Clarendon Care Group Limited

Myford House Nursing & Residential Home

Inspection report

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Shropshire
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27 October 2017

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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

Myford House is located in Telford, Shropshire. The service provides accommodation and personal care for up to 50 older people. On the day of our inspection, there were 28 people living in the home.

The inspection took place on 26 and 27 October 2017. Day one of the inspection was unannounced, and day two of the inspection was announced.

There was no registered manager at this service, and there had been no registered manager in post since May 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered providers and registered managers 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.

At our previous inspection on 14 and 15 August 2017, we found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These were in relation to staffing; person-centred care; safe care and treatment; dignity and respect; and good governance. The service was placed into special measures, which meant that significant improvements were required. At this inspection, we found the provider remained in breach two Regulations. These were in regard to the proper and safe use of medicines (safe care and treatment), and good governance. However, we found the provider was no longer in breach of the Regulations regarding person-centred care; staffing and dignity and respect.

Medicines were not always stored or administered safely. Not everyone had received their medicines at the correct time, which placed them at risk of harm.

Not all staff had received the necessary training relevant to their roles. The provider and manager had audits in place to monitor and improve the quality of care provided. Whilst the provider and manager had taken immediate action when health professionals the CQC had brought issues to their attention, their audits had not always been effective in identifying these concerns themselves.

People were sometimes placed in undignified situations and treated in a disrespectful manner.

There were sufficient staff on duty to safely meet people's needs, and staffing levels were kept under review. Safe staff recruitment procedures were in place to ensure people were only supported by people who were suitable to work in care.

People's weight, food and fluid intakes were monitored and action taken to maintain people's health. People had access to a range of healthcare professionals, and their changing health and wellbeing needs were responded to.

Staff were positive and enthusiastic about the improvements made at Myford House. and the on-going

improvements in place. Staff knew people well and there was a natural rapport and ease between staff and the people they care for.

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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 stored at the correct temperature, which affected their efficacy. People did not always receive their medicines at the correct times.

There were enough staff to safely meet people's needs. Staffing levels were reviewed and adjusted to ensure they were sufficient to keep people safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had received training relevant to their roles.

People's fluid intake was monitored to ensure they had enough to drink and stay hydrated. Where there were concerns about people's weight, action was taken. People's individual eating and drinking needs had been reviewed.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not consistently treated with dignity and respect.

People's relatives were able to visit the home freely. Staff understood people's individual communication styles and needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not always receive their medicines at the individual times required.

People were able to enjoy their individual hobbies and interests, and were encouraged to try new social and leisure opportunities.

Complaints and feedback were captured and responded to.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There no was registered manager in post. Audits were in place to monitor the quality of care provided, but they had not always identified shortfalls in the service.

Staff morale had improved, and the staff and management team were positive about the ongoing improvements. Concerns identified at the previous inspection had been acted on.

Myford House Nursing & Residential Home

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 made an unannounced inspection on 26 October 2017, and an announced inspection on 27 October 2017. The inspection team consisted of three Inspectors and one Pharmacist Specialist.

We looked at the information we held about the service and the provider. We looked at statutory notifications that the provider had sent us. Statutory notifications are reports that the provider is required to send us by law about important incidents that have happened at the service. This information helped us to focus the inspection.

We asked the local authority if they had any information to share with us about the care provided by the service.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people living at the home.

We spoke with eight people who lived at the home and five relatives. We also spoke with two healthcare professionals. We spoke with the Operations Manager; the manager; the lead nurse; two nurses and six members of staff. We also spoke with the kitchen assistant and the maintenance person. We looked at six care plans, which included risk assessments; care plan reviews; information about communication needs; healthcare information and capacity assessments. We looked at 10 medication administration records; the clinic room temperature records; 'as required' medicine protocols; handover records; medication audits; and the staff training matrix.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection, we found the provider was in Breach of Regulation 12 of the of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there was no oversight of the amount of medicines in stock; three stock checks of medicines showed discrepancies; and 'as required' medicines were administered without the lead nurse being aware and without being signed for on two occasions. The provider completed a risk reduction plan, which set out the improvements they would make. These included carrying out daily stock checks; undertaking medicine reviews, discontinuing any medicines no longer required; and reminding nursing staff of the need to ensure accurate medicine recording.

At this inspection, we found improvements had been made and the issues identified from the previous inspection had been acted upon. The provider told us their medicines management was now "significantly stronger and safer." However, the provider remained in breach of this Regulation. This was because additional areas of concern were identified at this inspection.

We found that five people were given certain medicines at the same time as both their food and other medicines; this was despite advice to the contrary on their medicine administration records chart and available national guidance. This could have resulted in one person experiencing a serious gastric side effect. We brought this to the attention of the manager and the provider, who told us they would change the timings of the administration of these medicines with immediate effect.

Room temperature checks were undertaken by staff daily to make sure that medicines were stored safely. However, staff had not documented actions when temperatures were recorded higher than was safely recommended. We found the room temperature was monitored from 1 August to 26 October 2017, with the temperature having exceeded 25 degrees on 77 out of 84 occasions. During our inspection, we found that one medicine may no longer have been effective as it was stored at a higher temperature than was recommended. This medicine was subsequently disposed of after we raised this issue. Fridge temperatures were correctly documented and were found to be within the recommended range. Medicines that required additional controls because of their potential for abuse (controlled drugs) were stored securely and recorded correctly. However, we found that one particular medicine, prescribed for a person to be used in an emergency, had been locked away and was not immediately available for administration. We brought this to the attention of the provider during our inspection.

People were prescribed medicines on a 'when required' basis. Some of these medicines had detailed information with the medication administration records to show staff how and when to give these medicines. This meant that staff were then able to give them in a consistent way that met people's individual needs. However, we found that one person did not have a sufficiently detailed protocol for staff to be able to use for a medicine that that might be needed for an emergency. Specifically, the protocol was not detailed enough around administration of the medicine for seizures, which should be administered after five minutes and repeated after 10 minutes. This could have resulted in the medicine not being administered promptly as directed by the prescriber, which would place the person at risk of harm.

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

At our previous inspection, we found that whilst individual risk assessments were in place which set out how to keep people safe, these were not always followed and this placed people at risk of harm. At this inspection, we found that improvements had been made in this regard. We found that people's needs had been assessed, reviewed and that most risk assessments had been updated. However, one person's risk assessment contained inaccurate information about their safety needs in relation to their specialist bed. We brought this to the attention of the manager, who rectified this. Another person's risk assessment was in place in regard to the use of bed rails. It stated this was to be reviewed every three months. However, the last review had taken place in February. We discussed it with the manager who confirmed there had been no change in the person's needs since then, but agreed the risk assessment should have been updated to reflect this.

At our previous inspection, we found the provider was in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because a new agency nurse was given the autonomy in their role to make clinical judgements about people's 'as required' anti-anxiety medicines, despite them being unaware of people's needs and histories. We also found the agency nurse had not been supervised in this role by the lead nurse, with their being no clinical oversight. The provider completed a risk reduction plan, which told us where a senior practitioner is available on site, they must be involved in the clinical decision regarding the administering of 'as required' medicines. At this inspection, we found improvements had been made and the provider was no longer in breach of this Regulation.The provider, the manager, the lead nurse and care staff consistently told us the main improvement since the previous inspection was in regard to clinical oversight. There was an induction check-list in place for agency nurses, and new agency nurses were no longer responsible for making clinical judgements about people's 'as required' medicines. This reduced the risk of harm to people as it meant that 'as required' medicines were only administered where there was a clear clinical rationale for doing so.

People and relatives told us they did not have any concerns about staffing levels at Myford House, and that people did not have to wait long for staff assistance, when needed. As the number of people living at Myford House had decreased since the previous inspection, the provider had reduced staffing levels to three carers and one nurse at night. However, following feedback from staff about these reduced staffing hours, a 'twilight' shift had been introduced from 6pm to midnight, with plans to review in two weeks' time. We observed that people's call bells were responded to quickly, and that staff were available to help people with mobilising and eating and drinking. One relative we spoke with told us, "I have never had concerns about the staffing levels here. Whenever I have rung the call bell, they (staff) have always been prompt."

At our previous inspection, staff told us they would not feel confident in raising a safeguarding concern with management at the home. Since that inspection, the provider and manager had discussed this matter with staff individually and in staff meetings and reassured them that any concerns they raised about harm or abuse would be listened to and acted on. At this inspection, staff told us they now felt able to raise any concerns, and we found that one member of staff had recently contacted the provider's Director of Compliance to discuss a concern they had. This assured us that staff would now report matters to management. Staff we spoke with were clear about what their roles were in regard to recognising and reporting suspected abuse or harm. One member of staff told us, " If I thought a person was being abused, I would report it to the nurse or the manager, otherwise directly to CQC. We are encouraged to report to external organisations if we are not comfortable or feel we are not being listened to."

At our previous inspection, we checked two staff employment files to ensure the necessary checks had been

carried out before they were allowed to work at the home. At this inspection, we found the provider continued to obtain references and checks with the Disclosure and Barring Service (DBS) before new staff members could start work at Myford House. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working in care.

Requires Improvement

Is the service effective?

Our findings

At our previous inspection, we found that the system used for monitoring people's weight was not always effective. At this inspection, we found that improvements had been made and it was now clear how weight loss was being managed. Staff now recorded exactly what people had eaten throughout the day, and any concerns in this regard were highlighted and communicated to the wider staff team. One relative we spoke with told us, "[Person] was always a funny eater, but they do weigh [person] regularly. [Person's] weight has stabilised since coming here." Staff told us there was a strong focus by the manager in ensuring people's nutrition and hydration needs were met. One member of staff told us, "There have been dramatic changes in the last few months. Meals are planned more effectively, snacks are available throughout the day we are all made aware of people's dietary needs, and we have a weight-management programme."

The manager had also introduced a system where people's individual daily fluid requirements were set out, so staff could see how much people needed to drink and ensure this was given. Staff told us this was a great improvement and that they all knew the importance of 'pushing' fluids where people were at risk of dehydration. We observed throughout both days of our inspection that people were offered plenty to drink, with a choice of drinks always readily available.

At our previous inspection, we found that people had not always been referred to Speech and Language Therapy (SaLT) when there were concerns about their eating and drinking needs. At this inspection, we found that people's needs had been reviewed and where applicable, there was updated SaLT guidance in place. Where there were concerns about people's weight, referrals had been made to the relevant health care professionals. We also found that people had access to a range of other healthcare professionals, as and when necessary.

We looked at the on-going training and support staff received in their roles. At our previous inspection, staff told us they wanted more face-to-face training. We saw that staff had since received face-to-face training in first aid and behaviours which challenge. We looked at the provider's staff training matrix, which showed us that there were gaps in the training staff had received. These gaps were in key areas such as dementia; falls; pressure ulcer prevention; dysphagia (difficulty or discomfort in swallowing) and infection control. Whilst we did not observe any concerns about staff's practise in these areas, it is the provider's responsibility to ensure that all staff receive appropriate support. training and professional development as is necessary to enable them to carry out the duties they are employed to perform.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes and hospitals are

called the Deprivation of Liberty Safeguards (DoLS). We checked whether the provider was working within the principles of the MCA.

Staff we spoke with had an understanding of the principles of the MCA. One member of staff told us, "I am aware of my responsibility about obtaining consent. I always ask if people can communicate. Even if someone cannot verbally communicate, they can communicate through their body language." Where appropriate, the manager had ensured people access to a Relevant Person's Representative (RPR). An RPR is someone who is appointed under the MCA to represent and support people who are deprived of their liberty. We spoke with one person's RPR, who told us that staff knew people well, responded to their needs and that staff had an understanding of the MCA and the DoLS process. Staff we spoke with had an awareness of who had a DoLS in place, why they were in place for each individual, and what these restrictions meant in regard to their day-to-day practice.

Requires Improvement

Is the service caring?

Our findings

At our previous inspection, we found the provider was in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people were not always treated with dignity and respect because their personal care needs were not always attended to, particularly in relation to their nail care.

At this inspection, we found that improvements had been made and the provider was no longer in breach of this Regulation. Each person living at Myford House now had their own individual nail care kit and systems were in place to ensure staff knew to carry out nail care checks and clean and cut people's nails, as necessary. Staff we spoke with were positive about this system and told us it worked well; we saw that people's fingernails were clean and trimmed, and people told us staff helped them to keep their hands and nails clean.

However, we saw that one person was wearing a dirty top, which had ridden up and was exposing their bare stomach. We brought this to the attention of a member of staff, who recognised the person's top needed changing and made sure it was changed immediately. We mentioned this to the manager, who told us that whilst progress had been made in promoting dignity and respect, they recognised that there were still further improvements needed in this area. Staff were receiving ongoing guidance and training in this area to make sure dignity and respect underpinned their practice at all times.

Since our previous inspection, dignity audits were now carried out, and one was in place during the first day of our inspection. The member of staff carrying out this audit told us they were checking to make sure people did not look unkempt; that people were not placed in undignified situations; and that staff interactions were respectful.

On both days of our inspection, the majority of interactions we saw between staff were respectful and caring. Staff knew people well as individuals, and were skilled at putting people at ease, particularly if they were distressed or restless. However, on the second day of our inspection, we observed an agency nurse feeding a person their lunch whilst looking at an electronic device. They did not give the person their full attention, and did not look at them as they fed them their meal. We brought this to the attention of the provider and the manager, who raised it with the agency nurse member in question and told them this was not good practice.

Relatives told us they felt people were well cared for, and that there were no restrictions on when they could visit. On the second day of our inspection, one relative visited the home with a family pet and they told us the provider welcomed this as they knew the person enjoyed seeing their pet. The relative also told us that when it had been a milestone wedding anniversary for them and their wife who lived at Myford House, the provider had arranged a celebration at the home as a surprise, and the owner of the home had personally attended. The relative told us, "You would not get that type of thoughtfulness everywhere; it was absolutely lovely of them."

Staff we spoke with had an understanding of people's individual communication needs, styles and preferences; we observed staff tailored their communication style to each individual. Staff had an awareness of the importance of independent advocacy services for people, and we saw a local advocacy service had been contacted in order to try and support a person in making sure their views were known and taken into account regarding a matter.

Requires Improvement

Is the service responsive?

Our findings

At our previous inspection, we found the provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because people's health and wellbeing needs were not always responded to, with there being a 'set-days' approach to when people saw the GP. At this inspection, we found that improvements had been made and the provider was no longer in breach of this Regulation. People's changing needs were responded to and acted upon. For example, one person was having difficulties with their body clock, which meant they were asleep in the day and awake all night. Staff and the manager had tried different ways to support this person to try and help them with their sleep pattern so they could be awake in the day and get a better quality of life. Staff knew people well and were vigilant to any changes in their behaviour or health. A relative we spoke with told us, "They (staff) are very good at keeping me informed about [person's] health. They recently suspected [person] had an infection and they called the GP. [Person] has had their feet and eyes seen to since coming here."

However, five people's medicines had been routinely administered as part of the standard medication round, not at the specific individual times they should have been given. By adopting this standard medication round approach to these individuals, their individual needs had not been met. We brought this to the attention of the manager and the provider, who immediately changed the times of when these medicines would be administered and made sure the timings coincided with the requirements of the prescriptions.

People told us they were able to pursue their individual hobbies and interests. One person had been supported in writing to their pen-pal. Another person had a toy animal which was important to them and the person had named. Staff referred to this animal by its name and spoke respectfully to the person about their 'pet', asking how it was, which the person enjoyed discussing. People's care plans reflected their individual preferences. Staff told us that one person's daily newspaper was important to them. We saw staff ensure this person had their newspaper, and the person then enjoyed reading this and discussing it. This preference was set out in the person's care plan.

On the day of our inspection, people enjoyed a trip to a local pub for a meal. People told us there were plenty of things for them to do and enjoy, including trips out and in-house activities. Recent events had included celebrations for National Cupcake Week. The manager told us that activity coordinator hours had increased since the previous inspection, and that the aim was to have a seven day activity programme for people to enjoy.

We found there was a system in place for capturing and acting on complaints and feedback. The provider had recently held a residents' and relatives' meeting and one relative we spoke with told us, "They spoke about the problems and what they were doing to put things right. They do listen to suggestions." Where formal complaints had been made, these had all been investigated and responded to.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection, there was no registered manager in post. The manager had been in post for 10 weeks and told us they had started the registration process. At this inspection, there was still no registered manager in post as no further progress had been made with the manager's application. The manager explained to us they had prioritised other work within the home in order to make improvements and as such, had not progressed their registration. We emphasised to the provider and the manager the importance of completing this registration process and that the provider was failing to meet the requirements of their registration. The provider assured us this would now be prioritised.

At our previous inspection, we found the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because the provider's systems were not effective in capturing and recording risks to people's health and wellbeing; handover systems used were unclear and contradictory; and not all the issues identified at our inspection had been detected through the provider's own quality assurance audits. At this inspection, we found although improvements had been made since the previous inspection, the provider remained in breach of this regulation. In addition, the provider had been in breach of this Regulation for a period of 19 months.

Since our previous inspection, there had been a focus on improving the clinical governance within the home, with the provider, the manager and staff telling us this was an area with the greatest improvements. Medication audits were now in place and looked at areas such as medication administration records; medication ordering; daily spot check counts of medicines; and running check counts and balances. We found these particular audits had been effective and that the concerns identified at the previous inspection had been addressed. However, the provider's audits had not identified the significant additional areas of risk we found at this inspection in regard to safe medicine administration and storage. Therefore, we could not be satisfied that the provider's auditing systems were broad enough to capture all key areas in relation to medicine management. We discussed this with the provider and manager, who told us they had taken immediate steps to address the issues identified, such as having the air conditioning serviced in the clinical room where the medicines were stored.

Since our previous inspection, the provider had improved the recording system in relation to people's food and fluid intake. It was now clear what people's individual daily fluid intake targets were; concerns about people's weight loss were clearly identified and actioned; and it was now clear whether people had eaten their meals. The manager had introduced summary fluid charts and for each individual, which they then audited to make sure people's correct fluid intake was being recorded. We found twelve instances in September where people's daily fluid intake was recorded as "offered 0ml, drunk 0ml." We raised this with the manager, who explained the reason for this was the date and time in which they had generated the report meant the correct amounts had not been captured; they were subsequently able to provide us with the correct fluid intakes for the people in question. We were assured throughout our inspection that the importance of offering fluids was understood by all staff, and that people had enough to drink. However, prior to us raising this, this incorrect audit information had not been identified.

Throughout our inspection, we found the manager and the provider were quick to respond to any concerns brought to their attention. For example, we found a fire exit to be blocked and the manager ensured this area was cleared when we pointed this out. Relatives and health professionals we spoke with also told us the provider and manager were quick to act. One relative we spoke with told us, "There was an occasion where there was a delay in getting my relative's prescription for three days. Once the manager found out, they were on the phone and sorted it." However, not all the issues we found on the inspection had been identified by the manager or the provider. This demonstrated to us that further improvements were needed in regard to the governance within the home so that issues were identified and resolved by the provider themselves.

This was a continued breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection, staff expressed low morale, and dissatisfaction with the home's management team. They told us they did not feel able to approach management with concerns, including whistle-blowing and safeguarding matters. At this inspection, we found that morale had significantly improved. One member of staff told us, "The things which we said then (previous inspection) needed to be said, but we have moved on since then and it is all about making improvements. " Another member of staff told us, "We are listened to now. When the report (CQC inspection report) came out, the provider met with staff and discussed it with us. They recognised how hard we all work and told us they want to support us." The provider and manager told us the actions they had taken since the previous inspection to improve morale. This included an overtime incentive, suggested by staff, to reduce the amount of agency usage; staff surveys; staff supervisions and staff meetings; and making sure the management team were accessible and visible. Staff told us the manager did spend more time interacting with them and people living at Myford House, but made suggestions for further improvements. One member of staff said, "I'd like to see [manager's name] taking time out to sit with people, have a cup of tea and chat." Another member of staff told us, "It is definitely better, but still a bit hit-and-miss. I still go to [Operation Manager's name] rather than [manager's name]."

We spoke with the provider and the manager about equality, diversity and human rights, and how they ensured people's rights were upheld. The provider had a "Fair Access, Diversity and Inclusion" policy in place, which was to promote equality of opportunity, diversity and inclusion for people living at Myford House as well as staff. Staff told us there was a diverse staff team, and that they felt the home was an open-minded place to both live and work. The provider was receptive to feedback about how they could think about building on this approach to ensure that their promotional materials and pre-assessment process were fully inclusive. We signposted the provider to a national organisation which would be able to give further guidance and training in this area.

The provider had identified improvements needed to the physical environment, including the need for 'dementia-friendly' flooring in the dementia unit of the home. At the time of our inspection, the work on this flooring had not yet begun. The manager told us the provider was committed to making improvements to the home and that they listened to their feedback and suggestions.

The provider had, when appropriate, submitted notifications to the CQC. The provider is legally obliged to send the CQC notifications of incidents, events or changes that happen to the service within a required timescale. Statutory notifications ensure that the CQC is aware of important events and play a key role in our ongoing monitoring of services.

We checked whether the provider had displayed the current rating of the home, and we found this was

displayed visibly for people, in accordance with their regulatory requirements,

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 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not always stored or administered safely. People did not always receive their medicines at the times directed by the prescriber. 'As required' medicine protocols were not always detailed enough, particularly in regard to emergency medicines.

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 Although there were quality assurance measures in place, these were not always effective in identifying shortfalls in the service. For example, the provider's medication audits had not identified significant concerns about safe storage and administration of people's medicines.