Barchester Healthcare Homes Limited

Hugh Myddelton House

Inspection report

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Overall summary

We carried out an unannounced comprehensive inspection of this service on 2 and 6 May 2014. Several breaches of legal requirements were found. As a result we undertook a focused inspection on 21 August 2014 to follow up on whether action had been taken to deal with the most significant breach.

You can read a summary of our findings from both inspections below.

Comprehensive Inspection of 2 and 6 May 2014

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 2008, and to provide a rating for the service under the Care Act 2014.

Hugh Myddleton House provides accommodation for up to 48 people who require nursing, personal care and support. At the time of our inspection 46 people were using the service.

People who used the service and their relatives were happy with the service received. Staff treated people kindly and with compassion. Staff were aware of people's likes, interests and preferences. However, we were not able to find evidence that staff understood people's care and support needs in all cases. The relatives we spoke with told us staff kept them informed of people's progress and any changes in their healthcare needs.

Ten people who used the service told us that they felt safe. Staff were knowledgeable in recognising signs of potential abuse and concerns were appropriately reported. We found the service to be meeting the requirements of the Deprivation of Liberty Safeguards.

Risk assessments and care plans were in place, however, we found that many of them lacked detail and there were some inaccuracies in the information recorded in people's care records. This meant we could not be assured that care was always tailored to people's individual needs and that preventative measures were put in place to protect people's welfare and safety.

The home did not meet requirements around the storage, safe administration and appropriate recording of medicines. This put people who used the service at risk of not receiving medicines safely.

People who used the service were offered a range of activities to suit their needs. They told us they enjoyed some of the activities offered, and told us that they were able to decide if they wanted to take part in activities or not.

The manager had been in post for six weeks and staff told us that, so far, they felt supported by her. Staff did not receive regular supervisions and appraisals which meant that staff were not being supported to deliver care safely and appropriately. The manager had not submitted an application to the Care Quality Commission to become the service's registered manager; however we were told that she had started the process.

Summary of findings

There were three breaches of health and social care regulations. You can see what action we told the provider to take at the back of the full version of the report. We considered the issues related to medicines management were serious enough to take enforcement action.

Focused inspection of 21 August 2014

One inspector and a pharmacist inspector carried out this unannounced inspection. The purpose of this inspection was to see whether the service had made improvements since our inspection on 2 and 6 May 2014, following enforcement action we had taken against the service. During our inspection on 2 and 6 May 2014, we were concerned that the service had failed to protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for obtaining, recording, handling, safe keeping, dispensing, safe administration and disposal of medicines.

During our inspection on 21 August 2014, we found that the service had taken appropriate action to ensure that the concerns raised at our inspection were addressed.

We will undertake another unannounced inspection to check on all other outstanding legal breaches identified for this service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

2 and 6 May 2014

Staff were knowledgeable in recognising signs of potential abuse and the reporting procedures to the local authority. Risk assessments were undertaken to establish any risks present for people who used the service, however, we found that management plans were not always put in place to minimise these risks. We also found that prevention plans were not always available, for example, to monitor that people were hydrated or regularly repositioned when they were at risk of pressure ulcers.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards (DoLS). The manager and staff were knowledgeable about DoLS. We saw in the past staff had followed relevant application processes and the conditions made by a supervisory body. Relevant staff -were trained to understand when an application should be made, and in how to submit one.

We found that the provider failed to protect service users against the risks associated with unsafe use and management of medicines, because appropriate arrangements for the recording, safe administration, safe keeping and disposal of medicines were not in place.

21 August 2014

We found that action had been taken to address the significant concerns about the management of medicines arising from our previous inspection. Appropriate arrangements for the safe management of medicines were now in place.

We will carry out another unannounced inspection to check on all outstanding legal breaches identified under this question.

Hugh Myddelton House

Detailed findings

Background to this inspection

This inspection report includes the findings of two inspections of Hugh Myddelton House. We carried out both inspections under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspections checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, looked at the overall quality of the service, and provided a rating for the service under the Care Act 2014.

The first, a comprehensive inspection of all aspects of the service, was undertaken on 2 and 6 May 2014. This inspection identified breaches of regulations.

The second inspection was carried out on 21 August 2014, and focused on following up on action taken in relation to the most significant breach of legal requirements we found on 2 and 6 May 2014. You can find full information about our findings in the detailed findings sections of this report.

Comprehensive inspection

We undertook an unannounced inspection of Hugh Myddelton House on 2 and 6 May 2014.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Before our inspection we reviewed information we held about the home including the last inspection report from September 2013. We visited the home on 2 May 2014 and 6 May 2014. The inspection team consisted of an inspector, an expert by experience who had experience of services for people with dementia and a professional advisor, who in her full time employment was a pharmacy advisor.

We spent time talking with people living in the home, their relatives, visitors, the manager, nurses and care staff. We observed care in the dining room at lunchtime and used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who were not able to speak with us. We looked at all communal parts of the home and some people's bedrooms, with their agreement. We also looked at five care records and records relating to the management of the home. We asked the provider to complete a 'Provider Information Return', but we did not receive the document in time for this report.

We spoke with 11 people living in the home, three relatives and visitors, five care workers and nurses, the home's manager and one visiting social care professional

Focused inspection

We took enforcement action for one of the breaches identified at our inspection on 2 and 6 May 2014. This concerned the management of medicines. We carried out an unannounced focused inspection of Hugh Myddleton House on 21 August 2014 to check that improvements required following our enforcement action had been implemented. We inspected the service against part of one of the five questions we ask about services: Is the service safe? The inspection was carried out by one inspector and a pharmacist inspector.

Is the service safe?

Our findings

Findings from the comprehensive inspection of 2 and 6 May 2014

Ten people told us they felt well cared for and safe in the home. Their comments included: "yes, I feel very safe here;" "I do feel safe here," and, "I am confident that dad is safe here". People and their relatives also told us staff usually responded to requests for care and support promptly. People who used the service told us that there was usually a quick response to call bells. However, one person said, "The response for calls for help at weekends and night time is not that quick and I sometimes have to wait for a long time to get help." The manager was in the process of auditing the call bell response by staff, but at the time of our visit had not completed it.

Staff spoken with demonstrated a good understanding of how to report safeguarding concerns and told us that they were confident that senior management would deal appropriately with allegations or concerns. One care worker told us that they would contact the operations manager or the CQC if they felt that issues were not dealt with locally. The home had a safeguarding adults procedure available, which could also been accessed electronically through the provider's website. Staff told us that they had received safeguarding training; however, the manager undertook a training audit on 27 February 2014, which showed that 19 staff required training in this area. We discussed this with the manager who told us that all staff had received a letter reminding them to complete their online training.

The service was not always identifying or managing risks appropriately. We viewed accident and incident records. The records were detailed, however there was little evidence that actions were taken to reduce the risk of similar accidents or incidents happening again. The manager undertook an accident and incident audit in April 2014.

We observed staff responding to behaviours presented by people who used the service and found staff demonstrated good understanding of how to respond pro-actively, by diverting people's attention or offering alternatives. For example, we observed a person becoming anxious. Staff knew how to offer support and settled the person down. We saw from training records that eight staff attended non-abusive psychological and physical intervention (NAPPI) training on 24 April 2014.

CQC is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The provider was meeting the requirements of the Deprivation of Liberty Safeguards. While no applications had been submitted, appropriate policies and procedures were in place for staff to refer to. Staff received training to understand when an application should be made, and how to submit one. The most recent training was attended by 12 staff on 4 March 2014.

We found inconsistencies in people's care records. In one example, a person was known to refuse their medication, but there was no risk management plan or strategy in place to address this. In another, a person's fall was recorded in one section of their file, but was not acknowledged in their risk assessment, so the increased risk was overlooked. In a third case, a person was assessed to have a low risk of choking despite a hospital admission for aspiration.

We found unsafe practice was taking place. People's medicines were not being managed so they were received safely. We looked at medicines records, medicine supplies and storage arrangements for five people living at the service. These records included medication administration records (MAR), and records of medicines received and disposed of.

On the first day of the inspection we found the ground floor medication room with the door open and without a member of nursing or care staff in attendance. The drug trolley had been left wide open with three people's medicines within easy reach of passers-by. The staff nurse explained that these medications were left over from the morning round and they had not yet had time to destroy them.

We found that the drug trollies were not secured whilst in the medicines room. The first floor medicines' fridge was not lockable. An unlabelled box of Paracetamol was stored; it was not clear why or for whom it was prescribed.

The ground floor medication trolley did not store external products separately from internal medication, for example,

Is the service safe?

fungal nail infection treatment was stored next to injections and oral medication. We checked the controlled drugs (CD) cupboard and saw evidence that staff reordered CDs without considering the balance in stock.

We inspected the medicines administration records (MAR) for five people who used the service and found discrepancies in all of them. In one case the person had a known allergy to common medicines and this was not recorded on the MAR chart. In another case, a medicine was only supposed to be administered if the person's pulse was within a particular range. There was no evidence that pulse checks had been carried out.

These factors amounted to a breach of the relevant legal regulation (Regulation 13).

Findings from the focused inspection of 21 August 2014

At this inspection we looked at the actions taken by the provider in respect of the breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. We will follow up the breaches found under other regulations at the previous inspection at a later date.

We found that the provider had met the shortfalls in relation to the requirements of regulation 13 we found previously, as described above.

During our inspection on 2 and 6 May 2014, we were concerned that the service had failed to protect service users against the risks associated with the unsafe use and management of medicines. Our inspection found that arrangements were not in place for the safe administration of medicines. There were discrepancies on the medicines records we looked at. We also found differences in the quantities of medicines that should have remained in stock, and the actual quantities in stock, if the entries on medicines records were correct. Further, some medicines were not stored safely. One person had an allergy

to commonly prescribed medicines and this information was not recorded on their medicines record. Another person was having a medicine administered routinely without the necessary pulse check monitoring being carried out.

Our inspection on 2 and 6 May 2014 found that there was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 in respect of management of medicines. We consequently took enforcement action for the safety of people who used the service by issuing a warning notice requiring the service to become compliant with this regulation by 24 June 2014.

We visited the service on 21 August 2014 to check whether the service had made the necessary improvements, and we found that they had. We found that all members of staff with responsibilities for administering medicines had received a copy of the provider's medicines policy, had received medicines refresher training, and their medicines competency had been assessed. There had been a recent change in the controlled drugs regulations, and we saw evidence that the provider had notified staff of the change.

The provider had also implemented a system of daily medicines audits to check that medicines were being given as prescribed. Staff we spoke with were aware of the procedures to follow for medicines incidents.

During our inspection, we checked medicines and medicines records for six people on each of the three units at the service, and we found that records were now completed fully and accurately. We checked a sample of medicines stocks and compared this to medicines records, and found that there were no discrepancies. We saw that when people had allergies, that this was recorded clearly on their medicines record. We saw that some people kept and self-administered their medicines to retain their independence. We found that staff supported them to do this, and carried out regular checks to ensure that they were managing their medicines safely.

We observed staff administering medicines to people, and saw that this was done safely, in a caring manner, without rushing. We saw that staff carried out regular daily checks at each handover to ensure that medicines had been administered as prescribed and that medicines records had been completed accurately. We saw evidence that people's medicines were reviewed regularly by the GP, with input from other healthcare professionals when needed, such as the local palliative care team.

We inspected the storage of medicines on all three floors of the service, and we found that medicines were now stored securely and at the correct temperatures to remain fit for use. Unwanted medicines were disposed of safely and regularly. We saw that controlled drugs were stored according to legal requirements, and appropriate records

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were kept when these were administered to people. We found that medicines were now being given safely and as prescribed by staff whose medicines competency had been assessed.

However, when we checked the process for using prescribed barrier and emollient creams for three people, we found some discrepancies. We saw that nursing staff signed medicines records indicating that prescribed creams had been applied by carers; however we saw that there was no process to check that these creams were available and had been applied as prescribed before signing the medicines record.