Ashberry Healthcare Limited

Moorhouse Nursing Home

Inspection report

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Date of inspection visit:
02 February 2017

Date of publication:
08 March 2017

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was carried out on the 2 February 2017. MoorHouse Nursing Home is registered to provide support and accommodation for a maximum of 38 older people who require residential or nursing care. Services offered at the home include nursing care, end of life care, respite care and short breaks. At the time of the inspection there were 23 people living at the home.

We carried out an unannounced comprehensive inspection of this service on 22 November and 2 December 2016 and identified a breach of regulation 18 as the provider had not ensured that sufficient numbers of staff received support, training, professional development and supervision in order that they could fulfil their duties and responsibilities. As a result we issued a requirement notice. After the comprehensive inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breach of regulation. The rating awarded to the service was Requires Improvement.

After that inspection we received concerns in relation to staffing levels at the home. As a result we undertook a focused inspection to look into those concerns. This report only covers our findings in relation to those topics. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Moorhouse Nursing Home on our website at www.cqc.org.uk.

There was no registered manager in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

There were insufficient staff available to safely meet people's needs. Call bells were not answered promptly which meant people were waiting for extended periods of time before staff attended to them. People and relatives all said that there were not enough staff working in the home and that the staffing levels had been reduced recently which had impacted on the quality of care being provided.

There should have been regular analysis completed by the manager of call bell response times. However the call bell monitoring system had a technical fault which meant that the data was not available for this analysis to be completed. The manager told us this was being addressed by the software company.

There had been no review of recent accidents and incidents, people who had recent falls had not had their needs reviewed to minimise the risk of falls re-occurring.

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.

There were not sufficient staff available to safely meet people's needs.

Moorhouse Nursing 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 undertook an unannounced focused inspection on the 2 February 2017. The team inspected the service against one of the five questions we ask about services: is the service safe. This inspection was carried out due to concerns raised about staffing levels within the home.

The inspection was undertaken by three inspectors. Prior to the inspection we reviewed the information we held about the service. This included information sent to us by the provider, about the staff and the people who used the service. On this occasion we did not ask the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During the visit we spoke with 16 people, one relative, six members of staff, the providers' representative and a consultant they had employed. We looked at a sample of three people's care records. After the inspection we requested copies of staffing rotas and call bell audits which were provided. We also spoke with another relative after the inspection.

Requires Improvement

Is the service safe?

Our findings

We asked people whether they felt there was enough staff at the home. Comments from people included "I haven't been to the toilet this morning I've been waiting for two hours", "Waiting in the mornings is a regular problem" and "Staff seem so busy". One person told us they had been waiting to get up for two hours whilst another told us they had been occasions when they had an 'accident' whilst waiting for staff to attend to them. They added that they had to "Bang my cup on my table as I needed to use the commode". One person was nursed in bed, they told us that they frequently slipped down the bed and needed help to be moved but sometimes had to wait for staff to help them. They added that when staff did arrive some did not seem to know them. Both relatives we spoke to said that they thought that more staff were needed at the home.

There were not enough staff working at the home and this placed people at risk unsafe care. People waited for extended periods of time for their call bells to be answered by staff and on several occasions' inspectors had to intervene and find staff for people who needed help and support with their personal care. Our inspection started at 8.20 am, throughout the morning call bells were heard to be going off constantly as people waited for staff to attend to them. One person who was incontinent wanted help to go to the bathroom. They had pressed their call bell however this had still not been answered for 15 minutes and as a result we had to find a member of staff to help them. During this time the person told us that it 'Didn't matter now" as they had been incontinent.

This persons care records stated that their call bell should be answered promptly to avoid their anxiety and frustration when they required assistance to use the toilet. Two recent entries in the person's daily notes read that they had been 'Very angry about call bell response times' and having to wait.

When we arrived in the morning the nurse was undertaking the medicines round, by 10.55am they still had three people to administer medicines to. This meant that they did not have time to undertake other nursing duties. The nurse told us that they would often complete nursing tasks in their break. The manager (who was also a nurse) would provide additional clinical support however they were on leave that week and no additional clinical support had been arranged.

The providers' representative had assessed the staff levels as needing one nurse and five care staff during the morning and one nurse and four care staff in the afternoon. We found that although these levels were mostly being met this was not sufficient to meet the needs of people. There were days when there were less staff than assessed as required by the provider. Over a recent four-day period in January 2017 there were only three care staff working in the afternoon. This was less staff than were working at the time of our inspection. Of the 23 people living in the home we were told by the provider that there were 14 people who required nursing care. Of these, eight people needed to be hoisted to move and seven people required support to eat. One member of staff told us, "More work needs to be done on (people's) dependencies." They said that staffing levels had not been calculated correctly.

Staff told us that the staffing levels had reduced recently and that they were finding it difficult to cope with

this. Staff were seen to be doing their best but they did not have time to provide care to people when they needed. Staff reacted to call bells as best they could but were rushed and did not have time to spend in any meaningful interactions with people. One member of staff told us they were frustrated that they did not have the time to care for people properly. Another described the lack of staff as a "Crisis". Domestic staff also helped care staff where they could, however this meant that they were taken away from their own work. On the day of the inspection we were told laundry staff were not working so this work needed to be covered by those staff working in the home.

People were at risk because incidents and accidents had not been acted upon after they occurred. One person had fallen three times in a period of five days but there had not been any review of their care needs as a result. Another person had a diary which detailed that they had fallen seven times in five days. There had not been a review of their risk assessments since this had occurred.

Other risks to people were not always managed in a safe way. One person who was at risk of pressure damage to their skin required a cream to be applied and their fluid intake to be monitored which should have been recorded by staff. The fluid charts had not been totalled with the amount of fluid recorded and was below the recommended daily amount required. The nurse confirmed that they had their cream applied but said that staff had not recorded this or the fluid intake appropriately. Staff did not have an appropriate record of how much the person had drunk to ensure that they were hydrated.

There had been a number of complaints from people the previous year about call bell response times. The providers' representative had introduced a 'nurse call protocol' that guided staff on what the response times should be. This stated that an initial response time of 10 minutes was expected but at busier times it could be extended to 15-minutes. It stated that 'If an emergency call bell was pressed then an immediate and prompt response was expected'. However if people wanted to use the toilet this would be a long time to have to wait. The protocol also detailed that call bell response times would be monitored each week and a report generated. We asked for information in relation to call bells audits after the inspection and were told by the manager that there was a technical problem with their call bell monitoring system which meant the data was not available. They had asked the software company who maintained this to investigate and resolve this. It was not clear when this technical issue had started from and whether there had been any formal monitoring of call bells as per the providers own protocol.

The providers' representative told us that they had been advised the previous day that the home was short staffed and immediately increased the staffing numbers however from our observations people's needs were still not being met. They added that they had taken the decision to reduce the nursing staff by one as they had 14 people with nursing needs and had "Too many hours". They also told us they had reduced the care staff by one since the beginning of the week. The providers' representative used a dependency tool to assess the staff levels however it was not effective due to the concerns that we found. They told us that they had reduced the staff levels whilst the manager was on leave and that it was "Not a great idea to change (staffing) whilst she (the manager) was away". There had been no monitoring of the impact in reduction of staffing levels within the home at the point of lowering the staff levels.

After the inspection the manager informed us that they had increased the nursing staff to two nurses each morning however it was not clear how this would impact people receiving their care when they needed.

Failure to ensure there are sufficient numbers of staff is a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) 2014.

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 Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to meet people's needs.