

Caring Homes Healthcare Group Limited

Huntercombe Hall Care Home

Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

This inspection was carried out on 29 November and 2 December 2016.

At our inspection on 21 and 22 October 2015 we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found improvements had been made. Medicines were managed safely. Where risks were identified there were management plans in place to manage the risks. People's care records were accurate and up to date. People were supported in line with the Mental Capacity Act 2005, however we found there were not always mental capacity assessments for specific decisions.

Huntercombe Hall Care Home is a care home providing nursing and personal care for up to 42 people. The home supports people living with dementia. At the time of our inspection there were 38 people using the service.

The home had a new manager who was in the process of registering with CQC to become the 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.

People were positive about living at Huntercombe Hall. People enjoyed a variety of activities and had contact with local community groups. People were able to spend their day as they chose.

People's relatives and staff were positive about the manager and the improvements that had been made since the new manager came in to post. The manager promoted an open culture and everyone felt confident to raise any concerns.

Staff were knowledgeable about people's needs. Staff received regular support and had the skills to meet people's needs. Staff supported people with care and compassion. There was a relaxed atmosphere throughout the inspection and requests for support were responded to promptly by all staff.

There were sufficient staff to meet people's needs, however staff were not deployed effectively at mealtimes. People did not always receive person-centred support at mealtimes. The chef was knowledgeable about people's specific dietary needs and ensured food provided met people's needs.

Staff felt well supported and had access to development opportunities to ensure their skills and knowledge was let up to date. Staff were positive about the communication between staff and management.

The provider had not taken action to resolve issues identified at our inspection in October 2015 in relation to people's mealtime experience.

There were effective systems in place to monitor and improve the service. Accidents and incidents were monitored to ensure themes and patterns were identified.

There were systems in place to monitor the safety of the environment and equipment.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good ●

The service was safe.

People were supported by staff who understood their responsibilities to identify and report concerns relating to the abuse of vulnerable people.

Risks to people were identified and management plans in place to ensure risks were managed.

The provider had effective recruitment systems in place to ensure staff employed were suitable to work with vulnerable people.

Is the service effective?

Requires Improvement ●

The service was not always effective.

People did not always received food and drink in a way that was person-centred.

People were supported in line with the principles of the Mental Capacity Act (MCA). Care plans did not always contain capacity assessments for specific decisions.

Staff were knowledgeable about people's needs and received training to ensure they had the skills and knowledge to meet people's needs.

Is the service caring?

Good ●

The service was caring.

Staff showed kindness and compassion when supporting people.

People were encouraged to maintain their independence.

People's confidential personal information was kept securely.

Is the service responsive?

Good ●

The service was responsive.

People had access to a variety of activities that interested them.

People's care plans reflected their individual needs and people were supported in line with their care plans.

The provider had a complaints policy and procedure. People and relatives felt confident to raise concerns.

Is the service well-led?

The service was not always well-led

People, relatives and staff were positive about the manager and improvements that had been made.

The manager promoted an open culture. Staff felt valued.

The provider had not taken action to resolve issues identified at the previous inspection in relation to people's mealtime experiences.

Requires Improvement 

Huntercombe Hall 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 29 November 2016 and 2 December 2016. The inspection 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 care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications received from the provider. A notification is information about important events which the provider is required to tell us about by law. We spoke with commissioners of the service.

During the inspection we spoke with 12 people and six people's relatives. We spoke to the home manager, the deputy manager, two nurses, two care staff, the activity coordinator, the chef, the maintenance person, the home administrator and the receptionist. We carried out a Short Observational Framework for Inspection (SOFI) over the lunchtime period. SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also observed care practices throughout the day.

We looked at seven people's care records, six staff files and records relating to the management of the home.

Is the service safe?

Our findings

At our inspection on 21st and 22nd October 2015 we found that medicines were not always managed safely. This was breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our inspection on 29 November and 2 December 2016 we found improvements had been made.

Where people were prescribed a thickening agent for their drinks, this was stored safely in a locked cupboard in people's rooms. Staff were knowledgeable about the consistency of drinks people required. This ensured people's drinks were being thickened as prescribed.

Medicines were administered safely. The staff checked each person's identity and explained the process before giving people their medicine. Medicines were stored securely and in line with manufacturer's guidance. We observed a nurse supporting people with their medicines. We saw correct procedures were followed ensuring people received their medicines as prescribed. We checked stock balances against balances recorded on medicine administration records (MAR) and found them to be accurate. MAR included people's name, photograph, and details of all prescribed medicines. MAR were accurately completed.

Where people were prescribed 'as required' (PRN) medicines, there were protocols in place to ensure people received their PRN medicine when they needed them. We saw one person was receiving their medicines covertly. Covert administration of medicine means when medicines are administered in a disguised format, for example in food or in a drink, without the knowledge or consent of the person receiving them. Records showed this had been discussed with the person's GP, other professionals and the person's relatives. The deputy manager told us this was only used as a "last resort" and that on most occasions the person could be encouraged to take their medicines without having to give them covertly.

People's care plans included risk assessments and where risks were identified there were plans in place to manage the risk. For example, one person was assessed as being at 'high risk' of falls. The person could not bear weight. Staff were guided to 'hoist the person for all transfers'. Two staff were required to support this person. We saw this person being supported by two members of staff and the correct equipment being used.

Another person was at risk of developing pressure ulcers. Professional guidance had been sought and staff were advised to monitor the person's skin and apply cream to the skin twice a day. A pressure relieving mattress was also in place. Daily notes evidenced this guidance was being followed and the person did not have a pressure ulcer.

A risk assessment for the main staircase was in place. All people had been assessed in relation to this staircase. The staircase was monitored by staff and access to the staircase restricted. Approaches to the staircase were free of trip hazards and obstacles and a clean, non-slip environment was maintained. Following an incident in the home additional measures had been put in place to reduce the risk of people accessing more remote stairs in the home.

Staff were knowledgeable about their responsibilities to identify and report any concerns relating to the abuse of vulnerable people. Staff comments included: "I'd report any concerns to senior staff, social services or the police"; "I would call my manager or I can whistle blow"; "I'd discuss concerns with management. I can also call the social worker" and "I am confident my staff know how to identify and raise safeguarding concerns".

The provider had a safeguarding policy and procedure in place. Records showed that where concerns had been raised the manager had notified the appropriate agencies and had carried out thorough investigations.

There were sufficient staff to meet people's needs on the day of our inspection. However, some people and relatives told us there were not always enough staff. One person said, "Not enough staff, they really are rushed". A relative told us, "Not enough of them (care workers)". Other people told us there were sufficient staff. One person told us, "When called, they come quickly".

Staff told us there were enough staff to meet people's needs. Staff comments included: "I think I have enough staff to run my unit"; "Yes, I think we have enough (staff), things run pretty smoothly" and "Yes I do think there is enough staff here".

During our inspection we saw staff had time to stop and speak with people and any requests for support were responded to promptly. Call bells were answered in a timely manner throughout the inspection.

The manager used a dependency assessment tool to determine the number of staff required to meet people's needs. People's dependency assessment was reviewed monthly. Staffing rotas we looked at for a six week period showed that the assessed staffing levels had been achieved on most occasions. On the three occasions where staffing levels were not achieved the provider had taken all appropriate action to access additional staffing.

The provider had effective recruitment systems in place. Staff records showed checks had been carried out to ensure staff were suitable to work with vulnerable people. Checks included Disclosure and Barring Service checks (DBS) and references from previous employers. These checks enabled the provider to make safer recruitment decisions and prevent unsuitable people from working with vulnerable people.

There were effective systems to monitor the safety of the environment and equipment. This included regular monitoring of fire systems, water temperatures and window restrictors.

Is the service effective?

Our findings

At our inspection on 21st and 22nd October 2015 we found that people were not always supported in line with the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards. This was breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our inspection on 29 November and 2 December 2016 we found some improvements had been made.

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. The registered was knowledgeable about how to ensure the rights of people who were assessed as lacking capacity were protected.

We saw that some people's records contained mental capacity assessments relating to specific decisions. Some records showed that a best interest process had been followed to ensure any decision was made in the person's best interest. For example, one person was using bed rails. There was a capacity assessment relating to the person's ability to consent to the bed rails. There was a record of the people consulted to ensure the decision was in the person's best interest. However, we found that not all care plans were completed in line with the principles of MCA. We spoke to the manager who showed us a mental capacity assessment tool that was being implemented by the provider. The manager told us all care plans were currently being reviewed to ensure they met the requirements of 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 authorisation procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). The manager had carried out assessments to ensure appropriate DoLS applications had been made. However, there was no record in people's care files that DoLS applications and been made. There was no review of restrictions to ensure they remained the least restrictive. We spoke to the manager who told us the new MCA documentation would include information relating to DoLS.

Staff understood their responsibilities in relation to MCA and how to support people in line with the principles of the act. Staff comments included: "This is about capacity and people's ability to make decisions. I assume they have capacity and I always seek their consent"; "It is their right to choose, and refuse. It is their decision at the end of the day"; "I assume residents have capacity and we always work in their best interests" and "Consent is simple. I just ask, every time".

At our previous inspection we found that people were not always supported to eat and drink at a pace that met their needs. People who chose to eat their meals in their rooms did not always receive food that was hot. At this inspection we found improvements had not been made.

We observed the midday meal experience. On the unit supporting people living with dementia three people were being supported by one member of staff. All three people required support to eat their meals. This meant the staff member had to divide their attention between all three people and we saw this was not effective. Two people consistently fell asleep and did not eat when the staff member's attention was with the third person. When the staff member supported the others this third person got up from the table and walked away leaving their meal. This meant none of the people were able to enjoy their meal in a relaxed manner without interruption or distraction.

People who were eating their mid-day meal in the conservatory required supervision and support with their food. However, people were left unsupervised when one care worker was asked to serve food to people in their rooms. The care worker who remained with people in the conservatory was unable to give all people the support they needed. One person got up from the table on several occasions and the care worker had to leave the person they were supporting to encourage the person to return to the table.

People who chose to have meals in their rooms were served their soup and main meal at the same time. The soup was served in plastic jugs that were not insulated to retain the heat and on unheated trolleys. This meant people were at risk of receiving food that was not at a correct temperature. We spoke to the chef who told us they had submitted a costing for insulated flasks and hot trolleys to the manager in order to address the issue of the food temperatures.

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

People told us that most of the time the food was good. Comments included: "Food is OK. It's not the Ritz but we are not in the Ritz"; "It is good palatable food, well prepared" and "Food is ordinary, not the greatest". People told us that if they did not like the menu choices they were offered alternatives.

Where people had specific dietary requirements we saw they received food and drink to meet their needs. People who had been identified as at risk of weight loss received fortified food.

The chef was knowledgeable about people's dietary needs. The chef was provided with a 'resident fact file' for each person which was updated weekly. This included information relating to people at risk of weight loss, special dietary requirements and people's likes and dislikes. This ensured people received food and drink to maintain their wellbeing and meet their dietary needs.

Staff we spoke with were knowledgeable about people's needs and the support people required to meet their needs. Staff were positive about training they received. Staff comments included: "I've had some really good training that keeps me involved and up to date. Dementia training was really good"; "I get lots of training. Really useful and informative"; "We always need training to update us. We get that training" and "This is good. I am now qualified to do medicines and I am halfway through my NVQ level three qualification".

There was a record of all training staff had completed. This enabled the manager to monitor when training updates were due to ensure staff skills and knowledge were kept up to date.

Staff felt supported and benefitted by regular supervision in line with the provider's supervision policy. Staff comments included: "I think there has been some big improvements. Yes I am supported and I get regular supervisions" and "I am supported here. I've had supervisions and I do find them helpful. I have raised issues before and they were dealt with". Staff records contained records relating to supervision and showed staff

were encouraged to identify development needs.

People were supported to maintain good health. Various professionals were involved in assessing, planning and evaluating people's care and treatment. These included the GP, care home support service (CHSS) and speech and language therapist (SALT). Visits by healthcare professionals, assessments and referrals were all recorded in people's care plans.

Is the service caring?

Our findings

People were positive about the caring nature of the staff. Comments included: "There is gentleness. The staff are lovely, very cheerful. They are very thoughtful"; "The staff are wonderful, they come and talk, even when they are off duty" and "Very good, excellent". Relatives were also complimentary about the caring approach of staff. One relative told us, ""Nursing is very good, very kind and attentive".

Staff spoke in a caring manner about people. Staff comments included: "I definitely have caring relationships with residents. I communicate well with all my clients, I'm a chatterbox. I have a good rapport with them"; "I feel like I am doing something to help"; "Everyone who comes here say's staff are very good. This is a people place, we are all human"; "I do care, I treat resident as I would treat my parents" and "I love it here, they (people) are such fantastic people".

People were cared for by staff who were knowledgeable about the care they required and the things that were important to them in their lives. Staff spoke with people about their careers, families and where they had lived. During our visit we saw numerous positive interactions between people and staff. For example, we saw one person being supported to go to the lounge. The staff member supporting them chatted with the person who smiled and laughed. Once in the lounge the staff member made the person comfortable and asked if they needed anything. When the person said no the member of staff touched the person's hand and said, "Call me if you need anything".

People's dignity and privacy were respected. One member of staff told us, "I make sure clients are covered up with personal care. I try to put myself in their position". When staff spoke about people to us or amongst themselves they were respectful and they displayed genuine affection. Language used in care plans was respectful. We observed staff treating people with dignity and respect. Staff knocked on people's doors before entering their rooms. Where staff supported people in their rooms they closed doors.

People were encouraged to maintain their independence. For example, we saw one member of staff supporting and encouraging person to walk. The member of staff walked with the person prompting them to use their walking aid. Staff understood the importance of supporting people to do things for themselves. One member of staff said, "I always let people do what they can do themselves".

The provider ensured people had access to information about the service and other services they may need. People were given a service user guide that provided them with information about the home, services available and how to access them. For example, the guide contained a booklet by the Oxfordshire Advocacy service. This gave information about this service and details of how to contact them.

People's personal confidential information was kept securely. People's care plans and other personal information were stored in a locked office.

People's wishes relating to 'end of life' care were recorded and respected. Advanced care plans recorded people's preferences and how they wanted to be cared for at the end of their life. For example, one person's

advanced care plan stated the person 'did not wish to be hospitalised if they became very ill'. This had been signed by a person with legal authority to make this decision on the person's behalf. Staff we spoke with were aware of this person's wishes and told us people's preferences were always respected.

Is the service responsive?

Our findings

At our inspection on 21 and 22 October 2015 we found people's care plans were not always up to date and legible. This was breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At our inspection on 29 November and 2 December 2016 we found improvements had been made.

People's needs were assessed prior to admission to the service to ensure their needs could be met. People had been involved in their assessment. Care records contained details of people's personal histories, likes, dislikes and preferences and included people's preferred names, interests, hobbies and religious needs. For example, one person had stated they 'liked to get up late'. Another person had stated they 'wanted to attend church services'. Daily notes evidenced this person was supported to attend church services.

One person's care plan identified they could present with behaviours that may be seen as challenging to themselves or others. The person could become anxious and frustrated. The care plan identified staff needed to encourage the person and 'communicate with them verbally'. The care plan also informed staff the person responded to 'gentle touch' and staff needed to make eye contact with the person. We observed staff using these techniques effectively when supporting this person.

Another person was unable to communicate verbally. The person's care plan identified the different methods that had been tried to support the person and that the person had been referred to a specialist health professional for additional support. Staff we spoke with were understanding of the person's communication difficulties and the frustration and distress this caused the person.

The service responded to people's changing needs. For example, one person's condition changed and the person was referred to the GP. The person's medicine was changed to reflect their condition. Another person developed difficulty with swallowing and they were referred to a speech and language therapist (SALT). Guidance was provided and the person was prescribed fluid thickeners and recommended a pureed diet. We saw these measures were put in place to respond to this person's change of condition.

During the inspection nurses discussed a person's increased swallowing difficulties. The deputy advised the nurse to contact SALT before making any changes to ensure the risk was managed safely.

People's care was regularly reviewed and updated to ensure their needs were met. People were highlighted as 'Resident of the day' at least once a month. This ensured that all aspects of their care and support needs were reviewed at least monthly and if changes were required a full review of care was implemented.

People and relatives were confident to raise concerns and felt they would be taken seriously and dealt with in a timely manner by the manager. Details of how to complain were held in the 'service user guide' and were provided to people and their relatives when they entered the service. This gave guidance on how to complain and provided contact details for both the provider and the Care Quality Commission (CQC). There had been no formal complaints since the October 2015 inspection.

People were able to spend their day as they chose. One person told us, "I'm in control of my routine. I'm quite content".

People told us they had access to a variety of activities. People's comments included; "Activities are tremendous" and "There are lots of lovely things going on, you don't have to be bored here".

Activities were arranged by the activity coordinator and included a weekly film afternoon, weekly trips out, weekly visits by a hairdresser, weekly visits by a 'Pets as Therapy' (PAT) dog. People who chose to remain in their rooms benefited from one to one activities which included: listening to music; reading; manicures and reminiscence sessions. A notice board in the main entrance showed a full calendar of events for the Christmas and New Year.

People were complimentary about the efforts made for special events. One couple had recently celebrated an important anniversary. The service had hosted a family party and had decorated the conservatory for the event. The couple had clearly enjoyed the event. People were looking forward to Christmas. Family members were invited to spend the day with people. One relative told us, "They really pull out the stops".

The home enjoyed a large, well kept garden with a wheelchair friendly patio area. Furniture was in place for people to sit and enjoy the garden. The service held summer fetes in the garden and we saw photographs displayed in the reception area showing people enjoying the activities. These included games, dog agility, music, gardening and 'creative arts and crafts'.

Is the service well-led?

Our findings

People and relatives were complimentary about the new manager. One relative who had arranged a respite stay for a person told us the manager had been "Very flexible and accommodating with her stay". Another relative told us the management were "Very approachable". The relative told us there had been an on-going issue in a person's room which had never been resolved. The problem had been solved immediately and satisfactorily by the new Manager.

Staff were positive about the new manager and the improvements made. Staff comments included: "[Manager] is very nice. I find him very supportive and we have good communication. I do know what's going on"; "I've no problem with the manager, he's approachable and he listens"; "He's fine, very nice. I feel very confident with him"; "He is sorting things out and we're getting there. He's brilliant, supportive and approachable" and "He listens to any concerns and will take action. He has an open door policy and he's very supportive".

Staff told us there was an open and honest culture and that staff morale had improved. One member of staff said, "Big improvement with the new Manager. There is better staff morale". Throughout the inspection we saw the manager around the home speaking with people, visitors and staff. Everyone was relaxed when speaking with the manager who knew people well.

There were regular staff meetings and daily handovers which ensured effective communication between staff. One member of staff told us, "We share learning at handovers where information is passed on to the next shift. We also have staff meetings. Communication here is good".

There were systems in place to seek feedback about the service and this feedback was used to improve the service. People told us there were 'occasional residents meetings'. Records of one meeting showed that some changes had been made to the menu following feedback from people. There had also been feedback about the carpet in one area of the home. The manager told us there were plans to refurbish this area of the home. The provider carried out an annual survey. The survey for 2016 had recently been sent to people and relatives.

Regular audits were carried out to ensure the quality of the service was monitored and improved. Audits included: Falls; people's weights; care plans; infection control and kitchen. We saw that where actions were identified an action plan was in place. For example, the infection control audits had identified some areas of improvement. The action plan identified when the actions should be completed. We saw the action plan had been reviewed and all actions completed by the identified date. We saw there were monthly medicine audits in place and where issues were identified these had been addressed. For example, the audit had identified an updated guidance book was required. This had been ordered.

At our previous inspection on 21 and 22 October 2015 we identified concerns around people's mealtime experience and food being distributed around the home without maintaining the food at an appropriate temperature. The provider had been made aware of this issue at the last inspection and had not taken

action to ensure the quality of the mealtime experience was improved.

We spoke to the manager at this inspection and they told us they would look at ways to improve people's mealtime experience. Following the inspection the manager provided evidence that two hot trolleys had been ordered. This would enable food to be served to people at an appropriate temperature.

Accidents and incidents were monitored to look for trends and patterns. All accident reports were reviewed by the manager and entered on the provider's electronic system. This enabled the manager to analyse the information and identify any actions to reduce the risk of further incidents. Each incident record identified what actions had been taken. For example, one person had experienced a fall. The person had been referred to the care home support service (CHSS), the person's care plan had been updated and a sensor mat had been placed by the person's bed.

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	Regulation 9 HSCA RA Regulations 2014 Person-centred care
Treatment of disease, disorder or injury	People did not receive food and drink in a way that was person-centred.