Methodist Homes

Trembaths

Inspection report

Talbot Way
Letchworth Garden City
Hertfordshire
SG6 1UA

Tel: 01462481694
Website: www.mha.org.uk/ch54.aspx

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
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 inspection was carried out on 11 July 2017 and was unannounced. At their last inspection on 20 December 2016, they were found to not be meeting the standards we inspected. At this inspection we found that they had continued to not meet all the standards.

Trembaths provides accommodation for up to 51 older people, including people living with dementia. The home is registered to provide nursing care. At the time of the inspection there were 50 people living there.

The service had a manager who was applied to be registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the 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 and associated Regulations about how the service is run.

Systems in place to monitor the quality of the service did not identify shortfalls in some areas. This impacted on the safety and welfare of people and the quality of the service provided. We also found that the feedback about the management was mixed.

People were not always protected from the risk of harm as accidents, incidents and unexplained injuries were not sufficiently reviewed for themes, investigated or reported.

Staffing levels did not always meet people's needs. However staff were recruited through a robust process.

People were supported by staff who were trained, and although staff felt supported, they did not receive regular one to one supervision.

Staff adhered to the principles of the Mental Capacity Act 2005. People had regular access to health and social care professionals. People enjoyed a variety of foods and the mealtime experience observed was positive. People's medicines were managed safely.

People and relatives told us that staff were kind. People shared mixed views about whether they were involved in planning their care. Confidentiality was promoted and there were regular links to the community.

People's care plans were clear and included person centred information. People's care needs were met, however this was not consistently in a person centred way. People enjoyed a variety of regular activities and formal complaints were responded to.

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 consistently safe.

People were not always protected from the risk of harm.

Staffing did not always meet people's needs.

Staff were recruited through a robust process.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

People were supported by staff who were trained, and although staff felt supported, they did not receive regular one to one supervision.

Staff adhered to the principles of the Mental Capacity Act 2005.

People enjoyed a variety of foods and the mealtime experience observed was positive.

There was regular access to health and social care professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People and relatives told us that staff were kind.

People and their relatives were not always involved in planning their care.

Staff were not always attentive due to being busy.

Confidentiality was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care needs were met, however this was not consistently in a person centred way

People's care plans were clear and included person centred information.

People enjoyed a variety of regular activities.

Complaints were responded to.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems in place to monitor the quality of the service did not identify shortfalls in some areas.

The feedback about the management was mixed.

There were regular links to the community.

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Before the inspection we reviewed information we held about the service including statutory notifications. Statutory notifications include information about important events which the provider is required to send us. At their last inspection on 20 December 2016 the provider was found to not be meeting the standards we inspected. We reviewed the action plan that they sent us detailing how they would address the shortfalls.

The inspection was unannounced and carried out by two inspectors and an expert by experience. An expert by experience is someone who has used this type of service or supported a relative who has used this type of service.

During the inspection we spoke with 14 people who used the service, six relatives, nine staff members, the regional manager, the area support manager and the registered manager. We received information from service commissioners and health and social care professionals. We viewed information relating to seven people's care and support. We also reviewed records relating to the management of the service.

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

Requires Improvement

Is the service safe?

Our findings

People told us that they felt safe. One person said, "I like living here better than when I lived at home, I am safer." Another person told us, "I have an alarm, that means I'm safe, even if I have to wait I know someone will come." Relatives also felt that people were safe. One relative said, "I know [person] is safe here, if [they] fall, the staff sort it and let me know. I'm going on holiday for the first time in years." Staff were familiar with types of abuse and knew how to recognise and report concerns. One staff member said, "I look out for signs of mistreatment or abuse like bruises, marks or changes in the person, like if they are more withdrawn than usual or tearful. I really haven't had any concerns here but would report anything to the nurses and document everything." We noted information was displayed around the home raising awareness about safeguarding matters.

However, we found that there were a number of unexplained bruises or skin tears that had not been investigated by the home or reported to the safeguarding team. The manager told us that they signed off all incident forms and relevant actions were logged with photos of the injuries. However, we reviewed a sample of these forms and photos and found that this process had not been completed in the ones we viewed. We also found that remedial action, such as supervising staff for moving and handling competencies following a person sustaining an injury during transfer, had not been completed. In addition, one person had complained that night staff were 'rough' and hurt their arms. This had been discussed between staff and manager who told us, "The person always said things like that." As a result this had not been investigated, there had been no spot checks and no themes identified been though many of the bruises and skin tears were found in the mornings.

Therefore this was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People had their individual risks assessed. We saw these included pressure care, moving and handling, nutrition, choking and falls. We saw that staff generally worked in accordance with these assessments. We noted that when a person fell, a falls diary and monitoring was completed. The area support manager then visited and collated the falls to check all documentation was completed and sent actions to the manager to complete. However, the manager told us that they didn't use this information to help them identify themes or trends. When we reviewed the information for April and May, we found that the higher number of falls occurred during breakfast and morning care or supper and evening care. We had also seen during the morning of the inspection, a person who was at high risk of falls and who had experienced many falls, was sitting on the edge of their bed, with their call bell ringing intermittently for assistance for over 20 minutes.

People told us that they felt there was not enough staff. One person said, "I can't walk so I can't get out of bed, I stay here. The carers only come in to do something, they talk to me then, they are kind but they are so busy, no one just comes in to have a chat with me. It is quite lonely but I'm used to it." Another person said, "Sometimes I'm sitting in the dining room after supper and there is no carer in the room or if they are they are all sitting together in a corner chatting." Relatives also gave mixed views about staffing. One relative said, "I always see someone around." However another relative said, "They say they are better staffed than they

are, in practice there aren't enough." A third relative told us, "There are not enough staff, sometimes I have trouble finding a carer when I need one."

Staff gave mixed views on staffing. One staff member told us, "Generally we are ok in the nursing unit but sometimes short in residential. Sometimes there's not enough staff." Another staff member said, "It's do - able with the numbers if we work hard. Usually we have everyone up by 11.30am or 12pm. Today it was 11.30." We noted that people were receiving morning care up until 11.30am. We were unable to ascertain if this was their preference or due to staff being busy. We did see one person who was struggling to manage their own care and was waiting for someone to come and help them get dressed. They said, "I'm getting in such a muddle. I can't work it out. I'm cold." They were waiting 40 minutes so we asked a staff member to tend to them. The person then still had to wait another 10 minutes before a staff member was available. This was after 11am and they had their half-finished breakfast and a cold cup of tea in front of them. We also noted one person was calling out for the toilet, we walked around the section of the home three times to look for a staff member to assist them.

One person told us that they had wanted to get up at 8am but couldn't because of the shift change and so instead of waiting until later, "When everyone wants to get up and I can't guarantee whether they will come at 8.30 or 10.30.", the person told us that they opted to get up at 7am before the shift change and then they were put back to bed with their clothes on until breakfast time when, "…they transfer me to a chair and then to the dining room and then I wait for breakfast which could be anytime between 8.30 and 10am."

We also saw a staff member assist a person to have a beaker of tea. The tea, just poured from a teapot which indicated it was hot, was physically poured into the person's mouth very fast. They consumed the whole beaker of tea in less than one minute, as they were given large mouthfuls. The person, who was totally dependent, coughed at times. The approach was done to save time as the staff member then promptly moved onto the next person. The person did not enjoy the experience of having a cup of tea, it was also a missed opportunity to spend time with the person, but there was a risk of choking, as assessed in their care plan, due to the speed and volume of the fluid being poured in one go. We raised this with the management team.

We found that people had raised issues with delays in staff response to call bells at every meeting and survey we viewed. The manager told us, "They always say it and in response I do a monthly audit." We reviewed the call bell logs and found that when call bells were rung they were quickly reset, then the same bell rang again and the same process happened frequently over a 20 to 30 minute period. One person told us, "Sometimes come in to turn it off and go away again." We asked the manager about this as it indicated that staff were turning off the call bells without providing care and this meant the person needed to call the bell again. They confirmed that this was what was happening as staff would tell them they were with someone and would go back shortly. The manager also said that the sensors in rooms often made bells activate quickly.

We reviewed the system used to identify how many staff were needed. We found that the service worked on a ratio basis rather than the dependency and needs of the people they supported. For example, the ratio may be set at one staff member to five people, regardless if one or all five of them required two staff for all care needs. This meant that when people's needs increased, staffing did not fluctuate to accommodate this.

Therefore, this was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People were supported by staff who were recruited safely. Pre-employment checks, such as references,

criminal record checks and proof of identify, had been completed prior to a person starting work.

People's medicines were managed safely. We noted that the medicine administration was completed in accordance with good practice. Medicines records were completed accurately and the sample of medicines we counted tallied with the amount recorded. Staff had received training and there were plans in place for medicines prescribed on an as needed basis. This helped to ensure that people received their medicines in accordance with the prescriber's instructions.

Good

Is the service effective?

Our findings

People were supported by staff who had received the appropriate training for their role. People and relative told us that they felt staff were skilled and knowledgeable. One relative told us, "The staff are wonderful." Staff told us that they felt well trained. One staff member said, "The training here is good. I have done the normal ones like moving and handling and safeguarding but also things like falls awareness, and nutrition and hydration." Some staff told us they would enjoy additional training in other specific needs such as strokes and stoma care. We discussed this with the regional manager who told us they would look into this and work with other agencies to help provide to staff. We reviewed the training spreadsheet and saw that training was up to date. This included inductions for new staff, moving and handling, fire safety, food hygiene and safeguarding people from abuse.

Staff told us that they felt supported. However, we noted that one to one formal supervision was not taking place regularly. The manager told us that there had been a new format introduced and this was to be more beneficial to staff when it was completed as made supervision a positive experience.

People were supported to make their own decisions and where they were unable, a capacity assessment was completed. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can 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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and found that they were. We found that all applications for DoLS were still pending so the service operated least restrictive options to help ensure people were not unlawfully deprived of their liberty during this period. For example, by not using bedrails in all cases.

We saw that best interest decisions were documented to enable staff to support people safely. However we noted that where it had been assessed that a person did not have capacity, staff still encouraged people to make day to day decisions, such as what they'd like to eat or wear, to help encourage choice. We also found that staff asked people before supporting them to ensure they had their consent. One relative told us, "[Person] likes to look smart, they ask [them] what do you want to wear and [person] tells them."

People were supported to eat and drink sufficient amounts. The food was varied and people told us they enjoyed the food. One person said, "All home cooked food." Another person told us, "Yes I do like the food, it's good." we noted that the menu was on the tables and where needed, people were given a visual choice. The atmosphere during lunch was calm and there was positive engagement between people and staff. We found staff chatted and did not rush the person they were assisting to eat. Staff gently encouraged people to eat or drink a little more, explaining the importance. We also noted on one unit one staff member took control to ensure serving did not commence until everyone was seated and ready to promote the enjoyment

of the meal. We also found that during breakfast there were options and choices. We saw people choose between cereal, toast or a hot alternative, and in some cases enjoy all three options.

People had their weight and intake recorded. People identified as being at risk of not eating and drinking enough had closer monitoring. We found that referrals to health care professionals were made as needed and fortified foods were provided. However, we did note that fortified foods may also have been given to people who wanted to lose weight. The manager told us that this was not the case and that the kitchen separated those people's foods prior to fortification being completed. We reviewed this after the mealtime so were unable to check if this happened on the day of inspection.

People had regular access to health and social care professionals as needed. We saw from people's records that the GP, speech and language therapists and chiropodists attended the home regularly. We also noted that the hairdresser who was in the home during the inspection knew people well and people enjoyed having their hair done. People and their relatives also told us that the staff helped organise appointments. One relative said, "They are good, they arrange hospital appointments and usually one of us (family) will go if we can."

Requires Improvement

Is the service caring?

Our findings

People and relatives told us that staff were kind. One person told us, "The girls are nice, they are busy but they are lovely." A relative told us, "Carers always speak to us and I wouldn't hesitate to ask for anything we needed." Another relative said, "The staff are mostly very good. The handyman used to be a carer and he still cares so much for each of the residents. He always has time for them." We noted that the maintenance person spoke with everyone he saw and in one case chatted with a person who had an interest in fire safety about his fire alarm testing.

We observed that interactions and relationships between people and staff were positive. We found staff to be attentive and knew people well. For example, we heard one staff member say to someone, "I know you love the garden, you are my expert gardener I look to you for advice." However two people told us that if they had two staff supporting them the staff often chatted amongst themselves. However we also observed some practice which was not attentive or caring which we refer to throughout safe and responsive. Therefore this was an area that required improvement.

People and their relatives gave mixed views about if they were involved in planning their care. One relative told us, "We haven't had a meeting yet at all." They went on to say they assumed that the social worker would have provided the information they needed. However, another relative told us that they had sat with staff and discussed the person's needs. We saw that care plans included some personalised information such as life history which gave staff guidance about the person's life, employment, family, important events, preferences such as their favourite place or food as well as anything they disliked. One staff member said, "We do get time to get to know people." They went on to talk about a new person and information they had found out about their preferences. They said, "That way we can tailor [their] support and try to make it as good as possible for [them]. I think we are very person centred here." We noted that the manager had identified involving people in planning their care as an area that they were still working on developing. This was an area that required improvement.

Confidentiality and privacy was promoted. We found that staff spoke discreetly and sensitive information was stored securely. Care plans and daily notes remained in people's rooms in an unlocked cupboard but people, or their relatives, had given their consent for this. We saw staff knocked on people's doors and respected their right to be alone. We heard one member of staff say to a colleague, "[Name] doesn't want anyone with [them], so I will just keep popping back. I've put everything in reach."

People and their relatives told us that visitors were welcome at any time. We saw that there was a steady flow of visitors throughout the day. One person said, "Relatives can come in and visit whenever they want to." We noted that staff knew who relatives were and chatted with them while they visited. We also saw visitors had joined in the music therapy session.

Requires Improvement

Is the service responsive?

Our findings

People's care needs were met. One person told us, "I can have what I want when I want but mostly I can sort myself out anyway." However this was not consistently in a person centred way. For example, one person's plan stated that they enjoyed baths and would like one each week but we noted they were having a shower alternate days. We asked a staff member why this was and if they enjoyed a shower. They told us, "No, they don't like showers, they say it makes them feel unsteady but as [person] likes to be up early there isn't time to bath [them]." We asked if anyone had offered the person a bath and they told us that they had not.

Some people and their relatives told us that care was at times rushed. One person said, "They decide everyone needs to go to bed and then you have to wait. I would prefer to go to bed earlier." Another person told us, "Bathing is on a schedule, not much choice and usually a shower but then they are very busy." A relative told us, "[Person] doesn't like showers, by choice [they] would want a bath, but I suppose a shower is quicker so that's what they do."

We also found that some people were receiving personal care late in the morning. We were unable to ascertain if this was preference or due to demands on staff. The manager told us this was because they liked to get up later, however, one staff member told us, "We try very hard to personalise services but it's inevitable that people's times will be affected when there are very sick people here." This was an area that required improvement.
People's care plans were clear and included person centred information that took account of their preferences. We saw that they included detail about each assessed need such as mobility, communication and personal care. We also noted that they were reviewed regularly. The detail included how to promote independence and ensure needs were met. For example, one plan stated, '[Name] likes to have a warm milky drink prior to settling' and another stated, '[Name] needs staff to give [them] time and patience when assisting [them].'

People enjoyed a variety of regular activities. One person said, "I do go to anything I can. They come and ask me and I'll go." A relative told us, "They do use the garden, for tea in the garden and for doing some gardening too." During the inspection we saw a person helping with watering the garden, a very well received music therapy group, reminiscence and picture quiz and people enjoying one to one activities such as nail painting or drawing. One person asked us if we had seen the photos displayed of a recent coffee morning, they told us that it had been, "A lovely time and a great chance for everyone to get together." There were regular trips out and these had also been enjoyed.

We spoke with the activity organiser who was very enthusiastic and was excited about the upcoming activities. Dance therapy was due to start and this was being carried out as part of a study into the benefit of movement and music for people living with dementia. There were several tactile objects around the home and reminiscence displays. They told us that the current manager had made resources and events much more accessible to the home. We saw that after activities there was a review of who had joined in and if it had been enjoyed. This helped to ensure that activities and events on offer continued to appeal to people who lived at the service.

Formal complaints were responded to and we noted that the regional manager responded promptly. However, some relatives told us that at times they felt the manager was defensive and this made it difficult to raise any issues. One relative told us that they found the manager to be very approachable and supportive of any issues. We discussed the benefits of having a system in place to seek people's views about how they felt their complaints had been dealt with.

People had their feedback sought through meetings and surveys. We saw that many aspects of the service were discussed and most feedback was positive. We noted that a monthly food forum had been set up in response to comments about food and this had been impacting on food positively. However, we also noted that people commented about a delay in response to call bells at all meetings and some survey responses and this had not been resolved.

Requires Improvement

Is the service well-led?

Our findings

When we inspected the service on 19 July 2016 we found that the service was not meeting the standards. We carried out a focused inspection on 20 December 2016 we found that although there had been some improvements, systems in place to monitor the quality of the service were not sufficiently embedded to demonstrate their effectiveness. At this inspection we found that this remained an issue and the improvements made previously to address breaches of regulation had not been sustained.

We noted that the manager was supported by a regional manager, an area support manager and a business support manager. However, we found that systems in place did not robustly monitor the service.

This included areas such as fire safety, accident and unexplained injury monitoring, and staffing and call bell issues raised by people. For example, there had been no system in place to identify that an actions from the fire risk assessment had been completed and as a result, this had not been completed which posed a risk to people's safety. In addition, the manager had not identified the need for, and therefore had not implemented, a system to give them oversight of any issues in the home to ensure they could be resolved.

Fire alarm tests and drills and safety checks were completed by the maintenance staff. However this meant the manager did not have a plan of when actions needed to be completed. We saw that a fire risk assessment had identified the need for a night time fire drill but this had not been completed since September 2016. The manager did not know this had not been carried out. In addition there was no current legionella certificate. Even though there was regular checking and flushing of water systems, the annual required sample testing had not been completed since 2015.

There were audits carried out in relation to medicines, care plans and the environment. These had action plans developed in response and they were signed as completed in some cases. However, we found that other checks, such as the planned daily meetings were not always happening in accordance with the action plan the provider sent to us and spot checks, such as night visits, had not been completed even though a concern had been raised in relation to night staff.

We found that many of these issues were identified in July 2016 and there had only been some improvement when they were inspected in December 2016. This meant that they had not sustained any improvements that they had made.

Therefore this is a continued breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People and their relatives gave mixed views about the management of the home, some were not clear who the manager was. One person told us, "I don't know who the manager is, I don't think I've ever seen the manager, just the nurse." Another person said, "I don't know the manager, just the carers." The action plan sent to us following the last inspection stated that that the manager would be working on shift with staff to set standards and assess workloads, however, people did not recall seeing them on duty. A relative told us,

"The manager was very obliging at the beginning but perhaps not quite so much now, probably because we don't see much of [them]." However, another relative said, "[Manager] is great, don't know what I'd have done without [them]."

Staff were positive about the changes brought about by the manager and felt that the standards and atmosphere in the home had improved. One staff member said, "[Manager] is really good; doesn't take any rubbish. If he thinks a relative is being petty he will put them in their place in the nicest way possible." However, we were told that two relatives found the manager unapproachable and defensive. Another staff member told us, "The manager promotes good practice and is very person centred." A third staff member said, "He encourages us all to be the best we can. He may seem harsh to some people but he's not."

There was regular links with the local community through people visiting the home and people going out on trips and attending events. We saw that there was a local 'Knit and natter' group that attended the home as well as choirs and schools. There was also a collection of volunteers. One relative told us, "I love it here, I have just signed up to volunteer. I'm looking forward to all the things we've got planned." They told us that they were liaising with the activities organiser.

The manager had started a support group for relatives of those living with dementia. The first meeting had happened and one relative told us this had been a huge support. The manager told us they were planning on arranging a meal out for relatives to get together and chat over their experiences. We saw that the meeting was well advertised, along with other leaflets which offered advice.

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 Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment People were not always protected from the risk of abuse.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing People's needs were not always met in a timely manner.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Governance systems did not identify and therefore did not address shortfalls which may have impacted on people's safety and welfare.

The enforcement action we took:

We imposed conditions to set out what remedial action needed to be taken.