Four Seasons (Bamford) Limited

Holbeche House Care Home

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 caring?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 18 and 19 May 2015 and was unannounced.

At our last inspection on 20 August 2014, the provider was not meeting the law in relation to complaints and records. Following this inspection the provider sent us an action plan to tell us the improvements they were going to make. During this inspection we looked to see if these improvements had been made.

Holbeche House Care Home provides accommodation for up to 49 people who require nursing or personal care.

The home is split into two units, the general nursing unit and a unit for people living with dementia which was referred to as Littleton House. At the time of the inspection, there were 40 people living at the home.

The home had a manager in post who was currently applying for their registered manager status. 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.

Summary of findings

People and their relatives told us that they felt safe in the home. Staff were aware of the risks to people living at the home but risk assessments were inconsistently reviewed and not always completed in a timely manner.

We found a number of incidents of concern that had not been recognised as safeguarding concerns that neither us or the local authority had been notified about.

The manager had recently successfully recruited new staff to fill vacant positions in the home. However, despite attempts to provide consistent agency staff to cover vacancies this was not always the case leading people to receiving care from a number of different agency staff within a short space of time.

We found that people were receiving their medicines as and when they should. However, the system in place to ensure people received their medicines at specific intervals was not robust.

Staff felt well trained to do their job and felt fully supported by the manager.

The manager and staff had recently attended training in respect of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). However, there were inconsistencies in staff's level of knowledge and how it was put into practice; meaning there was a risk that people's rights would not be appropriately supported.

We saw that people were supported to have a nutritionally balanced diet and adequate fluids throughout the day. We saw that people were offered a choice at mealtimes. However, there was a lack of information regarding people's likes and dislikes which meant people were not always offered their preferred choices.

Parts of the environment required attention in the home and were sparse and unwelcoming. The manager had raised this with the provider and was also involving people and their families in the redecoration of their rooms. There was only one bath available for people to use in the home as the other three were out of action.

Relatives told us that staff were kind and caring and told us they felt involved in their relative's care plan. We saw instances where staff spoke warmly to people and offered reassurance when they became distressed. However, we also observed other instances where people were not treated with dignity and respect.

We saw that complaints received had been investigated, however the manager had failed to manage complaints in line with their own complaints procedure.

Arrangements had been made to carry out reviews of people's care needs every six months, but care records looked at were inconsistent and were not always completed in a timely manner.

We observed that there was a lack of activities and/or stimulation for people living at the home.

Staff and family members were confident in the abilities of the manager and commented on the difference she had made to the home since arriving in post. However, we found that the manager had not fully met the requirements of the action plan they had sent us to improve on shortfalls we had found at our previous inspection and that work was still needed to be done in these areas.

We found a number of concerns during our inspection which the manager's own audits had failed to identify. This meant that issues which could affect people's experience of the service were not being routinely identified and addressed.

The manager had failed to notify us of a number of matters which they are required to do so by law, in a timely manner.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and one breach of Care Quality Commission (Registration) Regulations 2009 (Part 4). You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires improvement

The service was not consistently safe.

People told us that they felt safe.

Where incidents and accidents had taken place, the manager had failed to report them to the appropriate external agencies.

Risk assessment paperwork was inconsistent and not completed in a timely manner.

The system to administer medicines at specific intervals was not robust.

Is the service effective?

Requires improvement

The service was not consistently effective.

People were supported by staff who felt well trained to do their job.

Staff had inconsistent knowledge about people's rights and depriving people of their liberty.

People were supported to have enough food and drink to meet their nutritional needs.

People were supported to access the healthcare they needed to maintain good health and wellbeing.

Parts of the environment were sparse and unwelcoming.

Is the service caring?

Requires improvement

The home was not consistently caring.

People told us that they were cared for by staff who were kind and caring.

People received care that met their needs.

We found that some staff required further training to ensure that people were treated with dignity and respect at all times.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Care records were not consistently completed which could lead to staff not providing the most appropriate care for people.

Complaints were investigated but the manager failed to manage complaints in line with their own procedure.

Some people participated in activities, but others received very little stimulation throughout the day.

Summary of findings

Is the service well-led?

The service was not consistently well led.

We found that the manager had not fully met the requirements of the action plan they had sent us to improve on shortfalls we had found at our previous inspection.

We found a number of concerns during our inspection which the manager's own audits had failed to identify. This meant that issues which could affect people's experience of the service were not being routinely identified and addressed.

People, their families and staff spoke positively about the manager and felt she had made a difference to the service.

The manager had failed to notify us of matters which they are required to do so by law, in a timely manner.

Requires improvement

Holbeche House Care 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.

This inspection took place on 18 and 19 May and was unannounced. The inspection was carried out by two inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. This expert by experience had experience of being a carer for an older person.

We reviewed the information we had about the home. We looked at notifications that had been received from the provider about deaths, accidents and incidents that they are required to send us by law.

We spoke with eight people who lived at the home, four relatives, the manager, the deputy manager, five members of care staff, the administrator and the cook. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke with other health care professionals and representatives from the local authority with knowledge of the service.

We looked at the care records of nine people living at the home, staff files, training records, complaints, accident and incident recordings, safeguarding records, medication records, rotas, handovers, menus, minutes of staff meetings, quality assurance paperwork and minutes of meetings with families.

Requires improvement

Is the service safe?

Our findings

We reviewed records in relation to accidents and incidents that had taken place. The appropriate company paperwork had been completed, and the company's own datix system had listed what had happened, what was done and any learning from this. However, the manager had not reported some of these incidents to the local authority or to the Commission. Following the inspection the manager required further prompting from the inspector to report these incidents.

This is a breach of Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2014.

People and their families told us that they felt safe in the home. One relative told us, "Very happy with the care here, the staff are good and friendly; we looked at other places this was the best and they [my relative] feel safe".

Staff spoken with were aware of the different types of abuse and what to do if they witnessed abuse. One staff member told us, "I would report it to the manager" and another member of staff said, "I would step in, report it and document it on our progress sheets".

We saw that risk assessments had been undertaken but they were inconsistent, often inaccurate and not reflective of people's current needs. We saw risk assessments were not fully completed; for example, we saw a risk assessment in place that provided an overall score with regard to the risk, but no explanation as to what that score meant. We saw that the records in relation to what people had eaten and drank each day had not been consistently completed. We saw when one person had been admitted to the home the recordings of their weight, blood pressure and their risk of malnutrition had not been completed. This meant that consideration had not been made to the potential risks to the health and wellbeing of this individual. One member of staff spoken with was aware of the basic risks to this person but they were unable to demonstrate to us how this information was cascaded to other staff.

We spoke with a new member of staff who confirmed that all the necessary checks had been put in place prior to them commencing in post. We also looked at three recruitment records and were able to confirm that the appropriate processes and procedures had been followed including checks with the Disclosure and Barring Service. This meant that processes were in place to reduce the risk to people of being supported by unsuitable staff.

People spoken with did not raise any concerns regarding the staffing levels at the home.

The manager told us that staffing levels were assessed using the provider's dependency tool which was based on occupancy and dependency levels. One staff member told us "Sometimes it's awkward with only three staff, I have to stop doing the medicines and watch the floor". During the medication round we observed the nurse having to do this. This meant that people were at risk of not receiving their medicines in a timely manner. The manager informed us that she had identified the need for an additional member of staff in the nursing lounge based on the layout of the building and the deployment of staff across the nursing unit.

We were told and staff confirmed that staff vacancies had been covered by agency staff; the manager told us that she had attempted to ensure the same agency staff were used. However, we checked the recent rotas for staff and noted that during one week in May there were nine different agency staff to act as healthcare assistants on the night shifts. This, coupled with the inconsistencies in care file recordings meant that people were at risk of not having their care needs met appropriately and safely.

We reviewed how medicines were managed within the service and found some issues of concern that could place people at risk of not receiving their prescribed medication as they should.

We looked in detail at five medicine administration records (MAR) and found that people's medical conditions were found on the whole being treated appropriately by the use of their medicines. However, we found that the service did not have a robust system in place to ensure that medicine prescribed to be administered at specific intervals was adhered to. For example, one person had been prescribed analgesia patches to be applied to their body every 72 hours; we found that these patches had not been applied at the correct intervals and that body maps to evidence that staff had followed the manufacturer's guidance in

Requires improvement

Is the service safe?

relation to appropriate rotation of the application site were not completed. This meant that people may be experiencing pain unnecessarily, particularly people who were unable to communicate their needs effectively.

We found that the information available to staff for the administration of 'as required' medicines was sufficient to ensure that the medicines were given in a timely and consistent way. We saw that medicines were being stored as per the manufacturer's guidelines in order to maintain their effectiveness in promoting good health. However, we found that systems for disposing of medicines were not always robust; we identified some medicines that were no longer required had not been disposed of in a timely manner.

Requires improvement

Is the service effective?

Our findings

Relatives spoken with told us they felt the staff were trained to meet people's needs. One person told us how pleased they were with their relative's recent weight gain since being at the home, they commented, "They must be doing something right". A person living at the home told us, "It's not too bad here and I'm comfortable, the girls are nice and they look after me". Staff spoken with demonstrated knowledge of the people living at the home and were able to tell us how they cared for them and met their needs.

Staff spoken with told us they felt well trained to do their job and meet the needs of the people they supported. They told us that the majority of training was on line or e-learning. One staff member told us, "I prefer sitting in the classroom with others when I do my learning, I find it easier than e-learning". Staff confirmed that there were a number of other training courses that were conducted in a classroom environment, on a practical level, including manual handling. We spoke with a new member of staff; they described to us their induction, which included spending time getting to know the people who lived at the home and told us that when their induction ended, they felt fully equipped to take on their new role. Another staff member told us, "I felt fairly settled after a couple of days, I pick things up quickly and was well supported by the manager".

Staff told us that they received supervision every six months plus an annual appraisal. One member of staff told us, "Every six months is fine. If I have any concerns before then I just go and speak to the manager". Another member of staff told us, "I have spoken to the manager about going on to do additional learning and she has been very supportive".

The staff and manager told us they had received training in respect of the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). DoLS are part of MCA 2005 legislation and ensures that, where someone may be deprived of their liberty, the least restrictive option is taken. A member of staff was able to describe to us the circumstances surrounding the authorisation to deprive a person of their liberty in the home and the reasons for this. However, we noted in this person's care record that there was no specific care plan or guidance in place for staff on how to meet the requirements of the DoLS and what it meant for the person. We asked a member of staff if there were any other people who had a DoLS in place and we were told, "No-one else is restricted – we don't do that". However, we did note that one person was being deprived of their liberty as their freedom of movement was being physically restricted as a result of the equipment they were using. Staff spoken with did not see this as a restriction to the person's liberty. We discussed this with the manager and she agreed to speak with representatives from the local authority with a view to making an application. This meant the manager and staff understanding of this subject was limited and could mean that other people were being deprived of their liberty in the home.

We observed that people were supported to have a nutritionally balanced diet and adequate fluids which were offered regularly throughout the day. At lunchtime we observed people being told what was for lunch and being offered a choice. One person told us, "Dinners could be better, they never look appetising – the sandwiches and puddings are alright though". We spoke to the cook and observed that there was written information available regarding people's specific dietary requirements; however no records were kept in the kitchen with regard to people's preferences and choices. The cook advised us that at times they were relying on agency staff due to staff vacancies; therefore the lack of information regarding people's preferences and choices available may mean that people did not receive meals of their choosing. The cook told us that it was the responsibility of the nursing staff in the home to keep the kitchen staff up to date with any changes in people's diet and to maintain the information on the whiteboard and that this system worked well.

At lunchtime we saw people were offered choices and asked what they would like. A member of staff told one person, "It's soup or sandwiches, or pasta bake", but didn't tell them what type of soup was available. We observed people being supported to eat during a mealtime. We saw that staff spoke to people whilst supporting them and other staff acknowledged people as they walked into the room. We saw one person supported to eat their soup but the staff member had to stop assisting this person and respond to another person in the room.

We saw that people were supported to access the healthcare they needed to promote good health and wellbeing. Staff liaised with GPs and people had access to the optician, dentist and chiropodist. Where appropriate records showed that referrals had been made to the falls

Requires improvement

Is the service effective?

clinic and support had been sought from the palliative care team. A member of staff told us, "The doctor and nurse practitioner visit weekly, if we need them, they will come straight away".

The building was split into two units. We saw efforts to provide items of interest on walls between the units but these were displayed in corridors that were not freely used by people who lived at the home. One relative described the overall environment as "Tatty" but added that "The care is good". The dementia unit had a large lounge area and separate dining room. Both rooms were sparse and unwelcoming; there was little decoration on the walls that may provide stimulation for people. A member of staff commented, "It doesn't feel homely, the lounge is like a throughway, a corridor". Some people were sat in chairs that were positioned around the edge of the room which could make they feel isolated but we saw that some efforts had been made to put chairs in the middle of the room to enable some people to sit in smaller groups. However, these efforts were ineffective as a number of people were left with a view only of the back of the other chairs. The dining room was sparse and the floor appeared worn. We noted that the majority of the dining room tables were unsteady and people were at risk of harm if they sat at these tables as their food or drink could have been knocked over. On the wall of the dining room was a large mural which was not designed for a dementia care unit.

We were told that out of four bathrooms in the home, only one bath was accessible to the people living there. There were also two shower rooms available but if people situated in the upstairs unit wanted to have a shower, they would have to wheeled down the long corridor to access it. This meant that people were restricted in their choice of bathing routines and that sufficient bathing facilities were not available to meet the needs of the people living there.

Requires improvement

Is the service caring?

Our findings

We observed that some staff were caring when they supported people. One relative told us, “They do care; when [person] came out of hospital, staff stayed on to make sure [person] was back safely and made sure there were sandwiches and coffee available”. Another relative told us, “I am very happy with the care; [person] is in good hands – I can sleep at night and know [person] is cared for”. People told us they were happy with the care their relative received and they had been involved in their care plan. In care records seen, we saw that people and their families had been consulted about their care plans.

At lunchtime we saw people being supported appropriately. We saw one member of staff discreetly suggest to one person, “Shall we put this on to protect your clothes” at lunchtime, however another member of staff, when carrying out the same task said, “Put your bib on” to another person. We saw one person become upset when they were presented with their meal as they felt there was too much food on the plate. Staff reassured this person and their plate was taken away and a smaller portion was returned to them which they were happier with. This meant that staff were inconsistent in their approach when providing care, which may be confusing and have an emotional impact on the people living at the home.

We saw that in the dementia unit that staff were sitting observing people, but there was little interaction between the staff and the people around them. We saw one person crying but no one approached the person to comfort them.

We saw that one person’s chair was sticking out of the doorway of the hairdressing salon in the corridor and that the chiropodist was sitting in the salon, tending to the person’s feet. We spoke to the chiropodist who told us that they usually provided care for people in the treatment room but he had been told that the room was not available on that day. He confirmed that he had not been asked to use the hairdressing salon before and that he had questioned staff regarding the arrangement but was told it would be ok. This meant that this person’s privacy and dignity was not always considered in relation to their care and treatment. Staff we spoke with told us how they treated people with dignity and respect, one member of staff told us that when providing personal care, they, “Close the curtains, cover people over, make sure they are happy”.

We spoke with an advocate who was acting on one person’s behalf, they told us, “I keep an eye on [person’s] care making sure their rights are protected”. Staff we spoke to were aware of how to access the local advocacy service for people.

Requires improvement

Is the service responsive?

Our findings

At our inspection of the service in August 2014 we found the provider was not compliant with the regulations in regard to Complaints. The provider did not have a robust system in place for formally recording, acknowledging or investigating complaints they received in a timely manner. At the end of our last inspection we saw the provider had received a written complaint on 12 August 2014; on this most recent inspection we checked to see how effectively this complaint had been dealt with. We found that although the issue had been investigated, the manager had never sent an acknowledgement or a formal written account of the findings to the complainant for several months after the complaint. We also saw that the letter sent out by the provider in answer to this and a further complaint they had responded to, did not contain advice for the complainant in respect of what further action they could take if they were dissatisfied with the outcome. This meant that the provider had failed to manage complaints in line with their own complaints procedure or have a system in place to deal with complaints in an efficient manner.

A relative told us, "The staff are very responsive and they anticipate the resident's needs as far as I can see". One family member told us that they had been involved in their relative's care plan before they were admitted to the home. We saw that arrangements had been put in place to carry out reviews of people's care every six months and staff were instructed that if families were unable to come into the home for the review, then to discuss their relative's care needs over the phone. However, records looked at did not demonstrate that families were always involved in this process.

Staff spoken with were able to demonstrate they were knowledgeable of people living at the home. However, there was very little personalisation within care plans and little documented evidence of people's likes, dislikes and preferences. Care plan documentation enabled staff to complete information on people's preferences, but this was done inconsistently. We also saw in a number of files where not all the care plan documentation had been completed, and a number of care plans had not been reviewed for 2-3 months. The manager told us that she had introduced a system to ensure all staff were given a number of care plans to review but this had not been consistently applied. We saw that some files held incomplete assessments, for example, assessments for pain; we were told these were done randomly and not for a particular reason. One person had a DoLS recommendation in their care plan that highlighted that this person required a structured activity plan in place but we did not see any evidence of this.

We spoke with a visitor and asked them if they had observed any activities taking place in the home. They told us, "When I first saw [person] there was not a lot of one to one activities being done – that has changed now; they take [person] outside to feed the birds and to see the garden".

We were advised that the activity co-ordinator was off work. We asked staff if they picked up this role during this person's absence. One member of staff said, "Sort of, but [person] is not going to be off long". However, staff were unable to access any of the activity materials as the activity cupboard was locked. A member of staff told us, "Activities provision is poor, we need more here, people are bored". We observed that people sat in their chairs, around the room, watching television, one person was having their nails painted. In one particular lounge, we observed staff turn the television down without asking the people watching it if they could still hear the programme. We observed carers were sitting with people but there was very little interaction between people living at the home and the carers who support them. This meant that people did not always have the opportunity to take part in activities which interested and stimulated them.

Requires improvement

Is the service well-led?

Our findings

We saw that the manager had in place her own system to audit care records but our findings demonstrated that this was ineffective. For example, we saw that the care plan for a new person living at the home had not been completed after they had been living at the home for three weeks. The manager told us that she would have expected it to be done within three days. We saw that the manager held a number of meetings with staff. At a recent nurses meeting she had highlighted that their review of care plans had 'fallen by the wayside'. Staff told us and we saw evidence of a new allocation system brought in place by the manager to manage this problem. However in a number of files looked at we found inconsistencies including care plans and risk assessments that had not been completed or reviewed in a timely manner.

We brought to the attention of the manager our concerns regarding a number of safeguarding's that had not been raised and also the need for an application to deprive someone of their liberty. This meant that the manager was not able recognise who was at risk or deprived of their liberty. Communication between the manager and staff was an issue. We identified a number of incidents that had occurred that had not been reported to the manager. Also, the manager's own monitoring systems of accidents and incidents had not highlighted these issues. Despite both the manager and staff receiving training in safeguarding and deprivation of liberty, there were inconsistencies in how this knowledge and training was applied and put into practice.

We saw that there was some quality monitoring in place, but it was not effective. For example, there was no monthly audit of accidents, incidents or safeguarding's. This meant that when incidents had taken place, there was no evidence of lessons learnt in order to lessen the risk to people living at the home and improve the quality of the care provided. The action plan in place in respect of previous non-compliance of records and complaints had not been fully met. We saw evidence of monthly audits in place for medicines; however these audits had failed to identify the issues raised during the inspection.

This is a breach of Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014.

Prior to the inspection we reviewed the notifications received from the home. On one occasion we did not receive the notification until four weeks after the incident had taken place. We also noted that a number of incidents had not been reported to us. On other occasions the manager had formally notified us of events within the home which may impact upon people's care or welfare. This meant the manager was not fully aware of her responsibilities with regard to consistently notifying us of events in the home.

This is a breach of Regulation 18 CQC (Registration) Regulations 2009 (Part 4)

A family member told us, "The manager here is very good, we have every confidence in her". Staff spoken with talked positively about the difference the manager had made to the service since arriving in post in June 2014. One member of staff added, "This manager has turned things round". Staff told us they felt supported by the manager, one commented, "I have spoken to the manager about going on to do further training, she's been very supportive; she is a caring manager and there for the residents".

Staff told us that they were aware of the home's whistleblowing policy. They told us that if they had any concerns they had every confidence that the manager would deal with them. One member of staff told us, "The manager is very focussed on making changes". We saw minutes of a recent staff meeting which was led by the manager. The manager had ended the meeting by thanking staff for their hard work and telling them that they were valued, but further comments made by the manager were negative and made with the use of inappropriate language.

We saw that staff supervision took place every six months and staff spoken with were happy with this. One member of staff told us, "Every six months is fine, if I have any concerns I just go and see the manager".

The manager advised us that when she commenced in post she was faced with a number of challenges and that a number of staff had left at that time. The manager told us that despite this, "I do my upmost best for people's loved ones". She told us, "I'm not happy with the environment, it needs some attention". She described to us and we saw evidence of, the efforts she had gone to, in order to obtain additional funding for works to be carried out in the home. We saw that some money had been allocated to refurbish the home and the manager told us that she had to

Requires improvement

Is the service well-led?

prioritise where she was going to spend the money. We saw that the manager had requested that the bathrooms be repaired on 31 October 2014 but the work remained outstanding.

The manager told us that she had originally been supported by a regional manager, but she had not received supervision since December 2014 and the regional manager had left in March 2015. She told us a new regional manager had recently been appointed but she was yet to meet with them. The manager was not yet registered with the Commission and was in the process of making her application to become the registered manager of the home.

We were told that surveys had not been sent out to people living at the home or their relatives but that there had recently been a relatives meeting. Minutes of the meeting demonstrated attempts to include families in the running of the home and asking people their opinions on the environment. People were given the option to assist their relative in choosing a colour scheme for their bedroom and a relative had suggested establishing a relatives committee. We also noted a number of boards up around the home which provided people or their relatives with feedback, for example, “We asked you what you wanted” and “This is what we did”.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment **The provider failed to investigate and report allegations or evidence of abuse in a timely manner.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Monitoring systems in place were not effective and did not identify where quality and or safety were being compromised.**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents **The provider failed to notify the Commission of abuse or allegations of abuse in relation to a service user.**