Barchester Healthcare Homes Limited

Hugh Myddelton House

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service responsive?	Good

Summary of findings

Overall summary

This focused inspection took place on 10 May 2016 and was unannounced. We undertook this inspection because we had received some concerns about staffing levels and how this impacted on people who use the service. This report only covers our findings in relation to staffing levels within the home within the safe section, how staffing levels impacted on mealtimes and the monitoring of people's food and fluid intake under the effective question and the management of complaints in respect of staffing levels under the responsive section. You can read the report from our last comprehensive inspection by selecting the 'all reports' link for Hugh Myddelton House on our website at www.cqc.org.uk

Hugh Myddelton House provides care and accommodation for a maximum of forty-eight people. At the time of our inspection, there were 46 people living in the home.

The home covers three floors. On the ground floor there is capacity for 19 elderly frail people. On the first floor there is capacity for 19 people living with dementia and on the second floor there is capacity for ten younger people with disabilities.

A registered manager was not in post. 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. An operations manager was managing the home on an interim basis with the assistance of the regional director until a newly appointed manager commenced employment.

One assessment had not been updated to reflect a person's current needs. On one occasion a risk assessment had not been completed for a person using the service.

We found that fluid intake for people at risk of dehydration was not always monitored. Guidance was not available for staff in relation to a persons minimum required fluid intake and the actions to be taken when people's fluid intake was low.

People told us they felt safe living at the home. Most people told us that there were sufficient numbers of staff to meet their care needs. Two people told us that they felt that there was insufficient staff during the night and they did not receive assistance from staff when they used their call bells. The service was unable to provide records of call bell response times at night due to a technical problem with the call bell monitoring system. Overall, people spoke positively about staff and how hard they worked.

Relatives and staff told us that staffing levels had been a concern previously when the number of carers had been reduced on the first floor following the completion of a needs assessment by the provider. The staffing levels had since been increased and staff and relatives told us that generally staffing levels were adequate.

Medicines were managed safely and effectively.

We saw caring and friendly interactions between staff and people who used the service. People spoke positively about staff. Staff worked together and assisted colleagues in other areas of the home to ensure that people's care needs were met and people received medicines and meals on time.

Mealtimes on the ground floor and second floor were relaxed and people received their meals on time. We saw on the first floor, where more people required assistance to eat, some people did not receive their meals in a timely manner despite staff being deployed from other areas of the home to assist with serving food. However, in the dining room we observed staff assisting people to eat in a patient and caring manner.

Complaints were recorded and investigated with a response sent to the complainant and actions had been taken and improvements had been made.

We identified two breaches of regulations relating to risk management and nutrition and hydration. 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. Risk assessments for people had not been updated and one person had no risk assessment in place.

People who used the service told us they felt safe in the home. Relatives and care professionals we spoke with said that they were confident the home was safe.

Staffing arrangements were adequate.

Is the service effective?

Requires Improvement

The service was not always effective. Fluid intake was not adequately monitored for people at risk of dehydration and actions had not been taken when low fluid intake was recorded.

People were supported to eat and drink. On the first floor some people did not receive their meals in a timely manner.

Is the service responsive?

Good

The service was responsive. There was a weekly activities programme and people had opportunities to take part in activities.

The home had a complaints procedure and complaints had been appropriately responded to with actions taken.

Hugh Myddelton House

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.

We undertook an unannounced focused inspection of Hugh Myddelton House on 10 May 2016. This inspection was carried out by two adult social care inspectors and one 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 inspection was carried out due to recent concerns that had been brought to the attention of the Care Quality Commission (CQC) in relation to staffing levels and how this was impacting on people who use the service and staff.

During the inspection we spoke with 15 people who used the service, nine relatives, the interim manager, the regional director, seven staff and two healthcare professionals. We looked at six care plans including risk assessments and daily recording records, staffing rotas and complaints log. We also used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people when they may not be able to tell us themselves.

Requires Improvement

Is the service safe?

Our findings

People were not always protected against risks and action had not always been taken to prevent the potential of harm. For example, one person who had been admitted to the home for respite care one week prior to the inspection did not have a risk assessment completed. We identified areas of risk for the person around the use of oxygen, nutrition and hydration. The person's care plan also contained minimal information. This meant that the person may not have received care best suited to their needs and potentially placed them at risk of harm.

Skin integrity was assessed using Waterlow charts to determine risk levels. In one care plan we saw that the Waterlow risk assessment had not been completed since 16 February 2016. This person at the time had been assessed as very high risk and required two hourly turning. We discussed this with the interim manager and area director who confirmed this would be looked into. We also saw that the person's risk assessment for falls, nutrition, hydration and choking had also not been assessed since 16 February 2016 despite instructions on the risk assessments to review on a minimum monthly basis. This meant that the person may not have been adequately protected from the risk of harm.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people we spoke with told us that there were enough staff during the day and they felt safe. Comments from people included, "During the day they are brilliant," "Staff are very kind. I do feel safe here" and "The carers are very good. They have a lot to do." A relative told us, "[My relative] is good, there is enough staff, there are lots of people to attend to [my relative] and they manage very well. One or two more would ease the pressure."

A healthcare professional told us that in general staffing numbers at the home were acceptable and the quality of care staff was good.

When we asked people about staffing levels at night, we received a mixed response. One person told us, "During the night they were not adequately staffed. They are pushed for time." Another person told us on a few occasions she had to wait 30 minutes after using the call bell in the morning at approximately 05:30 - 06:00 for assistance to use the toilet. The person told us, "I wake up and have to get up but there is nobody there." This person did also tell us that, "The girls [staff] are brilliant and they work their socks off." Another person told us, "I press the bell and the girls [staff] come all the time straight away."

We asked to see the records of call bell response times. However, due to a technical problem, the records between January 2016 and the day before the inspection were not accessible. When asked how the service monitors the use of call bells, the regional director advised that the maintenance team carried out a weekly check of call bells to ensure they were working. The management team then monitored call bell response times. After the inspection, the area director told us that as part of their audit of the home, they checked that call bells were working and staff were responding in a timely manner during their visit. A review of call

bell response times at other times or on other days was not carried out. This meant that the provider could not demonstrate that call bells were responded to in a timely manner during the night when there were less staff on duty and less managerial oversight. The regional director advised us that in future they would review the response times logged.

During the inspection we observed call bells in use and appropriately responded to in a timely manner. We saw call bells were placed in reach of people who were cared for in their rooms. Risk assessments were in place for people who were noted to have difficulty in using their call bell, and guidance was given to staff to support people to use their call bell so that people were able to summon help and support when required.

We discussed staffing levels with the interim manager who told us that during the day shifts there was usually one nurse on each floor supported by four care staff on the ground floor, four care staff on the first floor and two care staff on the second floor. At night there were two nurses on duty and four carers. The interim manager told us that the provider had to use agency nursing staff on a regular basis to ensure nursing cover at nights whilst they recruited more nursing staff. A senior nurse was acting as a deputy manager whilst the provider recruited a new deputy manager.

The provider used a Dependency Indicator Care Equation (DICE) tool to assess dependency levels and calculate staffing levels. The DICE is a tool that takes into account the person's needs and level of support and then calculates how many hours of support the person requires. The initial assessment was carried out by the manager or senior nurse and then reviewed monthly. As a result of the DICE assessment, the staffing levels on the first floor were reduced from four carers to three during the day. However, after approximately one month following concerns raised by people, relatives and staff, four carers were re-introduced again on the first floor during the day. Staff we spoke with said that the home had adequate staffing levels at present. Comments included, "A couple of months ago staffing was an issue but it is fine now, " and "Staffing levels had been set by using the DICE, but the DICE system was not working. We trialled the DICE for one month but it didn't work."

Staff worked as a team to ensure people's needs were met and staff told us that they often assisted their colleagues on different floors as required. One staff member told us, "The first floor is the busiest so staff from the second floor go and support." During the inspection, the nurse from the second floor assisted with the medicines round on the first floor when the nurse in charge on the first floor had to attend to an emergency situation.

Peoples' medicines were managed and administered safely. We checked the medicines administration records for ten people using the service and saw appropriate arrangements were in place for recording the administration of medicines. No gaps were identified on the Medicine Administration Record (MAR). People who used the service told us that they received their medicines on time and the nurse administering the medicines stayed with them while they took their medicines. We observed that staff were patient and caring when administering medicines and ensured people were ready before administering the medicines. Daily 'as required' (PRN) medicine stock checks were completed and a PRN medicines protocol was in place for people who used PRN medicines. Daily temperature checks for fridges containing medicines were recorded.

Requires Improvement

Is the service effective?

Our findings

We looked at three people's fluid charts and noted that fluid intake for these people were not always appropriately recorded. Fluid intake was not always recorded from the evening time onwards; minimum fluid intake guidance was not in place as well as what actions staff should have taken if people did not take the minimum fluid required. This meant that staff had no guidance as to when to take action if the person was not taking sufficient fluid.

We saw on one fluid chart between 1 and 9 May 2016, on three days staff stopped recording fluid intake in the early evening and on one occasion as early as 13:30. We saw that fluid intake was not recorded at night time. On 6 May 2016 the person's total fluid intake for that day was recorded as only 270mls. We checked the persons daily records and the entry stated, "[The person] ate and drank with encouragement." On another person's fluid chart, on 9 May 2016, the person was last recorded to have had fluid at 15:30.

These gaps in recording meant that people were either not being offered fluids after these times or fluid intake was not accurately recorded. This increased the risk posed to people who were already noted to be at risk of dehydration. This was brought to the attention of the interim manager and area director during the inspection.

This was a breach of regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us the care they received was good and they received care and support when needed. Comments included, "The carers are very good. They have a lot to do," and "They look after me." Comments from relatives included, "[My relative] has been here for five years, they are on the job," and "[My relative] thinks very highly of this place."

We completed observations at lunchtime on all three floors. On the ground floor, we observed that food was presented well and food was hot. Two staff were supporting four people in the dining room whilst the other two staff were taking meals to people in their rooms and supporting those people who required assistance. Food was covered before being taken out of the kitchen. People received their food within 30 minutes of the start of the lunchtime and were offered choices.

On the first floor we observed that lunchtime was quite busy. Staff from other areas of the home, including an office administrator, the staff trainer, activities co-ordinator and the interim manager were deployed to the first floor to assist with supporting people to eat. The regional director told us that this was a provider wide initiative to encourage teamwork especially around busier periods. A relative was also observed assisting with supporting other people to eat. However, despite the additional assistance received, we observed that some people in their rooms had not received their meal more than 30 minutes after the start of lunchtime. We discussed this with the interim manager who advised that she had recognised this was an issue and was going to consider bringing lunchtimes forward for those people who required assistance to eat so they could be supported first without delay.

In the dining room on the first floor we observed staff assist people in a caring and unhurried manner. We saw on one occasion, a person refuse to eat when assisted by a carer who had recently commenced employment at the home. The carer recognised that the person not knowing her may have been the cause and requested a colleague, who knew the person better, to continue with assisting the person to eat. The person subsequently started to eat and went on to finish most of her lunch. People were offered choices and staff gently encouraged people who were reluctant to eat.

On the second floor we observed that some people were being supported to eat and others were eating independently.

Good

Is the service responsive?

Our findings

Complaints and concerns were taken seriously and used as an opportunity to improve the service. A complaints policy was available and relatives told us they were supported to submit a complaint if necessary. There had been four complaints recorded since January 2016 and these had been investigated thoroughly, responses sent and actions taken as a result of the complaint. Staffing levels had been mentioned on three of the complaints submitted.

A relative we spoke with during the inspection told us that they had submitted a formal complaint in relation to aspects of their relative's care. The relative told us that and since doing so, they had found there had been "much improvement" in the care provided to their relative. An example they gave us was that initially their relative was transported around the home in a wheelchair and since making the complaint, the relative was supported by staff to use a walking frame which increased their mobility and promoted independence.

People were supported to engage in activities on a daily basis. Notices about activities and events were displayed around the home. During the inspection we observed a religious sermon and storytelling session where people were encouraged to participate. We spoke with the activities co-ordinator who enthusiastically discussed their upcoming events such as activities for dementia awareness week and how people were supported to attend weekly day trips.

The provider was in the process of introducing a new programme called '1066' which looks at supporting people living with dementia. It looks at promoting independence and providing people with a better quality of life. This has meant that significant renovation work was taking place on the first floor during the inspection. The regional director told us that the home was the pilot for the programme.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 (2)(b) People using the service were at risk because the service did not assess and mitigate risks identified as part of the care and support plan.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Regulation 14(4)(a) Nutritional and hydration intake was not monitored and recorded appropriately to prevent dehydration and malnutrition. Action was not taken without delay to address concerns.