Methodist Homes

Trembaths

Inspection report

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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 inspection was carried out on 19 July 2016 and was unannounced. When we last inspected the service on 29 June 2015 they were found to be meeting all the standards we inspected. However some areas required improvement. At this inspection we found that they were not meeting all the standards. This was in relation to safeguarding people from abuse, management of medicines, person centred care and the systems in place to address any shortfalls identified.

Trembaths provides accommodation, care, nursing and support for up to 51older people, some of whom are living with dementia. At this inspection 50 people were living at the service.

The service did not have a registered manager in post and the service was being managed by an interim manager employed by the provider. 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 and associated Regulations about how the service is run.

Where people had unexplained bruises, these had not been investigated at the time of our inspection. However, following our inspection, these were carried out. We also found that in some instances the local authority safeguarding process was not adhered to. People's medicines were not always managed safely and records were not accurate. At times this meant people did not receive their medicines in accordance with the prescriber's instructions.

People did not always receive person centred care. Staff were busy and this resulted in a task orientated approach and people`s care needs were not met promptly. People told us that staff were mostly nice but there were times when they were abrupt because they were busy. This did not promote people`s dignity or respect. People and staff told us that they felt there were not enough staff and this meant they often had to wait for care. Staff received appropriate training for their role and had regular one to one supervision. The service was planning to develop staff and introduce champions for specific areas.

Systems in place that had identified some of the issues found on inspection had not been effective in resolving these. The feedback about the interim manager was positive and staff felt supported.

There was a range of activities available and people were involved in planning these. However, they were not consistently involved in planning their care and support needs. Care plans were clear and in most cases reviewed monthly. People knew how to make a complaint and we saw these 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 abuse.

People's medicines were not always managed safely.

A review of staffing and deployment was needed.

People were supported by staff who had been through a robust recruitment process.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People did not all enjoy the food and the mealtime experience needed improvement.

People were asked for their consent and the principles of the Mental Capacity Act were followed.

Staff received sufficient training and felt supported.

People had access to health professionals when needed.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People were not always treated with dignity and respect.

People were not always involved in planning their care.

People told us that most staff were kind, but busy.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's needs were not always met in a person centred way.

People had care plans which set out their needs. However, reviews were not always consistent.

People had access to activities.

Complaints were followed up.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Systems in place to address shortfalls were not always effective.

Staff were positive about the interim manager.

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 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. We asked the provider to complete a Provider Information Return (PIR). This is a form that requires them to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection we spoke with 10 people who used the services, five staff members, six relatives, the interim manager and business quality partner who was responsible for the training and quality of the service. We reviewed the recent reports from service commissioners. We viewed information relating to four people's care and support. We also reviewed records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they mostly felt safe living at the service. One person said, "I feel safe here, we have a buzzer which we wear if we move around." However, another person said, "It makes me feel safe having this around my neck but it doesn't make me feel safe having to wait for over half an hour for someone to come."
Staff were aware of how to recognise abuse and how to report concerns within the home and outside of the organisation. We saw that there was information displayed so that people and staff had the information accessible. However, we noted that people sustained unexplained bruises and these were not always investigated by managers to satisfy themselves that these were not as a result of abuse. We also saw that where there had been an allegation of rough handling a person, this had not been dealt with in accordance with the local authority safeguarding process and had been dealt with internally as a complaint. Following our inspection the provider carried out internal investigations in regards to all unexplained bruising and found there to be an explanation in most cases.

However, due to the investigation not commencing prior to it being identified as part of our inspection and the correct process being adhered to, this was a breach of Regulation 13 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People's medicines were not always managed safely. We saw that there was a staff signature list, a profile sheet for each person detailing what support they needed to take their medicines and regular audits were completed. However, we found that there were gaps in the medicine records that did not correspond with the prepacked medicines and of the nine boxed medicines we counted, eight of those included the wrong quantity. This indicated that people had missed doses of their medicines and therefore did not receive them in accordance with the prescriber's instructions.
We also found that although protocols were in place for medicines prescribed as and when required , these were not completed for everyone.

Therefore this was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People told us that there were not enough staff to meet their needs. One person said, "One time recently I waited an hour for someone to help me to the toilet, when I was on the toilet they said they would be back in 5 minutes and they came back in half an hour. It was very painful waiting an hour for the toilet." Another person said, "They are very short of staff here, we can wait for ages – half an hour or more." A third person said, "Sometimes they take forever to come." Relatives gave mixed views about the staffing levels. One relative said, "There is enough staff." However, another relative told us, "Today is a particularly bad day it seems but it isn't unusual to not be able to find people (staff) when you want them, you have to actually go looking." A third relative said, "I suppose you just have to accept that you have to wait. They get to you eventually!" Staff told us that there was not always enough staff. Some staff said when they were fully staffed they were able to meet people's needs, however, staff shortages had been an issue. Other staff members told us that even when fully staffed they struggled to meet people's needs and people had to wait. We reviewed the rota for the previous week and saw that shifts were recorded as being covered, some of those

shifts by using agency staff. The interim manager and quality business partner told us that staff felt they were short staffed if they had to work with agency staff. We discussed the deployment and management of the staff teams with the manager and business quality partner and they told us were that the approach and culture of the staff needed addressing.

The lack of a person centred approach to people's care was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People had their individual risks assessed and a plan in place to help mitigate those risks. For example, in relation to falls, moving and handling and behaviour that challenged. Staff were able to describe people's individual risks and how they supported them with this. For example, in instances when people displayed behaviour that challenged staff had strategies to follow which helped reduce their anxiety and identified potential triggers. We saw that accidents, incidents, pressure ulcers and infections were reported to the provider monthly to help them identify any themes or trends. However, we noted that did not identify the shortfalls in unexplained bruises being investigated.

People were supported by staff who had been recruited safely. We saw that personnel files included appropriate pre-employment checks and these were completed before the staff member started work. This included a criminal records check, written references and proof of identity and qualifications. This helped to ensure that staff working at the home were fit to do so.

Requires Improvement

Is the service effective?

Our findings

People told us that they did not like the food and we observed people had not received sufficient support with eating and drinking. The interim manager told us that they had identified that feedback about meals was poor and they had met with the chef who was creating a new menu for the upcoming weeks and had been encouraged to speak with people to get their views. Comments about the food included, "The food is terrible, I like vegetables and they are either cold or not cooked properly.", "I prefer to have my main meal at lunch but they change it around so you never know. Anyway it is much too spicy." And "I like fish and chips but I don't like them here, not nice."
We noted that breakfast was still served at 11am and lunch was a disorganised. One person told us, "In the evening we eat between 5 and 5.30 but we have to wait a long time and anyway it's too early, make lunch later and evening meal later. No-one wants too much lunch if they haven't had breakfast until 10."

We asked staff if they used a menu list to ensure that everyone received their meal. Staff told us they did not but wrote people down on a piece of scrap paper or their names on the tray liner. We discussed the potential risk of people being missed, especially on the unit where people walked around frequently. One person told us, "One day I was sitting in the corridor and they forgot to take me to lunch." The interim manager and quality business partner told us they would introduce a menu form promptly.

We also saw that people did not receive appropriate support with eating. Where people had an allocated staff member to assist them to eat, this was done in an unrushed manner, however, with little or no interaction. The support for people who needed assistance or encouragement to eat their meals was often delayed or inconsistent. One staff member told us that a person did not like to be assisted to eat. However, after waiting 25 minutes and struggling, when assistance was offered the person promptly accepted.

The interim manager had identified that some people had lost weight. To address this they instructed kitchen staff during a meeting to fortify food and provide smoothies in the afternoon. We spoke with the kitchen staff who told us they did not fortify foods and smoothies were only provided when asked for. We did not see any smoothies being provided on the day of our inspection.

The lack of regard for people's well being in relation to their nutritional needs was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

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 whether any conditions on authorisations to deprive a person of their liberty were being met and if the service was working in accordance with the MCA

and DoLS guidance.

We found that the service was working in accordance with MCA and DoLS and the appropriate assessments, including best interest meetings were carried out to help ensure people's rights were protected. We noted that people were asked for consent in most cases before they were supported. Staff had a good understanding of MCA and DoLS. One staff member said, "Just because people don't have capacity it doesn't mean they can't make some decisions, DoLS are about keeping people safe not about choices about what they want to wear." Care plans included consent forms and in most cases these were signed by the people they related to, in other cases a relative had signed on their behalf.

People told us that they felt staff were appropriately skilled for their role. One person said, "The staff are good but they don't have any time, they are good at what they do though and they make sure we are safe (referring to hoisting)." Staff told us that they felt they had enough training for their role. They told us they had particularly enjoyed the recent fire training as they experienced being evacuated by their colleagues. One staff member said, "It makes it easier to take it in when it's face to face and hands on like that." We viewed the training records and saw that most areas were up to date and those that were due to be updated had been booked and posters were displayed advising staff of the dates. Staff told us they felt supported and had regular one to one supervision which gave them the opportunity to discuss any issues and personal development.

People had access to health and social care professionals as needed. One person said, "We just ask to see the GP but the nurse will usually check first." We saw that appropriate referrals were made to dieticians, mental health team and the speech and language team (SALT). People told us that occupational and physiotherapy was not always provided by the GP. One person said, "The physio comes in once a week, we pay for that." We saw that that there was a visiting hairdresser, optician and chiropodist.

Requires Improvement

Is the service caring?

Our findings

People were not always treated with respect and not always had their dignity respected. One person told us that after asking to be assisted from the toilet when waiting for 30 minutes they were told that they were not a priority. The person said, "They told me 'you're not a priority'. That hurt me." Other people told us that they were made to feel guilty for using their call bell. One person said, "They told me 'there are a lot of people much worse off than you'." Another person said, "They said 'you're not the only one who needs care'." We discussed this with the management team who were aware there had been concerns in regards to some staff member's attitude and approach and had a plan in place for addressing this issue and were using their disciplinary process. However, this was an area that required improvement.

We were unable to see many examples of meaningful relationships between people and staff. The staff were busy and they didn't appear to have the time to stop and talk to people, they finished focussing on one task and they were off onto the next. This demonstrated a task orientated approach rather than a person centred approach. However, people we spoke with told us that most staff were nice. One person said, "There are some good and some bad but most are good." Another person said, "They are mostly kind and caring." People attributed the, at times, abrupt approach to staff being busy rather than them not being nice. Relatives told us that they felt staff were kind and caring. One relative said, "They are excellent, they always have people's best interests at heart."

We did observe some staff were attentive and caring throughout our inspection. Examples were limited due to the busyness of staff and the majority of people receiving support in their rooms. However, we noted that one staff member was particularly bright and cheery when they walked into a room and spoke with affection to those they supported. We also observed another staff member encouraged a person to taste their dessert to help them remember what it was. When they did they visually seemed to enjoy it.

People and their relatives were not consistently involved in planning and reviewing people's care. Only one of the people we spoke with told us they had been involved and some relatives said they hadn't been involved. We reviewed involvement in the care plans and saw that this did tend to defer to relatives rather than to the person it related to. However, we also saw that relative involvement was not consistent. We did note that some plans had a regular record of people's relatives being informed of any significant event. For example, a fall or a GP visit. In spite of this, this was an area that required improvement.

People's records were stored in their bedrooms, although plans were stored out of sight, daily care notes were left on tables or dressers. To help maintain privacy, they were in closed folders, however, they could have been accessed by people or visitors who had no right to do so. We saw that when personal care was being delivered staff turned a notice on the door to state no entry as care was in progress. This was turned back when they had finished. This helped to promote people's privacy.

Requires Improvement

Is the service responsive?

Our findings

People did not always receive the support and care they needed in a person centred way. We observed the time it took for staff to respond to people's needs. We found that people had to wait to use the toilet with one person telling us that recently they had waited an hour and the person told us they were in pain as a result of the long wait. Other people also told us they often had to wait for assistance to use the toilet and often needed to wait for other support as well. One person said, "I have cream to put on (for a skin condition) but they are too busy." We found that care was delivered when staff were able to provide it rather than in response to people's preferences. For example, people told us that baths and showers were on a scheduled day and not when people wanted them. One person told us, "We have a bath or a shower once a week and if I forget which day it is I just ask and they tell me which day I can have one."

We also noted when we arrived on one of the units at 8.45 am that one person was walking around in their nightclothes with a strong odour of urine. This person did not receive personal care until 9.40am even though the fact that they needed assistance would have been obvious to any staff member passing them. We saw this person, still in need of personal care, on another person's bed and we heard staff looking for them as they had not seen where they had gone. We also observed one person who was in bed naked from the waist down. Staff were assisting other people with breakfast at the time so were unable to support the person to be washed and dressed until over an hour later.

People did not always get the appropriate support or supervision with eating their meals and people did not receive their morning personal care until 11am. This meant that these people had their breakfast just one and a half hours before lunch was served.

People who needed support or supervision didn't receive this. We observed one person have their food taken by another person and even though they shouted, "No, no, no." Staff didn't notice and we had to intervene to ensure they did not miss their meal and the other person didn't eat half eaten food. Another person was not placed at the table in an appropriate position to be able to see over the top of the table. Their care plan detailed that needed to be seated at the correct height and have adapted crockery. This did not happen. They were left for over 15 minutes with their head resting on the table until staff placed a bowl of soup in front of them. They struggled to eat the soup but couldn't see what was on the spoon. The clothing protection had slipped from the correct position and the soup wasn't going into their mouth. A staff member then came and tried cleaning the person up and transferred the soup into a cup and walked away. The person couldn't drink out of the cup because it was not very full so kept tipping it and nothing was happening. The staff member came back and filled it up but the person continued to struggle and gave up very quickly. A staff member said, "Would you like a jacket potato." The person said no but the staff member wasn't listening and brought back a potato with very little cheese on, mashed it up a bit, put a fork into the person's hand and walked away. The person was still talking but the staff member couldn't see that because they were not at their level. The staff member walked away again and the person could only get very small pieces of potato onto the fork. At this point another staff member saw us observing the person and said, "[Person] doesn't like being fed." The staff member returned put another mouthful on the fork and walked away again, they returned 4 minutes later but by this time the person had had enough but accepted

jelly and ice cream. After 25 minutes from the start of this person's lunchtime the staff member offered help and the person said 'yes please' and finished the bowl of jelly and ice cream. There was no interaction. This person was clearly able to communicate but because their head was bent and all the staff stood above them they could not even see that the person was talking. They then gave the person a cup of apple juice, they tried it and said 'there's nothing in it' and was offered a straw. The person finished the juice really quickly and asked for more but was told, "No, it's finished, have your tea." We also observed another person who suffered tremors and did not have any adapted cutlery to make eating easier.

Staff told us that they felt people's needs were met but not always on time or in a person centred way. One staff member told us, "The care happens, but not always on time, especially if agency staff are on duty." We observed this to be the case. For example, one person told a staff member, "I've been in this chair since half past eight, that's more than four hours (just over 5 hours)." The person told us that they were only able to sit in the chair for four hours to reduce the risk of them developing a pressure ulcer. The person was then moved.

Due to the inconsistency of person centred care and the lack of appropriate support in regards to nutrition, this was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People had care plans which set out their needs to enable staff to deliver safe care and support. However, reviews were not always consistent. For example, one area of the plan may have been reviewed but this was not always throughout the plan. The plans set out specific details, such as triggers to behaviour that challenged, support with moving and handling and people's life histories and staff were able to tell us about the people they supported.

People had access to a range of activities but they told us often staff were too busy to get them to group activities that were going on in the main lounge. One person said, "They are often too busy to take us." Another person said, "I like to go to activities but often they are so busy that I can't get ready in time to get there."
However, other people were positive about the activities provided. One person said, "We have lots of different things going on and the activities organiser is very good. We have outings sometimes and someone plays the harp." Another person who spent most of their time in bed said, "I have a hand massage, it is lovely." We also found that there were regular clubs at the service that people could enjoy. One person said, "A knit and natter group come in, they didn't have anywhere to go and so they came here and we can go. It's lovely and they make us cakes sometimes too."
People also told us that there were opportunities for going out. One person said, "We have outings sometimes, I really like that." However we overheard a conversation between a staff member and person who lived at the home. The person was heard to say, "I'd like to go on an outing" to which the staff member replied, "Well the next one to Duxford is full, you went on the last one anyway. There are some more (listed two) I'll see if they are full and put your name down." There was no interaction with the list about what the person might have enjoyed doing in the past and which might be suitable. We saw that the activities organiser audited the month's events and activities and used this, along with a meeting with people, to plan activities for upcoming months. One person told us, "They are thinking of starting a scheme to have a collection of magazines that people can borrow, that's a good idea."

Most people knew how to make a complaint and felt that their minor complaints (apart from food and staffing) were dealt with. Some people felt that they should not raise issues in the first place as these should be identified by the management team. One relative told us that laundry was frequently lost and items never returned and when they had made a complaint, this had not improved the situation. We reviewed the complaints log and saw that these were responded to in accordance with the complaints policy.

Requires Improvement

Is the service well-led?

Our findings

The registered manager had recently left the home and the service was being supported by an interim manager who was employed by the provider. The interim manager had only been in post a matter of weeks and had identified areas that they felt needed further improvement. These areas included the management of medicines, the approach and culture of some staff and the mealtime experience. We also saw that the business quality partner had identified these areas as needing further development.

We saw that checks, audits and meetings were in progress to monitor these areas. Action plans had been developed and these had been communicated to the staff team. However, we found that these areas were still a concern and the actions put in place to resolve the issues were ineffective. For example, in regards to the approach of some staff, shortfalls in relation to medicines management, the support people received with nutrition and the inconsistence of person centred care provided. We also found that the service had not identified the concerns in relation to the safeguarding process not being adhered to and therefore had not reported these concerns to us.
We also found that there were gaps in record keeping. This included repositioning charts and fluid intake charts. Staff told us that the care was delivered but they at times either forgot or were too busy to complete them. We spoke with a nurse who told us that poor fluid intake was reported in the handovers so staff were aware of which people needed more encouragement. They also told us that they were confident that repositioning took place and it was a gap in recording.

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

Following our inspection the manager and management team undertook an investigation and audits of the areas of concern we had raised and sent us a response very promptly. This demonstrated that they wanted to work with us to help ensure people received the care and support they needed.

People had been informed of the change in management and this was displayed around the home. People told us that they had spoken with the interim manager and attended meetings they had chaired. People told us they hoped that the home would soon have a permanent manager again. They told us that they had raised the concerns about staffing and mealtimes with the management team and they were waiting for improvements to be made. The manager told us that they felt staffing numbers were sufficient and that in regards to the menu, a new menu was due to start with people's suggestions included. We discussed the need for the management team to review staffing, whether that be numbers, deployment or leadership as feedback from people and our findings during the inspection was that this was an area that required improvement. People had been asked for their feedback since our last inspection. Much of the feedback was positive. However, some feedback was received about the food and staffing levels and but this had not been addressed.

Staff were positive about the new manager and told us they would be sorry to see them move on when the home appointed a permanent manager. One staff member said, "[Manager] is great, around checking, I feel

really supported, more than ever before." Staff also told us that the business quality partner was normally in the home and prompted them to check on things, such as people having drinks available. One staff member said, "[They're] on the ball."
Staff had meetings with the manager since they started where they told us they were told of any new information, lessons learned and any updates. However, we noted that some of these actions from meetings were not yet embedded and needed further input from the management team. For example, the approach of staff and the provision of fortified foods and smoothies.

The management team were working on developing the staff team to ensure they worked in accordance of the ethos of the provider in a person centred care way. This included working with a local training provider to develop champions in key areas such as dementia care, nutrition and falls. One staff member said, "It's a great place to work, they really care about the residents." The interim manager told us that they were working on changing the approach of staff by being out on the floor observing practice and giving feedback as staff needed it. This had resulted in unrest for some staff who were finding the shift in culture and approach a challenge. The interim manager told us they expected all staff to be on board and work in accordance with their vision for the service. They told us that they recognised this was a challenge that wouldn't happen overnight. The interim manager had support from a senior management team to help them achieve their goals for the service.

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 9 HSCA RA Regulations 2014 Person-centred care People did not receive person centred care.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People's medicines were not always managed safely.

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 abuse.

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 Systems in place had not addressed the issues.