Barchester Healthcare Homes Limited

Mount Tryon

Inspection report

Higher Warberry Road
Torquay
Devon
TQ1 1RR

Tel: 01803292077
Website: www.barchester.com

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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?	**Good**
Is the service responsive?	**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 older people, people with a physical disability, people with dementia and younger adults. On the day of inspection there were 37 people living at the home. There were 20 people on the ground floor nursing unit and 17 people on the upper floor dementia care unit. The registered providers told us they were not admitting people to the service until improvements had been made.

This inspection in May 2016 took place over three days. The first visit started at 9pm on a Saturday evening.

There had been a number of management changes at Mount Tryon which had negatively impacted on the care and support people had received. These changes had occurred both at service level and at regional level. Actions to address risk had either not been taken or taken and not sustained through those changes.

Mount Tryon did not have a registered manager. 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. A new manager had been appointed and had applied to CQC to register as manager.

Since January 2015 Mount Tryon had been inspected on five occasions. Each of those inspections had resulted in CQC telling Mount Tryon that improvements were needed to ensure people received a safe, responsive, effective, caring and well led service.

The service was last inspected in March 2016 in response to concerns we had received about whether people had enough to eat and drink in order to maintain their health. That focussed inspection found the service could not demonstrate people were being supported to eat and drink enough. We issued a warning notice telling the provider they must take action by 18 April 2016. During that inspection we also found people were not receiving safe care and quality assurance systems failed to identify and address risk.

During this inspection in May 2016 we found the warning notice had been complied with. However, whilst people were receiving enough to eat and drink, records were not always up to date or accurate. Records kept in relation to what people eat and drink are an essential part of any risk management strategy and must be up to date and accurate.

In January 2016 we carried out a focused inspection in response to concerns about staffing levels, the high use of agency staff and staff lacking the knowledge to meet people's needs safely. We found no evidence to support those concerns. However, we made a recommendation that the level of staffing at mealtimes be looked at in order for people's nutritional needs to be met promptly. In response to this, we were told Mount Tryon had set up two meal time sittings to ensure there were always enough staff on duty. We found at this inspection in May 2016 that this had not continued, and there were not enough staff to support people with

eating at all times in a person centred way.

We carried out comprehensive inspections in January 2015 and October 2015. These resulted in an overall rating of 'requires improvement' on both occasions. Our main concerns were that people were not receiving safe care and treatment and the service was not well led.

Prior to carrying out this comprehensive inspection in May 2016 we had received concerns relating to: insufficient staff, particularly at night, to meet people's needs; staff not having the skills or knowledge to meet people's needs, especially in relation to people living with dementia; Induction for new staff was insufficient; people were still up at 1am or 2am due to lack of staff to help them to bed; people being funded for individual staffing were not receiving this; there were no snacks on the drinks trolleys for people on soft diets; no beakers were left in people's rooms when jugs of drink were left; the management of the service did not take note of relative's concerns and did not inform them of changes in people's health; there was poor recording on people's food and fluid charts; there was poor communication between staff. This and the poor recordings meant staff did not have up to date information about people.

We found that some of the concerns raised with us were founded. There were sufficient staff at night, and there was no evidence people waiting until 1 or 2am to go to bed. However, on the night we inspected all the staff on night duty were agency staff who would not be as familiar with the home or people as permanent staff. Important information about people was not always communicated to staff.

Induction for staff was not robust. Although staff training had not been sufficient for all staff, it was being enhanced. We did not find evidence that staff did not have the skills to care for people with dementia. Snacks were available for people but the management team, nurses and carers could not assure themselves that people were getting enough to eat and drink because records were incomplete. We saw one person did not have a beaker from which to drink. We found relatives were updated about people and complaints were investigated. However, one person was restricted to raising further concerns by email to a named person only. This meant the complaint system was not fully accessible to them and could lead to a delay in any necessary action being taken.

During the inspection the new management team shared with us their drive to improve the communication, leadership and culture within the home. However, the provider did not always enable and encourage open communication with people who use the service and those that matter to them.

There were few effective quality assurance systems in place to monitor care and plan on-going improvements. Records were not well maintained. Re-positioning charts were not always completed and care planning documents contained conflicting information. Care plan documents were lengthy and it was difficult for staff to find the most up to date information about people. Reviews did not always reflect the current needs of people. People's risk assessments were not always up to date. This meant people were at risk of not having their identified needs met appropriately.

Staff understood the principles of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards (DoLS). We heard that relatives had been involved in making best interest decisions about their relation's care. However, records did not always support this.

Some aspects of medicine management were not safe. There were gaps on Medicine Administration Records (MAR) and topical cream application records. This meant it was not possible to confirm people had received medicines as they had been prescribed. We also found cupboards containing medicines open and accessible to people living at the home and to visitors.

We saw one person's pressure ulcer had improved significantly and that another person's weight had increased. Staff ensured people received personal care and support that was responsive to their needs. People's needs were met by kind and caring staff. Staff ensured people's privacy and dignity was respected and all personal care was provided in private.

People's needs were met in a safe and timely way as there were enough staff available, except at meal times when one member of staff was supporting three people to eat. The high reliance on agency staff at times meant people were not always cared for by staff who knew them well. One person said the staff were very good and they could "find no fault" with the home. One relative told us if they ever had to move into a care home they "would be happy to live in this home".

People told us they enjoyed the meals. One person said the food was "excellent", and another told us the food was "very good" with "plenty of choice". There was a good selection of meals prepared each day as well as a menu of other meals that could be prepared upon request.

People were protected from the risks of abuse as staff knew how to recognise and report abuse. Thorough recruitment procedures ensured the risks of employing unsuitable staff were minimised.

An activity organiser was employed for 40 hours per week and we saw some activities taking place. We saw people taking comfort from cuddly toys and dolls. One person enjoyed pushing a pram in and out of the lounge. However, there were limited opportunities for people to engage in meaningful interaction and activities.

People, staff and visitors felt the service was improving. Although it had not always been the case, people were confident that if they raised concerns they would be dealt with efficiently. People had confidence in the new manager and felt things had already started to improve. All the issues we identified during our inspection had already been identified by the management team. Everyone's care plans were to be reviewed and the management team would be working alongside staff to ensure they were provided with support and mentoring. How well staff performed their duties and their contracts were also to be reviewed. We were told this was important as previously there had been 'no consequences' for staff who had failed to meet expectations.

We have made recommendations in relation to documentation relating to mental capacity assessments, the provider's policy on restricting visiting and the provider's communication systems.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this report.

The overall rating for this service is 'Requires improvement'. However, we are placing the service in 'special measures'. We do this when services have been rated as 'Inadequate' in any key question over two consecutive inspections. The 'Inadequate' rating does not need to be in the same question at each of these inspections for us to place services in special measures.

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 timeframe.

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. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

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

Aspects of the service were not safe.

The management of medicines was not always safe. Records relating to medicines were not well maintained or accurate.

Information on the risks to people's physical health was not always up to date. This meant people were at risk of receiving inappropriate care.

There were enough staff to meet people's needs in a timely way. However, the high use on the use of agency staff could put people at risk.

People were protected from the risks of abuse as staff knew how to recognise and report abuse.

Thorough recruitment procedures ensured the risks of employing unsuitable staff were minimised.

Is the service effective?

Requires Improvement

Aspects of the service were not effective.

People may not be receiving sufficient food and fluids because the records relating to this were incomplete.

Training was being increased to ensure staff could meet people's needs.

People's human rights were upheld because staff displayed a good understanding of the principles of the Mental Capacity Act 2005 and the associated Deprivation of Liberty Safeguards (DoLS).

People were supported to receive the healthcare they needed.

Is the service caring?

Good

The service was caring.

People's needs were met by kind and caring staff.

Staff ensured people's privacy and dignity was respected and all personal care was provided in private.

People and their relatives could be involved in making decisions about their care if they chose.

Is the service responsive?

Requires Improvement

Aspects of the service were not responsive.

People's care plans were bulky and it was not easy to see people's up to date care needs.

There were limited opportunities for people to engage in meaningful interaction and activities.

Concerns were not always dealt with in a way that allowed for necessary action to be taken, or in a way that was fully accessible.

Staff ensured people received personal care and support that was responsive to their needs.

Is the service well-led?

Inadequate

Aspects of the service were not well led.

There was no manager registered manager for the service and frequent changes in the management team had led to a deterioration in governance and leadership.

Records were well not maintained. They did not evidence where care had been provided.

Quality assurance systems in place to monitor care and plan on-going improvements were not effective.

Staff thought things were improving. However, consistent high quality care had not been provided to people living in the service.

The provider did not always enable and encourage open communication with people who use the service and those that matter to them.

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 planned to check whether the provider was 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.

This inspection took place on 7, 10 and 11 May 2016 and the first two days of the inspection were unannounced. The first inspection started at 9pm on the Saturday evening.

The first inspection was carried out by three social care inspectors. On the second and third days of the inspection there were two social care inspectors and a specialist nursing advisor.

Before the inspection we gathered and reviewed information we held about the registered provider. This included information from previous inspections and notifications (about events and incidents in the home) sent to us by the provider. We also reviewed concerns that had been raised with us.

We met, spoke with or spent time with 26 people using the service, nine visitors, one health care professional and 21 staff. The manager, operations manager and regional manager were available throughout the inspection. We also obtained feedback from the local authority quality improvement team. Following the inspection we received an email from two relatives.

Requires Improvement

Is the service safe?

Our findings

This was the fourth time the Care Quality Commission (CQC) had inspected the key question 'safe' between January 2015 and May 2016. At three of the previous inspections this key question had been judged as requiring improvement. One inspection had not looked at this key question. At this inspection in May 2016 we found that although some progress had been made improvements were still required. Improvements were needed to the management of medicines and the management of records.

Some aspects of medicine management were not safe. Records were not always fully completed and staff could not be assured people received their medicines as prescribed. There were gaps on Medicine Administration Record (MAR) charts where staff had not recorded having given medicines to the person they had been prescribed for. For example, two people's medicines were not signed as having been given. We looked at the packs in which the medicines had been delivered to the service. We could see not all medicines had been given from the pack. This meant there was no way for staff to be assured the person was receiving their medicines as they had been prescribed. A medicine audit was carried out on 04 May 2016 and had identified there were gaps on the MAR charts, but no action had been taken to address the issues.

People who were prescribed pain relief to be taken as required were asked if they were experiencing any pain. However, people who were unable to verbally communicate were not routinely assessed to see if they were in pain. This meant staff may not always recognise when people were in pain. Records relating to how often topical creams had been applied were not always completed. Staff told us they applied cream each time they changed the person's incontinence pad but did not always record it as they always applied cream. Without this record, the management team and staff could not assure themselves that people were receiving their prescribed creams.

Medicines were not always stored securely. On one day of the inspection the medicine room had been left unlocked. The store cupboard attached to the wall, that contained medicine, had the key left in it. This meant that medicines were open and accessible to people living at the home and to visitors. However, the medicine trolley was locked and attached to the wall.

This was a breach of Regulation 12 (1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where required, the frequency and range of monitoring people's blood glucose was recorded in their care plans. The plans also contained details of action to be taken if the person's levels fell outside of the guidelines. Where this had happened we saw that staff had taken the appropriate action as detailed in their care plan.

People's personal risk assessments contained details on how risks were managed. Risks assessed included falls, pressure areas, nutrition and choking. While risks were reviewed regularly the most up to date information was not always readily available. Also, there was conflicting information on different assessments. For example, one person had four documents relating to their mobility but only one of the four

documents contained accurate information. This meant that the person was at risk of staff using a document that did not contain the correct information on how to safely meet their needs. To help manage risks when agency staff were on duty, there was a handover sheet which should have contained important information relating to people's care. However, we found important information was missing from this. This included the need for one person to wear hip protectors as they had a tendency to fall. People were, therefore, at risk of receiving inappropriate care.

People who were at risk of developing pressure ulcers had these risks assessed. Where necessary pressure relieving equipment was being used. For example, care plans showed two people were at high risk of developing pressure ulcers. Both people had air mattresses on their beds and one person who sat out of bed had a pressure relieving cushion on their chair. The pressure relieving mattresses were set at the right setting in accordance with the person's own weight. One person was being nursed in bed and had been admitted to the home with a pressure ulcer. Records for the week prior to the inspection showed the person had not had their position changed as often as stated in their care plan.

However, we saw an email from a tissue viability nurse dated 20 April 2016 stating, "the wound appears to have reduced in size". Photographs indicated there was a marked improvement over a period of two months. This indicated that despite records showing the person's position wasn't changed as per their care plan the person had received pressure area relief. If they had not received sufficient pressure area care the ulcer would not have healed as well as it had done. However, an accurate and complete record in relation to their care and treatment was not kept.

This was a breach of Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Nutritional care plans indicated whether the person had a history of choking or swallowing difficulties, needed assistance with eating or drinking and whether the person was under the care of the Speech and Language Therapy (SALT) team. There was guidance for staff about what actions to take should someone start to choke. The care plans indicated the type of diet people should receive and if thickeners were to be used for fluids. One person required a pureed diet due to chewing difficulties but could have normal fluids. The information about fluids was not readily available to staff. However, staff were managing this risk effectively and giving the person the correct consistency.

Accidents and incidents were monitored regularly. An electronic system was used to analyse events and graphs could be produced to highlight where and when accidents had happened. The information was then used to minimise the risks of the accidents happening again. However we noted that incident forms for medicine errors had not been completed to record these events.

Those people who were able, told us they felt safe at the home. Some people were living with dementia and were unable to tell us if they felt safe. Therefore we observed how they interacted with staff. People smiled and took hold of staffs' hands when talking to them, showing us they felt safe in their company.

People were protected from the risks of abuse. Staff knew about different types of abuse. They knew how to recognise abuse, and told us what they would do if they thought anyone was being abused within the service. They said initially they would tell the manager. One staff member said they "wouldn't be able to sleep if I didn't report it". However, they said they had never seen anything that gave them cause for concern. Staff had also received formal training on keeping people safe.

Recruitment practices ensured, as far as possible, that only suitable staff were employed at the home. We

looked at four staff files. All contained the required pre-employment documentation including disclosure and barring (police) checks, photo identity and references. They also contained an application form with a full work history. Where issues had been raised either on the police check or application forms these had been discussed and risk assessed to ensure the prospective staff member was suitable to be employed.

There were 37 people with varying needs living at Mount Tryon. People living on the ground floor had nursing needs and people living on the first floor were living with dementia. We had received concerns that on occasions there were not enough staff on duty to meet people's needs. We were told this was especially true on Saturday nights. Our first inspection was therefore on a Saturday night. When we arrived at 9pm there were three registered nurses and four care staff on duty. All the staff were agency workers. Staff rotas showed there would usually be two registered nurses on duty at night. The extra registered nurse was on duty because there were only agency staff on duty. All the agency staff had worked at the home before. They told us the staffing numbers were sufficient to meet people's needs. One registered nurse told us that staffing levels were much better than when they had first worked at the home. Another said "We're not struggling at all". One registered nurse had clear instructions about what to do in an emergency. They contacted a Barchester operations manager and the nurse in charge of the dementia care unit after we arrived at the home. They both arrived to help support the inspection and prevent it impacting on people's care. We discussed the use of agency staff with them. They told us there would not normally be only agency staff on duty, but no permanent Barchester staff had been available for that shift.

Our following two visits were during the day time and there was only one agency member of staff on each day of our inspection. However, relatives told us they felt the high use of agency staff may cause disruption for people living with dementia. We spoke with the regional director and the manager about the use of agency staff. They told us they were reducing the use of agency staff as new permanent staff were recruited. They were using only one agency and requesting the same staff were sent each time they were needed. This was to ensure consistency of care was maintained.

On duty on both days were two registered nurses (one upstairs and one downstairs) and nine care staff. Staff rotas showed this was the usual number of staff on duty each day. They were supported by a manager and deputy manager who were both registered nurses. An operations manager and the regional director were also present throughout the second and third days of the inspection. There was a variety of ancillary staff working on both days. These included three kitchen staff, five housekeeping staff, a maintenance person, a staff trainer, an activities organiser and two office based staff. The Barchester group had a specific tool that was used to calculate the number of staff needed. This used the numbers and dependency levels of people living at the home to determine the number of staff needed. The manager told us that there was also the ability to vary the staffing levels as needed.

Throughout the inspection we saw people's needs being met in a timely manner. Call bells rang for only a short time before being answered. We saw staff regularly going into people's rooms to check that they were alright and if they needed anything. Staff were quick to respond to people's needs and requests.

There were procedures in place to protect people in the event of an emergency. Staff had been trained in first aid and there were first aid boxes easily accessible around the home. Personal emergency evacuation plans were in place in an emergency folder. These gave staff information on how to safely evacuate people from the building should the need arise, such as a fire.

We had received information that there had been an outbreak of sickness and diarrhoea at the home, which had not been reported to CQC. We were told that relatives had not been informed about this and a lack of infection control procedures had resulted in the outbreak spreading. We found no evidence to support this.

Prior to our inspection we contacted the service and had been told there had not been an outbreak. During the inspection we asked staff if anyone had recently had sickness or diarrhoea. We were told no-one had had sickness and diarrhoea although some people had had loose bowels due to taking antibiotics.

Staff had received training in infection control and were seen using protective equipment when needed. Staff told us there was always plenty of equipment available. The home was clean and tidy and there were no unpleasant smells. The premises were well maintained. When staff identified maintenance issues they recorded them in a book. The maintenance person then attended to the issues and recorded they had been completed in a timely way. Records showed that equipment such as hoists were regularly maintained and serviced to ensure they remained safe to use.

Requires Improvement

Is the service effective?

Our findings

This was the fourth time the Care Quality Commission (CQC) had inspected the key question 'effective' between January 2015 and May 2016. At two of the previous inspections this key question had been judged as requiring improvement. One inspection had rated it as inadequate. We carried out a focussed inspection in January 2016 when we recommended 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. The then registered manager told us they were looking to implement two sittings. They said 'protected mealtimes' had been put in place and no staff had their break during this time. A further focussed inspection was carried out in March 2016. We found these improvements had not been maintained. We also found improvements were still required to ensure people had sufficient food and drink to maintain their health and were supported to eat their meals in a timely manner. This key question was therefore rated as inadequate. Following that inspection we issued a warning notice that needed to be complied with by 18 April 2016. The warning notice was issued in relation to Regulation 14 Meeting nutritional and hydration needs. We told the provider: that people were not being weighed often enough to determine if they had gained or lost weight; that due to incomplete records it was not possible to determine if people had received sufficient food and fluid to maintain good health; that due to incomplete records it was not possible to determine if people had received nutritional supplements as prescribed; When people had not eaten all their meal no additional nutrition was offered; people were not supported to receive their meal in a timely manner.

On this inspection in May 2016 we found there was no longer a breach of Regulation 14. People looked well hydrated and throughout the inspection we heard people regularly being offered drinks. However, improvements were still needed to the way records were maintained and the way mealtimes were supervised. We also found that improvements were needed to the staff induction system and the way documentation relating to the Mental Capacity Act 2005 was managed.

Since our inspection in March 2016 we received further concerns about people not having enough food and drink. The concerns were that there were not always beakers left with jugs of fluids and people on soft diets did not always have snacks available to them. Throughout the inspection we saw that people were receiving fluids in forms such as soup and ice cream. When the snack trolleys were taken around we heard people being offered a variety of drinks and snacks. These included, crisps, cake, ice-lollies, fresh fruit and chocolate. People on soft diets were offered smoothies, soup and fortified yoghurts. We heard one staff member offer a person a variety of drinks until they found something the person wanted. However, one staff member promised a person some soup but when we checked the person had not had the soup.

Concerns had also been raised that food and fluid charts were not being filled out correctly so it was not possible to know if people were receiving enough to eat and drink. One relative told us they thought there were some issues about people not getting enough to drink. They said "some mid-morning drinks don't get given out until nearly lunchtime" and "afternoon drinks are often late or not given at all if staff are busy". Although we found no evidence people were receiving insufficient food and fluid, records relating to people's intake were not always fully completed. For example, some people's charts showed they had not received sufficient fluids every 24 hours. We discussed this with staff who told us they always ensured people

received sufficient fluids but sometimes forgot to record this. We also noted that when people were being given soups and ice cream this was not being recorded as fluids.

On the first night of our inspection all rooms we went in had cups and jugs of fluid. On the second day of our inspection one room had a jug of fluid but no cup. We told the manager about this who said it was possible staff had taken the beaker away to wash it. We later saw the cup in the room had been replaced.

We asked the head of the dementia unit if they had any concerns about people having enough fluid. They told us they did not "have any concerns that people were not getting enough fluid just the recording". We saw that where issues had been identified with people not receiving enough fluid, information was transferred to the person's care plan for staff to follow up the next day. However, once again although staff and management felt people were getting enough to eat and drink, records did not support this.

Staff had received training in the importance of completing the charts. However, there were still times when the charts were not completed. The manager told us they had identified there were too many forms to be completed which all required similar information. They said they were planning to take all the documentation 'back to basics' to ensure staff only had to complete charts that were useful.

People's weights were monitored. People were weighed weekly or monthly depending upon their level of risk. Of the care plans we looked at two people had been identified as being at risk of malnutrition. Both care plans indicated they were to have "nutritional snacks in between meals" and these were recorded on their food intake charts most, but not all, days. The kitchen staff said they fortified food with butter, cream and milk powder. There was evidence both people had been referred to a dietician. However, there was confusion about one person's weight. Their records showed their weight had increased significantly over three days. Next time they were weighed it was recorded they had lost a significant amount of weight and they were referred to a dietician. It had not been recognised that the increase in weight had been over a short period of time and that overall the person's weight had increased slightly. This inaccurate record had not had a negative impact on this person. However, all records must be accurate to ensure risks to people are minimised.

This was a breach of Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff met every day to discuss any concerns they had about people's food and fluid intake. The operations manager told us they had concerns around two people who had been referred to the Speech and Language Therapy (SALT) team. The team had advised puréed diet, but the people would not eat it. This was because the people had fluctuating capacity, did not understand the risks and wanted the food they saw other people eating. The people were being referred again to the SALT team for further advice. While they were waiting for further advice staff were encouraging people to eat as much as possible while monitoring their risks.

We had had concerns over the lunchtime experience at previous inspections. Therefore at lunch time we used our Short Observational Framework for Inspection (SOFI) to help us understand the lunchtime experience for everyone living in the nursing unit. There were 18 people in the dining room at this time. One relative said there were more staff there to help people than usual. They said "you ought to come more often, I've never seen so many staff helping". There were nursing and care staff as well as kitchen staff and the activity coordinator assisting people to eat. At one point the administrator took over from the nurse who had been called to speak to a doctor over the phone. At our inspection in March 2016 we had concerns about one person who had fallen asleep between their starter and main course. At this inspection in May

2016 we saw they had someone sit with them while they had their lunch.

However, we also saw one member of staff assist three people to eat: they gave each of them their starter, then their main meal and then their dessert. This meant there was a delay between each course as we had seen previously in March 2016. For those people who were independent with eating, they were given their meals by the kitchen staff, who were also assisting people and there was again a delay between courses.

We discussed with the management team about having two sittings for meals as there were too many people to assist with the number of staff available. For example, a number of people had been brought in to the dining room and had fallen asleep at the table as staff were unable to provide them with their meal immediately. The was either because they were assisting other people in to the dining room or to eat their meal. The management team agreed to look at the possibility of two sittings for mealtimes. We had been told by the previous registered manager that this system had been adopted. However, it appears that due to the constant changes in management the system had not continued.

This was a breach of Regulation 9(1)(b) of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.

People told us they enjoyed the meals. One person said the food was "excellent", and another told us the food was "very good" with "plenty of choice". There was a good selection of meals prepared each day as well as a menu of other meals that could be prepared upon request. We spoke with the cook who told us they would prepare anything people wanted.

Since the inspection in March 2016 we had received concerns that staff did not receive training that gave them the skills and experience needed to meet people's needs. We spoke with the trainer based at the home and staff working there. We also looked at the staff training matrix and training records. These records showed a wide range of training was provided and that: 84.09% of staff (37 out of 44) had received training in health and safety; 88.64% of staff (39 out of 44) had received training in safeguarding people and 96.55% of staff (28 out of 29) had received training in pressure ulcer prevention. The manager had identified that several staff needed training updates. Several short training sessions were being held over the next week to ensure all staff attended the updates. Topics included, nutrition, choking risks, CPR (used to maintain circulation when the heart has stopped pumping on its own), fire safety, pressure area care and health and safety. On the third day of our inspection these sessions were taking place. Extra staff had been brought in to support staff to attend these sessions. More detailed sessions were to be held for new staff. Staff told us that they were encouraged to obtain further qualifications and the trainer would support them to do this. The trainer told us they had been supported to change their role to work full time as a trainer. They had obtained several qualifications including PTLLS (Preparing to Teach in the Lifelong Learning Sector) which enabled them to teach adults.

The trainer told us that because of the recent high staff turnover new starters had not received as thorough an induction as they should have. This was because staff were needed 'on the floor' as quickly as possible.

This was a breach of Regulation 18(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, they said things had improved and new staff could now get a full induction and as much shadowing time as needed. One newly appointed staff member came in during the inspection to do part of their induction. They had not yet started work at the home.

We had received concerns that agency staff did not receive a thorough induction or handover. This meant they did not have the knowledge of people needed to meet their needs. We were concerned that on the night of our first inspection all staff were from agencies. We spoke with the three registered nurses on duty. They told us they had worked at the home before and had received a thorough handover from the Mount Tryon nurses on the day shift. One agency staff told us it was their third shift at the home and "I got support. Really good, once I finish meds then I start getting people ready for bed". Another said it was their second shift at the home and "The induction was quite comprehensive I went through care plans yesterday". However, the two agency care staff we spoke with said they had not had much of an induction that night, but had worked at the home before. They told us they would always refer to the registered nurses if they were unsure of people's needs.

We spoke with a Barchester Group dementia care specialist who told us about the Barchester initiative to roll out a dementia care programme. A new observational tool had been devised that would enable staff to assess and manage the distress of people living with dementia. Most of the staff that had received training in caring for people with dementia in September 2015 had now left. Therefore Barchester planned to implement the new initiative at Mount Tryon in the near future to ensure staff had the dementia care training they needed. During the inspection we saw staff had the skills to enable them to care for people with dementia. For example, staff got down to the same level as the person they were speaking with, spoke slowly and clearly and gave people time to respond to any questions.

Staff told us and records confirmed that staff received regular supervision. The current system was one where a prepopulated form was used to discuss a variety of topics. There was no space for actions to be taken to be recorded. The manager told us that this was an area that needed improvement. They planned to ensure all staff were supervised at least every three months. They also said they planned more observations of staff doing their jobs to ensure they were working effectively.

Staff told us they felt well supported by the new management team. They said they now felt included in everything and were able to discuss anything with the new manager.

Some people living at Mount Tryon were living with dementia, and this could affect their ability to make decisions about their care and treatment. Staff had a clear understanding of the Mental Capacity Act 2005 (MCA) and how to make sure people who did not have the mental capacity to make decisions for themselves had their legal rights protected. For example, they were aware that people were always assumed to have capacity unless they had been assessed otherwise. They also knew that if people had been assessed as not having capacity to make a specific decision, best interest meetings must be held. Throughout the inspection we heard staff asking people for their consent before providing personal care.

The 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.

We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met. Where people had been assessed as not having the mental capacity to make decisions, meetings had been held in order to decide what was in the person's best interest. However, while the home was following the principles of the MCA there were few records to confirm this. For example, one person was living with a level of dementia that reduced their capacity to make decisions about their care. We spoke with their relative who told us they had been consulted over the use of equipment to alert staff when the person was moving. This was to minimise the

risk of the person falling, rather than as a means of restraint. However, there was no record of the consultations that had taken place. Another person had a mental capacity assessment which was not dated. The decision under review was, "That [person's name] lacks capacity to make important decisions and requires specialist support". This was too broad as all decisions should be specific. For example, 'Does [person's name] lack the capacity to consent to receive care and treatment'?

We recommend that the service reviews all documentation relating to the MCA.

People can only be deprived of their liberty so that they can 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). Applications had been made to the local authority to deprive some people of their liberty in order to keep them safe. Due to the large number of applications being processed by the local authority only one application had been granted.

Records showed people had seen their GPs and other health and social care professionals as needed. For example, staff had asked for a medicine review, the person was seen by their GP and medicines were changed. One person had been seen by the home's physiotherapist almost monthly since their admission to review their risk of falls. Another person told us they had been seen by the physiotherapist and staff were supporting them with their arm and leg exercises. They said they had got much stronger as a result of this.

We had received concerns that community nurses were not happy about providing some services to the home. We spoke with a member of the community nursing service who told us they had no issues with providing any service to the home.

Good

Is the service caring?

Our findings

This was the third time the Care Quality Commission (CQC) had inspected the key question 'caring' between January 2015 and May 2016. At the inspections in January 2015 and January 2016 this key question had been judged as requiring improvement. This was because people's privacy and dignity was not always maintained. People or their representatives were not routinely involved in planning people's care and most interaction between people and staff was task related. At this inspection in May 2016 we found improvements had been made.

All staff carried out their duties in a caring and enthusiastic manner. Staff spoke about people in a respectful and friendly manner. Staff demonstrated they understood confidentiality in relation to the people they cared for. When staff spoke together about people they ensured they could not be overheard. People were assisted with care tasks in gentle and caring ways. All personal care was provided in private.

Not everyone living at Mount Tryon was able or wanted to be involved in planning their care and were happy for staff or their representatives to do that. Some care plans contained signatures of the person's representative indicating they were happy with the care provided.

People talked about how well they were being cared for. One person said the staff were very good and they could "find no fault" with the home. A member of staff told us "The staff are very loving towards the residents here".

Staff at Mount Tryon treated people with dignity, respect and kindness. For example, staff addressed people with their preferred name and spoke with respect. People responded to this by smiling and engaging with staff in a friendly way. For example, we saw a member of staff go in to someone's room unprompted and ask if they were alright and comfortable. They asked if the person would like anything else to eat or drink and if they would like the light left on. The person asked for the window to be opened which the staff member did.

We heard one member of staff wake one person very gently and ask them if they were ready to have a wash and freshen up. The person agreed to do this. Another staff member woke them a little later to see if they would have a drink. The person was a little upset when they woke and were concerned they had done something wrong. The person and the staff member chatted nicely and the person was reassured. The staff member asked the person if they wanted to sit out of bed, but they declined. They both chatted again for several minutes and the person asked for their face cream which the staff member got for them and helped them with.

One person told us they, and their husband who was being cared for on the dementia care unit, were being "very well looked after". They said, "the girls are lovely, they are very good". They also told us the staff had helped them during the night and had done so "really well". Another person described the care and support they received as "excellent". They said routines were flexible and they could get up and go to bed when they wished. When asked if there was anything that would make life more comfortable for them, they said there wasn't.

One relative told us if they ever had to move into a care home they "would be happy to live in this home". A relative stated "I am satisfied with my [relative] staying here, he has been to two other homes, this is a far better home".

Following our inspection we received an email from a relative who wrote 'I have visited the home every single day…. I have witnessed the care and compassion of many of its staff members over that time'. They went on 'I have seen the standard of care at the home generally improve over the six years my [relative] has been resident there'.

All six relatives we spoke with said they were very happy with the care their relations received. One said, "I think this is absolutely brilliant. If I've got to come in to a home, I hope it's here". Another described the staff as "very pleasant". Another relative said "wonderful" and "excellent" when talking about the care their relation received. However, prior to our inspection we had received emails from a relative who had not been happy with the care their relative received.

Visitors told us they could visit at any time and some visited every day. However, we saw a letter in which the provider had imposed conditions on one relative's future attendance at the home.

We recommend the provider reviews their policy when placing restrictions upon relatives visiting.

Requires Improvement

Is the service responsive?

Our findings

This was the third time the Care Quality Commission (CQC) had inspected the key question 'responsive' between January 2015 and May 2016. At the inspections in January 2015 and January 2016 this key question had been judged as requiring improvement. This was because we found inconsistencies in the way staff responded to people's social care needs. Also some staff were unaware of people's specific care needs.

People's needs were assessed before and while living at Mount Tryon and care plans were developed following the assessments. The care plan files we looked at held a pre-admission assessment and a summary of their care needs. However, care plans were bulky documents and it was difficult to find the most up to date information. This meant staff may not always be aware of changes to people's needs.

Care plans had not changed since the inspection in October 2015. There were a number of documents referring to the same issues in different sections. For example, the section relating to mobility, moving and handling had a number of documents all with slightly different information on, rather than one document containing all the necessary up to date information. Much of the current information about people's care needs was written on the second page of each care needs topic. It was therefore not easy to identify people's current care needs.

Care plans did not always give staff the information they needed to meet people's needs. For example, one person's care plan identified they could become confused, agitated and distressed. But there was no further guidance about how to support them when they became distressed. We discussed this with senior staff who agreed the current system was too bulky and didn't provide easy access to a good description of people's care needs and how they should be met.

The handover report for staff did not provide enough information about people's care needs such as pressure area care or mobility needs. For example, it referred to one person's history of falls but not to their high risk and that they were to wear hip protectors. Neither did it state they were living with dementia and became confused and anxious. This was concerning as it was the handover report given to agency staff who may not know people well and who were relying on this information to meet people's needs.

There was some clear guidance for staff about some aspects of people's care. For example, one care plan stated that the person preferred female staff to assist them and "[person's name] likes to look smart and well-groomed at all times". We saw that only female staff attended this person and that they looked smart.

Daily care notes were task focussed and detailed personal care issues and whether the person had eaten. There was very little reference to people being involved in any meaningful engagement during the day. Also there were some gaps in the recordings. This meant on some days there was no evidence of what care people had received.

This was a breach of Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

However, staff were aware of people's individual needs and they responded to people's needs in a manner that relieved their distress and reduced their anxiety. Staff met people's needs in a sensitive manner. For example, one person began to remove items of clothing inappropriately. Staff responded discreetly to help the person maintain their dignity. Another person was walking around the lounge looking rather lost. Staff found them a baby's pram and the person began to push the pram around with a big smile on their face. We observed people got comfort from carrying soft toys and dolls. We saw staff spent time with people on an individual basis. Staff spent time with people who did not leave their rooms.

Staff were able to tell us about people's needs and how they liked them to be met. They told us this was because they knew the people well, through regular handover meetings and reading progress notes. They said that they did not have time to look at care plans as they were too detailed.

Although there were some activities on offer, there was limited opportunity for people to engage in meaningful interaction and activities. One person had individual support during the afternoon but there was no indication they had spent their time in any meaningful way. A form entitled, "Activity Plan – all about me" identified things important to or enjoyed by the person. For some people this was detailed, but for others it was less so. For example, for one person, their plan stated 'likes to read a book, likes to engage with all staff, likes to have a glass of Baileys'. While another just stated 'likes to have the curtains opened in the mornings'. One person's interests were identified as 'likes to read a book in her room, (Catherine Cookson)'. We saw that the person had such a book within easy reach. One relative told us the management had supported them to have the use of the homes mini bus. This meant they could take their relative to a local hotel to meet their extended family.

People had 'communication books' in their rooms. Visitors could record matters in the books so they could be dealt with by staff. However, information in the books was not being used effectively. For example, one entry for one person stated 'I've bought a radio for [person's name]. It is tuned to radio 4 because she loves the Archers, at 2pm and 7pm everyday'. This information was not included in their Activity Plan and staff did not ensure the person had their radio on at the right time. The manager was going to remove the books and request information was passed directly to them so they could take any action needed.

A weekly list of available activities was displayed around the home. On our third day of inspection we spent some time observing interaction in the main lounge of the dementia unit. We saw the activity co-ordinator encouraging people to take part in an arts and crafts session. Some people enjoyed this while others preferred to sing along with other staff. The manager acknowledged activities and social engagement were areas that needed improvement. One activity co-ordinator was employed by the home to work 40 hours a week. Another activity co-ordinator was being recruited. The manager planned to increase the number of activities and the amount of time spent with people on an individual basis.

People and their relatives could have a say in how the service was run. There was a Relative and Residents' committee, and meetings with management were held to discuss issues. These meetings had not been held regularly, The last one being held on 4 April 2016. The manager told us they were intending to hold meetings more regularly and one was planned for 20 May 2016. Following the inspection we were sent minutes of the meeting. These showed the new manager had introduced themselves to people at the meeting and the recent CQC inspection had been discussed. However, prior to the inspection one relative told us they felt these meetings were not useful and their concerns were not listened to during the meetings.

We looked at the complaints received by the home over the previous 12 months. Three complaints had been investigated and all had been concluded. However, the provider had restricted one person's ability to have full access to the complaint system by restricting them to making complaints by email to one named person

only. This could result in a delay in necessary action being taken in response to complaints made.

This was a breach of Regulation 16(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

One person told us "I have no concerns" and told us they felt able to talk to any of the staff about anything they were concerned about. They said they liked the new manager and had confidence in them. Another person told us they had no concerns but would be confident talking to the staff or manager. A relative told us they felt they could raise concerns with any of the staff and the manager. They said they had brought one concern to the manager and it had been responded to immediately. One relative wrote in an email 'When a person has such a high level of dependency there will always be small errors or omissions as far more responsibility is placed on the carer to think for that individual. In the six years [person's name] has been resident at Mount Tryon I have been able to approach management discuss worries and have changes made where necessary. I too have been treated with courtesy and respect'.

Inadequate

Is the service well-led?

Our findings

There had been a number of management changes at Mount Tryon which had negatively impacted on the care and support people had received. At two inspections, one in January 2015 and one in October 2015, the service had been rated as requires improvement with repeated breaches of fundamental standards.

Changes to the management and leadership had occurred both at a service level and at regional level. These changes had led to weak and inconsistent management, leadership and poor oversight of the service. Actions to address risk had not been taken, not been sufficient, or taken and not sustained through those changes. The service remains unstable.

This was the fifth inspection of Mount Tryon since January 2015. The home had been rated as "requires improvement" since the publication of the first comprehensive inspection report in April 2015. In March 2016 CQC rated the key question 'effective' as inadequate and issued a warning notice in relation to Regulation 14 telling the provider they must take action to ensure people were receiving enough to eat and drink. At this inspection in May 2016 we found action had been taken. However, improvements were still needed to the way records were maintained and the way mealtimes were managed. We also found improvements were needed in other areas if the service was to ensure people received a safe, effective, responsive and well led service.

Since a registered manager had left Mount Tryon in July 2015 there had been a number of operations managers overseeing the home while a new manager was recruited. A manager had been registered for the service in January 2016 but had de-registered in May 2016. Another new manager had been appointed and had applied to register as manager. The new manager had been in post for a week when we carried out this inspection.

There were some systems in place to assess and monitor the quality and safety of care. However, despite the audits identifying issues, no action had been taken to rectify the matters. For example, a series of audits were undertaken on 3 April and 4 May 2016. These audits included looking at medicines, food and fluid charts and care plans. One medicines audit identified gaps in Medicine Administration Records (MAR). Food and fluid chart audits identified they were not being completed correctly. The care plan audit identified they were not being reviewed regularly. Action had not been taken to address these issues. These issues had been identified as requiring improvement by CQC in March 2016.

The Barchester Regulation Team had conducted an audit of the service in March 2016. They had used the Care Quality Commission's (CQC) five key questions to complete the audit. An action plan had been drawn up following this review to show how the issues identified were to be addressed. For example, it was identified medicine records 'were not accurately maintained to evidence the administration of prescribed creams'. Staff were to be reminded of the need to complete the forms and nurses were to check they had been completed by 01 May 2016. At our inspection on 10 and 11 May 2016 we found the charts were still not being completed.

Records were not well maintained and did not always provide staff with clear information relating to people's needs and rights. Records required under the Mental Capacity Act (2005) were not fully completed. Care plans were bulky documents and it was not possible to see the most recent up to date information relating to people. Records relating to people's dietary needs were not sufficient to give staff the required information. People's re-positioning charts, topical cream application records and food and fluid charts were not fully completed. Registered nurses had responsibility to check charts to ensure people received the care identified in their care plan, that they as registered nurses had prescribed and delegated. This was not happening and therefore staff could not judge if the care and treatment they were providing was appropriate. Nurses did not act on their responsibility. One relative told us their relation's care needs were generally attended to well, however at times their teeth weren't cleaned properly. This was also noted in in the person's care plan review with their relative in March 2016, but had still not been addressed.

This was a breach of Regulation 17(1)(2)(a)(b)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Relatives told us some items of clothing had gone missing, although staff told us this was now being addressed through the introduction of a new laundry system. However, it had taken some time for this matter to be addressed.

Staff told us they felt things had improved greatly in the short time the new manager had been at the home. One staff member told us the new management team were "Absolutely fantastic, a breath of fresh air". They went on to say "I'm excited, I really am. They talk to us and let us know what 's going on".

One person said "they are managing the home really well now". A relative told us things had improved since the previous inspection and they had confidence in the new manager. They and another relative said there was good communication between the home and them. We received positive comments from a number of relatives. For example, one said "I'm very satisfied with the care mum receives". They said they had seen an improvement in the last few weeks and the manager and staff "listen to you". Another told us there had been a very positive resident and relatives meeting recently and they felt very confident about the changes in the home. One person told us they were pleased the new manager had arranged for their room to be decorated. They said they had been asking for some time for this to be done.

During the inspection the new management team shared with us their drive to improve the communication, leadership and culture within the home. However, we saw the letter sent by the provider to a relative that did not promote open communication. The provider had failed to see how distressing receiving such a letter might be. We would expect that any communication to a relative would be focussed on resolving any tensions, not imposing restrictions or threatening other action.

We recommend the provider review their systems for enabling and encouraging open communication.

The manager, an operations manager and regional director were present during the inspection. Whilst all the issues we identified during our inspection had been identified by the management team, timely action had not been taken to address these issues. The new manager demonstrated good management and leadership skills in their conversations with us. They told us they planned to take the service 'back to basics' to ensure all staff had a thorough understanding of people's care needs and their responsibilities. They had undertaken a thorough review of the systems in place. They said there was now a plan in place stating everyone's care plans were to be reviewed and the management team would be working alongside staff to ensure they were provided with support and mentoring. Staff work performance and contracts was also to be reviewed. We were told this was important as previously there had been 'no consequences' for staff who

had failed to meet expectations.

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 9 HSCA RA Regulations 2014 Person-centred care People who use the service did not receive care that met their needs and reflected their preferences. Regulation 9 (1)(b).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who use service were not protected against the risks associated with unsafe management of medicines. Regulation 12(1)(2)(g)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The registered provider failed to operate effectively an accessible system for receiving complaints by a relative of a service user in relation to the carrying on of the regulated activity. Regulation 16(2).

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance Systems in place to monitor the quality of care provided by the service were not effective. Records relating to the care and treatment of people were not accurate. Regulation 17 (1)(2)

(a) (b) (c).

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 Staff did not receive an induction that prepared them for their role. Regulation 18 (2)(a).