

Barchester Healthcare Homes Limited

Mount Tryon

Inspection report

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Ratings

Overall rating for this service

Requires Improvement ●

Is the service effective?

Inadequate ●

Summary of findings

Overall summary

Mount Tryon provides nursing care for older people, people with a physical disability, people with dementia and younger adults. It is registered for a maximum of 59 people. The home has a dementia care unit situated on the first floor level, with people needing more general nursing or personal care on the ground floor. At the time of our inspection there were 46 people living at Mount Tryon.

There was a registered manager in post however they were not available at the time of this inspection. 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.

This unannounced inspection took place on 2 March 2016. The inspection was a focused inspection in response to concerns we had received about whether people were receiving enough to eat and drink to maintain their health. We therefore only looked at how well people were supported with their nutritional and hydration needs.

At our last comprehensive inspection of Mount Tryon in October 2015, the home was rated as 'requires improvement' with breaches of the Health and Social Care Act 2008 Regulations 2014 identified in Regulation 12, safe care and treatment and Regulation 17, good governance. The provider sent us an action plan which said the actions to address the issues would be completed by 1 March 2016.

The home was also inspected on 20 and 22 January 2016 in response to concerns raised with us about staffing levels and the high use of agency staff as well as staff lacking the knowledge to meet people's needs safely. Following that inspection, we made a recommendation that the deployment of staff at mealtimes was reviewed in order for people's nutritional needs to be met promptly and to improve the mealtime experience.

At this inspection, in March 2016, we found sufficient action had not been taken to ensure people received sufficient food and fluid to maintain their health, or in relation to the deployment and availability of staff to ensure people were supported to eat their meals in a timely manner. The home's overall rating of Requires Improvement made at the October 2015 inspection remains unchanged following this inspection.

While some people's nutritional needs were being well met, others were not. Care plans identified people's risk in relation to poor nutritional and hydration. Management and support plans identified the actions required to mitigate these risks. However we found these actions and plans were not always being implemented. For example, where a care plan identified a person should have their food and fluid intake monitored and their weight checked weekly, these actions were not occurring. Some people had not been weighed for several weeks and food and fluid charts were either not being completed or were not completed in full.

Some people had been prescribed nutritional supplements. Their medicine administration records showed these had been given to people, however records were not maintained of how much people had been able to drink of these. It was therefore not possible to ascertain if people were receiving the supplements as prescribed.

At the inspection in October 2015 we were told mealtimes were protected with staff not taking their own breaks to ensure people were supported with their meals. At this inspection we found some staff were taking their breaks during the lunchtime period and some people were not being assisted to eat their meals in a timely manner. For example, we saw one member of staff place a bowl of soup in front of one person and then leave. After 20 minutes another member of staff assisted this person with their soup. There was also a delay in people receiving their main meal as they had to wait until everyone else had received their starter before staff provided the main meal. This had an impact on how much some people had to eat.

Some people did not eat their lunchtime meal and were not provided with anything else to eat other than the routine drink and biscuits and cake during the afternoon. The catering staff were not informed of who had not eaten and had not been asked to provide alternative meals that may have been more appealing or tempting for those people who had not eaten.

One relative told us they were satisfied with the quality, quantity and nutrition of the meals provided but felt their relation was not getting enough to drink.

On the dementia care unit on the first floor there were two dining rooms, one for people who were more independent with their meals and one for those who required support. Over the lunchtime period in this unit, we observed people being supported with their meals individually and in a timely way. People were shown two plates of food to make a choice about what they wished to eat. We saw people given a choice of three desserts and one person said they would like all of them which staff gave them. Some people were being cared for in their rooms and staff were allocated to support these people with their meals.

Following this inspection, the registered manager informed us of the actions that had been and were to be implemented to ensure people's nutritional and hydration needs would be fully met. This included staff meetings; more thorough reviews and handover reports of people's needs; more scrutiny of people's food and fluid intake records and the actions to take should these be insufficient, as well as reviewing the timing of, and support available, during meals. The provider also confirmed there would be no new admissions to the home while they make the necessary changes to ensure people receive safe care and support.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service effective?

Inadequate ●

The home was not effective.

Some people did not receive sufficient diet and fluids to maintain their health. There was insufficient oversight by nursing staff and management to identify this.

Records in relation to how much people were eating and drinking were either not maintained or were incomplete.

It was not possible for staff and management to ascertain if people were receiving the nutritional supplements as prescribed.

Some people were not being supported to eat their meals in a timely manner.

Mount Tryon

Detailed findings

Background to this inspection

We carried out an unannounced comprehensive inspection of this home on 15 and 16 October 2015. In January 2016 we received concerns about staffing levels and the high use of agency staff as well as staff lacking the knowledge to meet people's needs safely. We undertook a focused inspection on 20 and 22 January when we made a recommendation that the deployment of staff at mealtimes was reviewed in order for people's nutritional needs to be met promptly and to improve the mealtime experience.

Following that inspection, we received further concerns about whether people were being provided with enough to eat and drink to maintain their health. As a result we undertook this focused inspection on 2 March 2016 to look at how well people's nutritional and hydration needs were being met.

The inspection team consisted of two inspectors. Before the inspection, we reviewed the information we held about the home and notifications we had received. Notifications are forms completed by the organisation about certain events which affect people in their care. We also looked at the action plan sent to us following the inspection in October 2015. An action plan was not requested following the inspection in January 2016 as no new requirement actions were issued.

We spoke with six people living at the home, five relatives and seven members of staff, including two nurses. We also spoke with the regional general manager for Barchester Healthcare who attended the home during this inspection. We reviewed seven people's care in relation to their nutrition and hydration needs. Many of the people living at Mount Tryon were unable to share their experiences with us. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

Is the service effective?

Our findings

At our comprehensive inspection in October 2015 we found improvements were needed in how the home monitored people's food and fluid intake. We found the food and fluid intake charts for people identified at risk of poor nutrition and dehydration had not been fully completed. It was therefore not possible for staff and managers to tell if people were receiving enough to eat and drink to maintain their health. This was a breach of Regulation 12 of the HSCA 2008 Regulations 2014.

Following that inspection, the provider sent us a report on the actions they planned to take to meet the regulation. This included reviewing the staffing levels and the staff support available for people who required assistance, and how mealtimes are arranged.

At our focused inspection in January 2016 we found lunchtimes to be disorganised, particularly when people needed assistance with their food.

At this inspection in March 2016, we found improvements were still required to ensure people had sufficient to eat and drink to maintain their health and were supported to eat their meals in a timely manner.

We looked at the care records for seven people in relation to how the home supported them with their nutrition and hydration needs. We found that while some people's nutritional needs were being well met, others were not. For example, one person's care plan identified them as having a "poor appetite" and being at a "high risk of malnutrition". The plan identified the support they required to manage this risk which included "monitor eating and drinking" and "monitor weight weekly". The care records showed this person had been weighed on 12 February 2016 but there was no record this person had been weighed since. One fluid intake chart was available dated 2 March 2016, the same day as this inspection. This showed staff had provided this person with something to drink several times during the morning. There were no fluid intake records for this person available prior to this date. It was not possible therefore to tell how well this person had been drinking since their admission to the home some weeks earlier. There were no food intake records for this person. Their daily care notes provided limited information about how well they had eaten and what they had had to drink. Entries included, "fluids encouraged and enjoyed", "eaten, little fluid intake" and "small appetite noted, fluids encouraged". One entry on 26 February 2016 noted "very poor food and fluid intake" while the next day records showed this person was "eating and drinking well". This person had been seen by the GP on 17 February 2016 who prescribed nutritional supplements to be given twice a day. The medicine administration records showed these had been given however there was no consistent record of how much of these the person had taken. For example, records for the 26 February 2016 showed they had drunk ½ the supplement. There was no other reference to this person drinking the supplement in their daily care records. It was therefore not possible for nurses or staff to ascertain how much this person was eating and drinking, or whether they were taking the supplements as prescribed.

Another person's nutrition and hydration care plan dated 23 July 2015 identified them as requiring "lots of encouragement to drink plenty of fluids, approximately 1,500mls a day". It also recorded they had lost 13kg over the past six months and a referral had been made to the GP and the specialist speech and language

therapist for advice about a pureed diet. The care plan went on to say "staff must ensure they have fortified meals and supplementary drinks to build up (their) strength". They were also guided to weigh the person weekly and to inform the dietician of any weight loss. Records showed this person had been weighed monthly, not weekly, and had not been weighed since December 2015. They had lost 2.5kg in weight between August 2015 and October 2015. There was an increase of 0.5kg in their weight in November 2015 and a further increase of 1.6kg in December 2015. There were no food and fluid intake records available for this person and their daily care notes did not record what they had had to eat or drink. It was therefore not possible to ascertain if this person was eating or drinking sufficiently to maintain their health and to reduce the risk of further weight loss.

At our inspection in October 2015 some staff told us there were not enough staff to meet people's needs, especially at mealtimes when people needed help to eat. During the inspection in January 2016 we were told protected mealtimes had been put in place, which meant there were to be no staff breaks during these times and this had helped reduce meal time pressures. However we still had concerns people were not being supported to eat their meal in a timely way. For example, we saw staff supporting people with their starter and then going on to support other people with their main course. This posed a risk that someone may not get their meal due to the confusing way support was being offered. Following the inspection in January 2016, we recommended the provider reviewed the deployment of staff at mealtimes in order for people's nutritional needs to be met promptly and to improve the mealtime experience. Staff told us that since then they had attempted to stagger mealtimes but this had not been working well as people did not to wait for their meals when they saw other people with theirs.

At this inspection in March 2016, we found the arrangements to ensure people were supported to have a meal in a timely way still required improvement. It was difficult to ascertain how many staff were available in the nursing unit to assist people over the lunchtime period as staff told us they were also taking their break. This meant that mealtimes were no longer protected.

We saw there was a delay between staff presenting meals to people and assisting them to eat the meal. For example, we saw staff place a bowl of soup in front of one person who needed assistance to eat. The member of staff left the person without explaining when they would return to help them eat. After 20 minutes we saw a different member of staff assist the person to eat the soup which would have been cold after this length of time. We also saw people being given their starter and having to wait until everyone else had received their starter before they were given their main meal. This had an impact on how much some people had to eat. For example, one person fell asleep while waiting for their main meal and could not be roused. This meant this person went without their main meal and dessert.

We observed some people refuse some or all of their lunchtime meal: some people did not eat anything while other people ate their dessert. We discussed with staff the arrangements for people who didn't eat at the set mealtimes. They told us people would be offered something to eat at varying times throughout the day. We checked with staff later in the day about what additional food the people who had not eaten their lunchtime meal had been offered. Staff told us nothing other than the usual drink and biscuits or cake offered in the afternoon.

At our inspection in October 2015 we identified food and fluid intake charts had not been fully completed. This resulted in staff not being able to judge if the care and treatment they were providing was safe. At this inspection we found food and fluid intake records were either not being completed for people identified as at risk of poor intake or were incomplete. There were gaps in recording and some records held no entries for the evening and overnight. For example, one person's fluid intake chart showed they had not had a drink after 17:30 on 22 February. On 23 February, this person had not had a drink between 13:00 and 17:30 and

had no more to drink after 17:30. Another person's fluid chart had one entry for 22 February 2016 at 02:20 and two entries for 23 February 2016 at 10:00 and 11:00. There were no other fluid charts available for this person after these dates. It was therefore not possible to ascertain if people were receiving sufficient fluids to maintain their health.

We looked at how the home managed people's risk of constipation due to the effect this could have on their ability and desire to eat and drink. Care staff told us they record when people have a bowel movement in their daily care records. We reviewed the care records for a person at risk of not eating well. The records showed this person had not had a bowel movement for nine days. We discussed this with the nurse on duty. They assured us this would not have been the case as the person was prescribed a laxative each day. This indicated staff were either not keeping an accurate record of people's bowel movements or action had not been taken to address the issue when records showed the person may be constipated.

This is a breach of Regulation 12 and 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed people's nutritional needs with the catering staff. They were knowledgeable about who required a pureed diet, but did say there had been a delay in them being notified of the needs of some people recently admitted to the home. They were not informed of who required a fortified diet and who was losing weight. They said they wanted to make sure people got enough calories and they "make everything as high calorie as possible". They confirmed they had not been notified of the people who had not eaten on the day of this inspection. They had not been asked to provide any alternative meals that may have been more tempting for people. They said yoghurts and extra desserts, as well as snacks such as crisps, biscuits and cakes were available throughout the day for staff to offer to people. Snacks that melted in the mouth, rather than those that created crumbs were available for those people at risk of choking. They said they would also prepare anything staff requested for people to encourage them to eat.

Based on the information we received we spoke with relatives about their views of how well their relation was supported to eat and drink. One relative told us they had been concerned their relation was not having enough to drink and they had spoken to the staff and management about this: they were more confident now. Another relative told us they were satisfied with the quality, quantity and nutrition of the meals provided but felt their relation was not getting enough to drink. They also said they frequently see drinks left to go cold as staff had not assisted people to drink them. Other comments included, "I would like to see her encouraged to drink more. Her jug of water is always by the bed but the level doesn't go down much". One person living on the nursing unit told us they had to wait a long time for a drink the evening before this inspection.

On the dementia care unit on the first floor there were two dining rooms, one for people who were more independent with their meals and one for those who required support. Over the lunchtime period in this unit, we observed people being supported with their meals individually and in a more timely way. People were shown two plates of food to make a choice about what they wished to eat. We saw people given a choice of three desserts and one person said they would like all of them which staff gave them. Some people were being cared for in their rooms and staff were allocated to support these people with their meals.

One person's care plan guided staff to take "every opportunity to increase (name) intake by fortifying their diet and taking advantage of the windows of opportunity when (name) is receptive to eating and drinking". We saw this person had been supported to have two bowls of soup at lunchtime, and as they no longer wished to remain at the table, they had their main meal a little later.

At our inspection in October 2015 we were told quality assurance checks had been implemented to monitor the quality of care provided. These checks included reviewing people's nutritional intake. At the time of that inspection we found these checks had not been effective in identifying the poor record keeping in relation to people's diet and fluid intake. At this inspection we found no improvement had been made with these records. There was not a robust system of recording that supported adequate care planning and decision making in relation to people's care needs. There was insufficient oversight by nursing staff and the management team to ensure people's needs were being monitored on a day to day basis, reviewed and changes acted upon.

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

Following this inspection, the registered manager sent us a plan detailing the actions that had been taken and those that were to be implemented to ensure people's nutritional and hydration needs would be fully met. This included staff meetings; more thorough reviews and handover reports of people's needs; more scrutiny of people's food and fluid intake records and the actions to take should these be insufficient, as well as reviewing the timing of, and support available, during meals. The provider also confirmed there would be no new admissions to the home while they make the necessary changes to ensure people receive safe care and support.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment
Treatment of disease, disorder or injury	People who use this service were not protected against the risks associated with unsafe care and treatment. Regulation 12 (1) (2)(a)(b)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance
Treatment of disease, disorder or injury	Quality assurance systems were ineffective in improving the quality and safety of the service Regulation 17 (1) (2)(a)(b)(c)

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs The registered provider failed to ensure the nutritional and hydration needs of service users were met. Regulation 14 (1) (2)(b) (4)(a)(b)(d)

The enforcement action we took:

Warning Notice