previous comprehensive inspection for these key questions were included in calculating the overall rating in this inspection

There were systems and processes in place to safeguard people from harm, and incidents were reported

appropriately. When mistakes were made by the provider or staff, these were acted on, lessons were learned and improvements were made.

The provider had policies and systems in place to protect people from the risk of infection. However, some staff did not always follow good practice in relation to infection control.

Medicines were not always managed safely. The provider was aware of this and was taking appropriate steps to improve this and reduce the risk of harm to people.

There were sufficient staff to support people safely although the way in which work was organised sometimes resulted in delays in meeting people's needs. The provider had effective recruitment processes in place.

There were risk assessments in place that gave guidance to staff on how risks to people could be minimised and these were regularly reviewed and updated when people's needs changed.

The provider encouraged feedback from people and acted on the comments received to continually improve the quality of the service.

The provider had a clearly defined set of values to underpin the service and these were known and understood by staff. The acting manager was prioritising the development of a more person centred culture within the service.

The provider now had effective quality monitoring processes in place to ensure they were meeting the required standards of care

Notifications were sent to the Care Quality Commission as required by law.

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

Medicines were not always managed safely. The provider had taken appropriate action to monitor and address this.

The provider had policies and systems in place to protect people from the risk of infection. Some staff did not always follow good practice in relation to infection control.

There were systems and processes in place to safeguard people from harm.

Risks to people were assessed and their safety monitored and managed so they could be supported to stay safe and their freedom was respected.

The provider's system for safe recruitment of staff was robust. There was sufficient numbers of staff to support people to stay safe and meet their needs, but staff were not always deployed effectively.

When errors were made by the provider or staff, these were acted on and lessons learned and improvements were made.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had a clear vision and credible strategy in place to deliver high quality care and support, and promote a positive culture that was person-centred, open, inclusive and empowering, and achieved good outcomes for people using the service. However, the culture of the service was still developing and required more time to ensure the service people received was person centred.

Systems to monitor the quality of the service were used effectively to ensure that shortfalls were identified and improvements were made.

The people who used the service, the public and staff were

engaged and involved in the service.

The service worked in partnership with other agencies.

Trembaths

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 was carried out to check on the improvements made since our last comprehensive inspection in July 2017. This inspection took place on 07 February 2018 and was unannounced. The inspection team was made up of two 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. The expert by experience at this inspection was an expert in the area of care for older people and for people who lived with dementia.

Following the inspection in July 2017, we placed a condition on the provider's registration that they must submit monthly reports to us detailing the action they had taken to make the necessary improvements to the service. Before the inspection we reviewed the information we held about the service including these reports and the notifications they had sent us. A notification is information about important events which the provider is required to send to us. We also reviewed information that had been sent to us from the local authority and members of the public.

During the inspection, we spoke with 14 people who used the service, three relatives and friends, the acting manager, the area manager, the business support manager, one nurse, five care staff, and two members of the domestic staff team. We also spoke with a volunteer. We looked at the care records for four people who used the service, the recruitment records for four staff. We also reviewed information on how the provider managed, assessed and monitored the quality of the service..

Requires Improvement

Is the service safe?

Our findings

At the inspection in July 2017, we found the provider was in breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because a number of unexplained bruises or skin tears had not been investigated by the home or reported to the local authority safeguarding team. There had been no themes identified through an analysis of incident and accidents. Therefore although we identified that many of the bruises and skin tears were found in the morning, this had not been recognised or addressed by the service.

At this inspection we found that improvements had been made and the service was no longer in breach of this regulation. From records reviewed at and before the inspection, we saw that concerns were now being reported appropriately to both the Care Quality Commission and the local authority safeguarding team. When incidents, accidents or falls occurred, these were recorded, cross referenced with care records to ensure appropriate updates were made and analysed effectively to identify themes and patterns. Action plans were developed and regularly updated to enable the service to learn when things went wrong and to make improvements to reduce the chance of incidents happening in the future.

At the inspection in July 2017, we found the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014. This was because there were insufficient staff on duty to meet people's needs safely and in a timely way. This resulted in people being rushed or having to wait a long time for support. At this inspection, although staffing levels were sufficient and the service was no longer in breach of this regulation, we found improvement was still required to the way staff were organised to ensure people's needs were met.

On the day of the inspection there were enough staff on duty to meet people's needs and keep them safe. We observed that call bells were responded to promptly on the day of our visit. Call bell logs we reviewed showed this was typical and that response times had improved significantly since the last inspection. However, a staff member told us, "People get good care generally but sometimes they have to wait." We noted that staff were very busy and not always deployed effectively to ensure people's needs were met in a timely manner. For example, after lunch, one member of staff said they needed to take a person downstairs for their activity but could not do so because some people needed repositioning, and two members of staff were on their lunch break. This meant that people had to wait to join their activity.

People we spoke with felt that there were usually enough staff on duty to meet their needs safely, although some people said that staff were not always able to meet their preferences for how care was provided due to a lack of time. One person said, "I have pads. I would prefer to go to the toilet but they don't have time as I need two people so I just have to have pads." At 11.15am there was a church service which a number of people wanted to go to. We observed that staff had to rush to assist people to get to the service on time, particularly those people who were upstairs. A visitor said, "I don't know why they don't take people down earlier – it's a nice room to sit in and wait. There is always such a rush to get people there." A relative said in response to this , "It's because they never finish breakfast in time or at least they can't guarantee when they might finish." This showed that staff time was not organised effectively to meet people's needs in a timely

way.

We looked at staff schedules and noted that each shift was adequately covered and that, where there were shortfalls, agency or bank staff were allocated in a timely way to ensure safe numbers of staff were maintained. The registered manager told us that they had been working hard to recruit permanent staff to the current vacancies, and that they were taking steps to ensure that staff with the right skills and values were appointed. In the meantime, the manager told us they tried to use the same agency and bank staff so that people were supported by staff who were familiar with their needs as far as possible.

Medicines were not always managed safely. There had been a number of errors identified by recent internal audits, and these were shared with us before the inspection. The acting manager demonstrated a full awareness of the extent of the shortfalls in relation to medicine management and provided a clear action plan that was in progress to make the necessary improvements. This included immediate targeted training and mentoring for staff involved in making errors, and the implementation of new systems and processes to check medicines being administered as well as strengthening ordering and disposal procedures. However, we saw that some errors had been made since the last audit. For example stock levels for one medicine indicated it had not been administered and one person's medicine administration record (MAR) had been signed to confirm that one medicine had been administered but it was found to be still in the blister pack. This meant that people did not always receive their medicine as prescribed.

There was some confusion as to how the administration of 'as required' (PRN) medicine should be recorded. For example, sometimes this was signed for on the PRN administration record, sometimes it was signed for on the back of the main MAR and sometimes it was signed for on both. Staff said this system was very new and they were still getting used to it. The acting manager confirmed this and said they would go over the expectations with staff again as soon as possible to avoid further confusion. We saw staff responded appropriately to people who required PRN pain relief throughout the day and one person told us, "I told them about the pain and the nurse gave me a painkiller straight away."

People had a medicine record that contained a photograph and information about allergies. Medicines profiles were seen although they did not contain information about what the medicine was for which would be best practice. Staff administered medicines in a friendly manner and with an appropriate explanation to ensure people knew what they were being given.

Medicines were stored appropriately and stock of these reconciled with records where checked. An administration chart was seen for a person who used pain relief patches, and staff alternated the location of where the patches were placed in line with the manufacturer's directions for use.

Staff were able to describe how they prevented the spread of infection and confirmed they had access to personal protective equipment. A member of staff said, "We use blue aprons and gloves for personal care. It gets thrown in a clinical waste bag before we leave a person's room and goes straight to the sluice." Although staff we spoke with demonstrated understanding of infection prevention and control measures, we observed several occasions where staff practice did not uphold good infection control practice. For example, a member of staff was seen touching a sponge pudding with their un-gloved hands before giving it to a person to eat. Plates taken to people's rooms were not covered . We saw that some staff did not wash their hands before supporting people with lunch and did not offer people the opportunity to either wash their own hands or use hand wipes before eating. We discussed this with the acting manager who was surprised at these findings having completed recent mealtime observations where good infection prevention and control practice was observed. She confirmed she would address this immediately with further targeted monitoring.

The service was sufficiently clean and housekeeping staff had good understanding in relation to their role in preventing the spread of infection. The service had responded appropriately to a suspected outbreak of flu over the Christmas period to ensure the risk to people and the general public was minimised.

People told us they felt Trembaths was a safe place to live. One person said, "The staff look after me well – most of them are very kind." A relative said, "I am overjoyed [relative] is here – compared to other places I've seen, [relative] is safe here and it is caring and friendly."

Staff had received training in safeguarding people and when asked, demonstrated good understanding of different types of abuse and the signs they should look for which may indicate that someone could be at risk of possible harm.

The provider had an up to date safeguarding policy that gave guidance to the staff on how to identify and report concerns they might have about people's safety. Information about safeguarding was on display throughout the home and it included contact details for the relevant agencies for staff to refer to when needed. Staff, including non-care staff such as house keepers, were able to tell us about external organisations they could report concerns to.

There were personalised risk assessments for each person to give guidance to staff on any specific areas where people were more at risk such as falls, nutrition, pressure areas, and mobility including those for people supported to move by staff. Where bed rails were in use, there were risk assessments in place to support this. The assessments maintained a balance between minimising risks to people and promoting their independence and choice. They had been reviewed and updated regularly or when people's needs had changed so that people received the care they required.

The provider had recruitment processes and systems to complete all the relevant pre-employment checks, including references from previous employers, proof of their identity, confirmation of the right to work in this country and Disclosure and Barring Service (DBS) reports for all the staff. DBS helps employers make safer recruitment decisions and prevents unsuitable people from being employed.

Requires Improvement

Is the service well-led?

Our findings

At the inspections in July 2016, December 2016 and July 2017, we found the service was in continuing breach of Regulation 17 of the Health and Social Care Act 2018 (Regulated Activities) Regulations 2014. This was because we found that, although improvements had been made after each inspection, these had not been sustained. At the last inspection in July 2017, we found that systems to monitor the quality of the service had not been used effectively. In addition, people did not feel that the manager was visible enough within the home. Of those people that knew who the manager was, a significant number did not feel they were approachable or responsive if they raised concerns. At this inspection, we found that significant improvements had been made, but more time was required to ensure these were sustained and embedded within the culture of the service.

The registered manager who was in post at the inspection in July 2017 had left the service and, until a permanent manager was recruited, an area support manager was acting into the role. The acting manager had commenced the process to register with the Care Quality Commission. The deputy manager role was also vacant, so the acting manager was supported by the provider's business support manager and the area manager with responsibility for overseeing the service.

People and relatives were positive about the acting manager and said that the management oversight of the home had improved. However, relatives expressed concerns about the stability of management of the service in recent times and there was uncertainty about management arrangements in the long term. One relative said, "I think we've had a bad run and we are all worried about who we might get next." Another relative said, "We are all fearful of who we might get next. [Acting Manager] is good but she is only interim." The acting manager had a hands-on approach to the role and people knew who she was because she was visible within the service. Staff said the acting manager provided strong leadership, and was approachable and responsive to issues they raised. A member of staff said, "Leadership is really good at the moment."

A member of staff told us about the support they had received from the manager following making a mistake in the course of their work. They told us, "I didn't just get told off and left feeling bad. I got really good support. I had one to one training which took me through every step of (the task) and by the end of it I was so much more confident and now really know what is expected of me. [Manager] is really good. You can ask her anything. She never rolls her eyes or gets impatient. She comes with you and shows you how to do things." We were impressed by the openness with which this member of staff spoke with us about errors they had made, and how they had learned from the experience. This demonstrated that there was an open culture within the service, where staff were encouraged to speak up and to learn from mistakes without fear of blame or recriminations.

Although the feedback about the overall management of the service had improved at this inspection, we received mixed feedback about the leadership of the individual units, with some people and relatives feeling there was not always clear direction given to staff, particularly on the nursing unit. One relative said, "It is still very difficult to find out who really is in charge (on the unit). I've been told it's the nurse but I have yet to see a nurse tell carers, "[Name] in room [number] needs someone; please go and help." Our observations on the

day of the inspection found there was a lack of direction given to staff in the nursing unit. For example, although there were enough staff at lunchtime, no one took charge. Staff did not question that gravy was added to food before it was served or that custard was added to sponge without asking people if they wanted it. Ice cream was served at the same time as the main meal which meant it was melted by the time people were ready to eat it. In contrast, at lunchtime on the residential unit, staff were provided with strong leadership, ensuring that people's needs and preferences were met. Staff told us they felt the nurses usually did provide good leadership, but when agency nurses who did not know the service well were in charge this sometimes slipped. One member of staff said, "Generally nurses provide good leadership but we are using agency. We try to use regular agency but this is not always possible."

The acting manager and the provider promoted a person centred culture and had worked hard with staff to change the more task oriented culture previously seen in the home. We observed, and the manager acknowledged, that although improvements in relation to this were clearly in evidence, work was still required to embed a more person centred and open culture. For example, we saw that several people remained seated in their wheelchairs with the hoist sling still in place throughout the day, rather than transferring to more comfortable seating. When we asked them if this was by choice, one person said, "The hoist sling is here all the time unless I sit somewhere else, but I'm usually left in the wheelchair." At lunchtime, we overheard one person tell a member of staff that they wanted to transfer from their wheelchair to a dining room chair. This was communicated to staff in the dining room, but when we checked a few minutes later, the person remained in their wheelchair at the table, where they stayed for the duration of lunchtime. Two people and relatives we spoke with told us that staff did not always speak with them when providing care, and sometimes held conversations with each other instead. One person said, "The staff often just talk across you to each other."

The staff we spoke with told us they felt able to contribute to the development of the service through team meetings. We saw from records that meetings for care staff, nurses and team leaders took place regularly and minutes recorded actions that were to be taken and by whom. People and their relatives were encouraged to share their views about the service and to be involved in making decisions about improvements. We saw that regular residents and relatives meetings were held to discuss recent events and activities and that people were regularly asked to provide feedback about various aspects of the service. The provider carried out surveys with people, relatives and staff and a report had been developed to show the results and to identify action to be taken as a result.

The provider's systems to monitor the quality of the service were being used effectively and the acting manager, along with the business support manager and the area manager had good management oversight of the service. Regular audits were carried out for specific areas of the service such as medicines, care planning, and infection control. We saw that these systems were used effectively to identify shortfalls and errors, and to take action to make improvements to the service. For example, we saw that the recent medicines audit had identified a number of errors, which were then addressed through training and updating medicine management systems. We saw evidence that information from audits was analysed and cross referenced to other records to enable the management to gain a full picture of what factors drove certain trends in the service. For example, an analysis of call bell response times was undertaken, and analysed alongside incident, and accidents, falls, and staffing levels. Once this information was analysed, the findings were shared with staff to discuss ways in which shortfalls in the service at key times could be improved. The result of this work was that call bell response times had significantly improved because staff became aware of times of day when incidents were more likely to occur.

The service worked closely with other agencies such as discharge planning teams and local hospitals, GP's and the local authority to ensure as far as possible that care was effective and responsive in meeting the

needs and expectations of people.