Barchester Healthcare Homes Limited

Mount Tryon

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

Mount Tryon is a care home with nursing. It is registered to provide care for up to 59 people with a physical disability and people living with dementia. On the day of inspection there were 31 people living at the home. There were 16 people living in the ground floor nursing unit and 15 people living in the upper floor dementia care unit.

This unannounced focused inspection took place on 21 September 2016 in response to concerns raised with us. These concerns related to whether the home was monitoring the food and fluid intakes of people who may be at risk of not eating and drinking enough to maintain their health. During this inspection we looked at whether people who were at risk of dehydration and malnutrition, were receiving safe care and treatment and whether the service was monitoring the support people received in relation to their nutritional and hydration needs.

Mount Tryon has been inspection on four previous occasions since it was rated as 'requires improvement' at the comprehensive inspection undertaken in January 2015. In October 2015 a comprehensive inspection continued to rate the service as 'requires improvement'. At both these inspections the service was required to improve how it ensured people received safe care and treatment and how it monitored the quality of care and support provided. In January 2016 an unannounced focused inspection was undertaken in response to concerns regarding the number of staff on duty. As a result of that inspection we made a recommendation that the home review its staffing arrangements at mealtimes in order for people to receive their meals promptly.

In March 2016 an unannounced focused inspection was undertaken in response to concerns that people were not being supported to eat or drink enough to maintain their health. At that inspection we found records were either not maintained or were incomplete and the arrangements to ensure people were supported to have a meal in a timely way still required improvement. We found there was insufficient oversight by nursing staff and management to ensure people received safe care and treatment. As a result we issued a warning notice to the provider as they had failed to ensure the nutritional and hydration needs of service users were met.

In May 2016 we undertook an unannounced comprehensive inspection as we had received concerns regarding staffing levels and whether staff were receiving the training they needed to carry put their roles;

poor record keeping, particularly in relation to people's food and fluid intake, and the manner in which the service responded to complaints. At that inspection we found the provider had met the requirements of the warning notice issued in March 2016 but was in breach of a number of other regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to people not receiving care that met their needs and reflected their preferences; the unsafe management of medicines; poor management of complaints; ineffective systems to monitor the quality of care provided by the service and staff not receiving an induction that prepared them for their role.

As a result of the inspection in May 2016, the service received an overall rating of 'Requires Improvement'. Mount Tryon was placed in 'special measures' as it had been rated as 'Inadequate' in a key question over two consecutive inspections.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this time frame. If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service.

Following the inspection in May 2016 the provider sent us a detailed action plan telling us how they would resolve the issues identified at the inspection.

This report only covers our findings in relation to the inspection in September 2016. You can read the report from our previous inspections, by selecting the 'all reports' link for Mount Tryon on our website at www.cqc.org.uk.

The home had a registered manager who had been appointed in May 2016. 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.

During this inspection we found the concerns relating to the monitoring of one person's nutrition and hydration needs to be substantiated. Records showed this person's food and fluid intake to be better on some days than others and although they were maintaining a stable weight, they remained at risk of always not eating and drinking enough to maintain their health. The registered manager confirmed the decision to stop the monitoring records had been undertaken by a nurse without consultation with them, and it was not a decision they supported. While the initial response from the registered manager prior to this inspection did not provide us with assurances that this person's needs were being monitored closely, the inspection found that action had been taken to reinstate this person's records and to review why the decision had been made. We found other people's needs in relation to their diet and fluid intake were being reviewed, monitored and met.

The risks associated with eating and drinking, such as choking due to swallowing difficulties, or poor intake due to a loss of interest in food and drinks, had been assessed for all those living at the home. For those people who had been identified as at risk professional advice had been sought from the GP, dietician and the community speech and language team. Management plans were in place to reduce these risks and careful monitoring ensured issues were identified early to allow for further intervention. Food and fluid intake records were carefully monitored and staff shared the responsibility for this and for taking action

should there be a concern. These records showed people were receiving enough to eat and drink to maintain their health.

Staff were guided about how to prepare people's food and drinks and care plans provided information to staff about how to support people safely. For those people who may have lost interest in food or who declined their meals, alternatives were suggested and people's more favoured foods were identified and encouraged.

Many of the people living at the home needed staff support to eat and drank, and were eating and drinking well. The staff told us that if this changed, they would report to the nurse on duty and they would commence monitoring of their intake.

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

People were protected from the risks of choking. Clear assessments guided staff about how to prepare people's food and drink to minimise their risk of choking.

Is the service effective?

Requires Improvement

The decision to stop monitoring the food and fluid intake for one person was not based on sound clinical judgement.

Robust assessment and monitoring processes were in place to reduce the risk of people not eating and drinking enough to maintain their health.

Health care professionals were involved in assessing and supporting people to eat and drink well.

Is the service well-led?

Inadequate

Thorough clinical and managerial review ensured people's nutritional and hydration needs were monitored.

Mount Tryon

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 carried out to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

This focused inspection took place on 21 September 2016 and was unannounced. One adult social care inspector undertook the inspection.

Before the inspection we reviewed information we held about the service. This included previous contact about the home and notifications we had received. A notification is information about important events which the service is required to send us by law.

During the inspection we reviewed the records for six people in relation to how their diet and fluids needs were assessed and met. We looked at the records for four people living in the nursing unit and two people living in the dementia care unit. We spoke with the registered manager, a senior manager from Barchester Healthcare Homes Ltd, a registered nurse, six care staff and the cook.

Requires Improvement

Our findings

At this focused inspection we responded to concerns about how the home managed people's needs in relation to their diet and fluid requirements, including for those people at risk of choking. The rating for this domain remains unchanged from the comprehensive inspection in May 2016 at 'requires improvement'. This domain will be inspected in full at the home's next comprehensive inspection.

Some of the people living at the home were at risk of not eating and drinking enough to maintain their health as they had swallowing difficulties which made it difficult for them to eat. We looked at how the home supported people at risk of choking and found there were thorough risk assessment and management processes in place to minimise risks.

All six of the people whose care needs we looked at had been assessed as being at risk of choking. Each person had been assessed by the speech and language therapy (SALT) team from Torbay and South Devon NHS Trust. (This team provides guidance to care homes about how to manage people's eating and drinking safely). Each person's care plan provided staff with clear instructions about how people's food should be prepared to reduce their risk of choking. For example, some people required their food to be prepared to a 'fork mashable' texture and others required theirs to be pureed. Where people required their fluids to be thickened this was also identified and a description given about what consistency the fluid should be thickened to, such as a syrup or custard consistency. This information was held in people's care plan files, in the records held in each person's bedroom and also in the kitchen to ensure the catering staff were fully aware of people's needs. We spoke with the catering staff and they confirmed they knew who required their meals to be prepared to a soft or pureed texture and we saw these being prepared and served at lunchtime. The care files also contained guidance for staff about how to assist people to safely reduce their risk of choking and what actions to take should someone start to choke. For example, staff were guided to offer small mouthfuls of food and to wait until the person had swallowed twice before offering more food.

Staff told us they were fully aware of people's needs in relation to how their diet and fluids should be provided. During the morning of the inspection, we observed staff assisting people to have a drink. The drinks were dispensed from a trolley and people had a choice of hot and cold drinks, as well as fruit smoothies. For those people who required their drinks to be thickened, their individually prescribed thickening powder was available on the trolley. We saw staff sitting next to people and assisting them to drink in an unhurried manner.

One person who was living with advanced dementia disliked their food pureed and their drinks thickened

and would refuse these when offered. Staff said this person had little interest in food but when they did eat, they would only eat normally prepared food and drinks. Records showed this person's GP was aware of the risks to this person of not eating enough and of their risk of choking. A 'risk feeding management plan' had been developed in July 2016 by Torbay and South Devon NHS Trust in consultation with the person's relatives and the GP. This guided staff to support the person to eat the food they liked and it recognised not eating posed a greater risk to the person's health than that of choking.

Requires Improvement

Our findings

At the inspection in March 2016 we found the home could not provide assurances that people were receiving sufficient diet and fluids to maintain their health. This was because the amounts people were eating and drinking were not being fully recorded, or monitored, and people were not always being weighed. At the inspection in May 2016 we found improvements had been made however, records of people's food and fluid intake were not being fully completed or reviewed by nursing staff. We also found the arrangements to ensure people were supported to have a meal in a timely way still required improvement. Although more staff were available to assist people with their meals, there was still a delay in people receiving their meals.

As this focused inspection we looked at how the home managed people's needs in relation to their diet and fluid requirements. The rating for this domain remains unchanged from the comprehensive inspection in May 2016 at 'requires improvement'. This domain will be inspected in full at the home's next comprehensive inspection.

Prior to this inspection, a concern had been raised with us that the home had stopped monitoring the food and fluid intake for one person who was at risk of dehydration. We found the concerns relating to this person were substantiated as records showed they did not always eat or drink enough to maintain their health and as such monitoring of their intake should not have been stopped.

For the one person whose monitoring records had been stopped, we saw that although they maintained a steady weight, their food and fluid intake could be variable. This indicated they were at risk of not always eating and drinking enough. The registered manager told us the decision to stop monitoring this person's intake had been taken by a nurse without consultation with them. They told us the decision had been wrong and was not supported by the information held in the person's care records. They told us this was not a decision they agreed with and that once this had been brought to their attention, they had reinstated the person's food and fluid monitoring charts. They said they were looking into how the decision to stop the charts had been taken and they would review the home's management policies in relation to nutrition and hydration with the nurse involved.

We looked at the records of five other people who required assistance to eat and drink and we found these people's care needs in relation to eating and drinking were being assessed, monitored and met.

We found that for people at risk of not eating or drinking enough, the record keeping and the monitoring of people's food and fluid intake by the nursing staff had improved since the previous inspection. There was now a robust system in place to review people's well-being, and to identify when additional support was needed to reduce the health risks associated with poor intake. Staff were instructed to record how much people had had to drink immediately following assisting them. A named member of staff each shift had the responsibility to check all the diet and fluid records each hour to ensure they had been completed as required. If there were any gaps in the recording they were to discuss this with the member of staff concerned. At midday staff would total how much each person had had to drink and also review how well they had eaten. Should there be any concerns the staff reported this to the nurse in change who reviewed the person and made recommendations to improve their intake or to seek medical advice. These records showed staff had brought concerns to the nurses' attention and the nurses told us they ensured people were offered drinks more frequently to increase their intake.

In the evenings the nurse on duty would total the amount each person had had to drink and again assess their food intake. Should any concerns be identified, this was reported to the nursing staff and the registered manager the following morning.

Each morning the nursing staff and all heads of departments, including catering, housekeeping, staff training, met with the registered manager to discuss any issues that may affect people's well-being. At this meeting the nurses discussed people's food and fluid intake. The registered manager reviewed each person's records to ensure these had been completed as required. Should any gaps in recording or low food or fluid intake be identified the registered manager spoke with the nurses and care staff involved to ensure peoples' needs were being closely monitored. We saw evidence the registered manager had reviewed the records and had identified those people who required further support.

Records showed people were being weighed either weekly or monthly to monitor them for weight gain or loss. A monthly nutritional report by the registered manager to the providers highlighted people who had lost weight and the actions taken by the home in response. Records also showed a dietician was involved in reviewing people's needs and people at risk had been prescribed nutritional supplements to increase their calorific intake.

For two people living with dementia and who frequently declined meals, their care plans guided staff to offer alternative high calorie snacks and identified the foods they were known to enjoy. We saw staff had offered alternatives to these people at different times of the day to encourage them to eat. Of the six people's care files we looked at, five had either maintained a steady weight or had gained weight. One person had lost weight and records showed the person's GP, the SALT team and a dietician were involved in supporting staff with their care.

We looked at the diet and fluid intake records for four people for two weeks prior to the inspection. These showed for each person their recommended fluid intake over a 24 hour period, and that for the majority of these days people were drinking sufficiently to maintain their health. However, there were days when records showed people had fallen below their recommended level of intake. There was evidence this had been identified in people's daily care notes and that the registered manager had reviewed the records. They and the nursing staff reviewed people's care to identify if there was a reason people's intake had reduced. Where necessary tests, such as urine testing for infection, were undertaken and referral made to the GP.

Many of the people living at the home, although needing staff support to eat and drank, were eating and drinking enough to maintain good health. We looked at the daily care records for two people who staff told us ate and drank very well. These described how well they had eaten and taken fluids, for example, "taken

diet and fluids well". Staff said that if a person didn't eat and drink as normal, this would be reported to the nurse in charge and monitoring would commence.

At the inspections in March and May 2016, we identified people were not being supported to have their meals in a timely way. At this inspection we found the home had reviewed people's mealtime experiences. Staff had undertaken observations to see whether people were assisted in a timely way and whether mealtimes were enjoyable. The results of these observations had been discussed at staff meetings. Staff reported the timings of meals had changed slightly to ensure all those who were independent with eating were not kept waiting for their meals while staff assisted others.

Inadequate

Our findings

At the previous inspection in May 2016, we identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to how the home assesses and monitors the quality of the service it provided. This key question was rated as 'inadequate' as records were not well maintained and people could not be assured of safe care and treatment, for example with their medicines.

As this focused inspection looked specifically at how well the home managed people's needs in relation to their diet and fluid requirements, the rating for this domain remains unchanged from the comprehensive inspection in May 2016. This domain will be inspected in full at the home's next comprehensive inspection.

At the inspection in March 2016, we identified there was insufficient clinical oversight in monitoring people's diet and fluid intake, and the home could not be certain people were eating and drinking enough to maintain their health. At the inspection in May 2016, we identified improvements had been made, but that the records used to monitor people's food and fluid intake were incomplete, and insufficient action had been taken to address this.

Prior to this inspection we asked the registered manager to look into how the decision to stop monitoring one person's food and fluid intake had been made. While their response identified the home's processes regarding risk assessment and management in relation to nutritional and hydration needs, we could not be assured people were being protected from the risks of poor food and fluid intake.

At this inspection, we saw the registered manager had taken action to review how the decision taken by one nurse with regard to one person's monitoring had some about. They had reviewed the person's care records and concluded the decision should not have been made to remove the monitoring charts. They confirmed the records had been reinstated as soon as the matter had been brought to their attention. The also said they were supporting the nurse to reflect upon their decision and to support them with regard to the home's policies.

Following the previous inspection in May 2016, the registered manager had implemented a robust system that improved how the home monitored people's well-being and which involved all staff in taking responsibility for people's care, including their nutrition and hydration needs. Staff were instructed to review people's intake throughout the day and to raise concerns to the nursing staff. In turn nurses were responsible for reviewing whether there was any clinical reason why someone's intake had reduced and if necessary, to make a referral to the GP. The registered manager met with the nursing staff each morning, for

an update on people's care needs. They said this enabled the nursing staff and themselves to be sure people's needs were being met.