Interhaze Limited

The Hunters Lodge Care Centre

Inspection report

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Wolverhampton
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Ratings

Overall rating for this service	Inadequate
Is the service safe?	Requires Improvement
Is the service effective?	Inadequate
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

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, and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

This was an unannounced inspection. This meant that the providers, managers and staff did not know we were visiting. At the last inspection in May 2013 the provider met all the regulations we looked at.

The Hunters Lodge Care Centre is registered to provide accommodation with nursing and personal care to 92 people. The home was undergoing significant refurbishment and currently there were 43 people living in three units. The nursing unit provided care for 20

Summary of findings

people with dementia care needs; the residential unit with 18 people living with dementia and four people were accommodated in the 17 bedded unit for younger people with mental health needs.

The home did not have a registered manager but a new manager had been appointed who was due to put in an application to register with us. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has a legal responsibility for meeting the requirements of the law; as does the provider.

We saw that some people's safety was compromised. Where people may have experienced emotional harm appropriate safeguarding referrals were not submitted. This meant that incidents may not be fully investigated.

Staff who were supporting people whose behaviour challenged did not have the appropriate training to do this safely.

Staff were not always following the Mental Capacity Act 2005 for people who lacked capacity to make a decision. For example, the provider had not made an application under the Mental Capacity Act Deprivation of Liberty Safeguards for one person, even though their liberty was restricted. This meant their rights were not being upheld.

People in the dementia care unit did not have enough to do. In the residential unit particularly staff did not have the time to spend with people to provide them with stimulation to promote their well-being.

Most people received care that took account of their wishes. However the home was not fully taking into account the cultural needs of some people.

Relatives of people living with dementia were satisfied with the standard of care provided. They told us their relative was well cared for and had their health and personal care needs met. They told us that staff were caring, treated them kindly and with respect.

People living in the younger persons unit told us they were happy with their care. They said they were well supported and were provided with choices about their lifestyle.

People were having their health care needs met. They saw the GP when necessary and had access to specialist health care support. People were supported to have their personal care needs met. The nutritional needs of people were identified and where needed a plan was in place showing the support they needed to eat and drink sufficient amounts. People had a choice of food and meal times were a positive experience for people.

Staff were caring and compassionate. We observed that they treated people in a gentle and caring way. People's dignity was promoted and they were spoken with in a respectful manner.

We found seven 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.

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 safe.

Staff were aware of safeguarding issues and acted upon concerns. The provider did not always appropriately refer for investigation incidents of potential emotional abuse. This meant that people may not be protected against abuse.

The provider was not always following the principles of the Mental Capacity Act 2005. This meant that people's rights were not upheld.

People were supported by staff that had gone through a robust recruitment process. Staffing levels were sufficient to make sure that people had their physical care needs met but not to sufficiently engage and interact with people.

Is the service effective?

Inadequate 

The service was not consistently effective.

Staff were not provided with all the training they needed to provide people with appropriate and safe care. This meant that people may not receive care that met their needs.

Relatives told us their family member was well cared for. People were supported to have their healthcare needs met.

People's nutritional needs were assessed and they were supported to have sufficient to eat and drink. People had a choice of meals.

Is the service caring?

Good 

The service was caring

Relatives told us that staff were caring towards their family member. We observed that staff treated people in a kind and compassionate way.

Staff knew about people's likes and dislikes and knew what was important to them.

Relatives told us people were spoken to in a manner that showed them respect. Staff supported people to have personal care in a discreet and sensitive manner.

Is the service responsive?

Requires Improvement 

The service was not responsive to everyone's needs.

Plans of care provided staff with information about each person's needs including their preferences.

Summary of findings

Most people received personalised care that met their health and physical needs. Staff were not responding to the cultural needs of a small minority of people.

Relatives told us that their relative had few things to do. We observed that was some opportunity for people to take part in hobbies and interests but most people in the dementia care units did not have enough to do. People were left for significant periods to sit and walk around without any stimulation.

Is the service well-led?

Requires Improvement 

The service was not well led.

There was not a registered manager in place. A new manager had been appointed and was due to apply to become registered with us.

The systems in place to check and monitor the quality of care were not effective. Where shortfalls in care were identified there was no information to show they had been acted upon to improve the service.

There was an open culture where people felt welcomed and staff felt supported. Relatives had the opportunity to express their views about the service. The home had implemented an approach to care that embedded the values of compassion and care.

The Hunters Lodge Care Centre

Detailed findings

Background to this inspection

The inspection team comprised of 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. The Expert by Experience had experience in dementia care and mental health.

Before the inspection visit we reviewed the information we held about the home. This included looking at previous inspection reports and notifications the provider had sent us. A notification is information about important events which the service is required to send us by law. The provider sent us a provider information return. This is information we have asked the provider to send us to explain how they are meeting people's needs and any plans for improvements to the service.

Prior to visiting the home we spoke with two social care and health professionals. Following our visit to the home we spoke with four relatives.

During the inspection we spent several periods including at mealtimes observing staff supporting people. We spoke with two people that lived in the younger person's unit. We spoke with seven relatives and visitors to the dementia care units. We spoke with the operational manager, the home manager, the unit manager of the nursing unit, the manager of the residential unit and ten care staff members. We looked at six care records including four in detail. We looked at three staff files and other records relating to the management of the service, including complaints and quality audits.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, the inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved for the key question 'Is the service safe?' to 'Is the service effective'.

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Requires Improvement

Is the service safe?

Our findings

Information we held, including notifications we received, confirmed that the provider was referring allegations of physical abuse to the appropriate authority. However, records showed that there were incidents reported by the staff where there was no physical harm but people may have suffered emotional and psychological harm. These were not referred to the local authority. This meant that harm to people may not be appropriately acted upon. Following feedback from the inspection team, the home has altered its practices and has referred incidents when people may have suffered emotional harm.

We saw records that confirmed that there were times when one person was being restrained. Our discussions with staff and a check on training records showed that not all staff had received training to undertake appropriate restraint. This meant that people who were restrained were at risk of harm. The provider was in breach of Regulation 11of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Records and discussions with staff showed that most staff were not trained in the Mental Capacity Act (2005).They had limited knowledge of the act and of the Deprivation of Liberty Safeguards. Senior staff told us that they had received training and the files we checked showed mental capacity assessments were in place for most aspects of people's lives. We saw confirmation that best interest meetings were held where complex decisions were needed.

The manager told us that following the recent high court ruling the home was restricting a high number of people and had put in five applications under the Deprivation of Liberty Safeguard (DoLS). Records showed that one person was being restricted on a regular basis and we were told this had been taking place for a considerable time. The provider told us that an application had been submitted but we later found out this had not happened. We informed the local authority DoLS team about this person and referred this as a potential safeguarding issue. We raised this with the unit manager and they told us they would immediately put in an application. This shortfall meant that the provider was not abiding by the principles of the Mental Capacity Act 2005 Deprivation of Liberty Safeguards and was not upholding this person's rights. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. of the Health and Social Care Act 2008.

During a period of observation on the nursing unit we saw that staff were available to provide people with personal care support. They were busy and had little time to spend talking with people. On the residential unit we observed that staff were extremely busy and care was task orientated. Some people required the use of a hoist to aid their mobility and we observed this was completed one by one in a regimented way. People received their personal care but there was no time for staff to spend with people. Our discussions with staff and with relatives indicated that on both the nursing and residential unit they felt there were sufficient staff to meet their physical care needs but not to engage and interact with people and to provide people with the opportunity to engage in hobbies and interests.

We asked senior staff how they set the level of staffing. We were told there was no system in place and the staffing levels did not take account of the dependency needs of people. The provider could not demonstrate there were sufficient staff on duty to meet people's needs. This meant that the provider did not have appropriate systems in place to assess and monitor that staffing levels were sufficient to provide people with appropriate care. This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Relatives of people on the residential unit we spoke with said they felt confident that their relative was kept safe. One person said; "They manage [person] well. They are safe". Another relative said; "Yes. I feel they are safe there". They were aware that some people's behaviour challenged and they could become aggressive but felt that staff managed this well.

Care staff we spoke with were aware of the different types of abuse and signs that may indicate someone was being abused but most had not had any recent training. They were aware of the actions they should take if abuse was suspected and reported concerns to either the unit manager, the manager or the operational manager.

On the younger person's unit we observed that people were well supported and staff were available to meet

Requires Improvement

Is the service safe?

people's needs. Two people on that unit told us that they were well supported. They said that staff were available to help them to make drinks and to help them to undertake independent living tasks in the unit.

Some people needed support due to behaviour that was challenging. There were comprehensive plans in place that outlined the triggers for individual behaviour and gave clear guidance for staff on how they should respond. Plans were based around distraction and de-escalation techniques that took into account the things people liked to do or talk about. Care staff we spoke with were aware of people's individual plans. One relative told us; "They seem to manage my relative's behaviour. They try and distract them. They take them for a walk". We observed three staff supporting people well. For example we saw an incident when one person became angry towards another person and staff managed this in a calm and sensitive manner that diffused the situation and provided both people with support.

Plans of care demonstrated that the provider was identifying and assessing risks to people. We saw that plans were in place aimed at keeping people safe. These included areas such as eating and drinking, mobility and going out into the community and in the grounds of the home. Risks were regularly reviewed and updated when people's needs changed.

The provider had a safe recruitment and selection process. We saw evidence of completed application forms and formal interviews. There was evidence of pre-employment checks being completed including references from previous employers and disclosure and barring (DBS) checks. The DBS check includes a criminal records check as well as a check on the register of people unsuitable to work with vulnerable people. This meant that the provider was making appropriate checks to make sure that staff were suitable to work at the home.

Inadequate

Is the service effective?

Our findings

Our discussions with staff and records confirmed that staff received induction training when they started working at the home. This included infection control, moving and handling, food safety and fire safety. Some staff had completed some recent training in medication and mental health. However the information both in the provider information return and the home's training matrix indicated that staff had completed minimal training for specific care needs. For example only some staff had completed training in managing behaviour that challenged although staff were supporting people with these needs. One staff member told us they were concerned they had not completed this training but were expected to support people who could exhibit aggressive behaviour. Records showed that only a few staff had completed training in dementia care and in the Mental Capacity Act 2005. This training was particularly relevant to the staff to provide them with the knowledge and skills to provide people with appropriate care. There was no information to tell us how many staff had completed a vocational qualification. This meant that staff were not provided with the training to meet people's needs in an appropriate way. The manager told us that they were aware that staff required training and said this was an area that needed to be improved. This meant that there was a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Staff we spoke with told us and records confirmed that the provider had a system in place to provide people with individual supervision. This gave staff the opportunity to discuss with a senior staff member any concerns they had and to talk about the people they provided care to.

People in the nursing unit and residential units were unable to tell us about their experiences however we did speak to relatives who were available to understand their experience of the care provided. Relatives told us they were satisfied with the care their relative received. They felt that care staff were knowledgeable and provided them with the care they needed. People that lived in the younger person's unit told us they were pleased with their care. They told us they liked the staff and they received the support they needed.

Records we checked, and discussions with staff, confirmed that people's health care needs were met. Most relatives we spoke with were satisfied that their relative had the health care support they needed. One was less happy and had raised concerns with the manager which were in the process of being dealt with. We saw that comprehensive plans of care covered people's health care needs. These were updated and reviewed.

Records showed that people received health care interventions. We saw evidence that people received regular visits from their doctor and that a local GP visited the home twice a week. People were referred for specialist health care support when needed. We also saw that people were supported by community psychiatric services. Records showed that an optician and chiropodist visited the home.

We spoke with two health and social care professionals. They told us they were satisfied with the care provided to the people living in the younger person's unit. They felt that they were well supported and their health care needs were met.

We spent time observing at mealtimes in the nursing and residential units. We observed that breakfast time was flexible and each person had something to eat when they got up. There was a choice of food. We saw some people eating porridge and other people having bacon sandwiches. Our observations showed that lunchtime was a positive experience for people. People had the support they needed to eat their meals. Some people needed meals that were pureed to reduce the risk of choking. We saw these were nicely presented. We spoke with two relatives and they told us they were happy with the quality of the food and were satisfied their family member received sufficient to eat and drink. Two relatives also told us they were welcomed at mealtimes and were able to support their family member to have their meals.

Record we checked showed that people's nutritional needs were assessed. Where necessary, a plan was in place to ensure that people received enough to eat and drink. We also saw confirmation that people were weighed regularly and where their weight changed significantly referrals were made for specialist support. One relative we spoke with said; "(person) has been well looked after. When [person] came here they had lost a lot of weight. Over three months they have encouraged them to eat and have put on weight. (person) is much better now". This meant that people were being supported to have their nutritional needs met.

Inadequate

Is the service effective?

We saw evidence that people had lots to drink. The units had their own kitchen where drinks and snacks could be made. We saw staff providing people with a choice of drinks during the day.

We spoke with two people in the younger adult unit. They told us that they could choose their meals have meals from the main kitchen, food from the kitchen to make their own meals or go to the shops to buy food. They told us that the staff supported them to make their meals. We saw that some people had specific nutritional needs and these were recorded. Staff we spoke with had a good understanding of people's nutritional needs. This meant that people within the unit were provided with a choice of food and were encouraged to develop their independent living skills.

Is the service caring?

Our findings

Relatives we spoke with told us that the staff were caring. One relative said; “They love and care for my relative". Another relative said; “The staff were lovely. Really caring”.

During our observations throughout the inspection we saw that staff were patient and caring. We observed that staff spoke with people in a gentle and respectful manner. There were positive interactions between staff and the people who lived at the home. Within the nursing unit we observed occasions when staff sat with people and spoke with them in a gentle manner and friendly way. We also saw staff holding people’s hands to offer them comfort.

People in the dementia care units were not able to express their views verbally. Staff we spoke with knew about people’s likes and dislikes, their individual needs, and people and things that were important to them. For example one person always liked to look well-presented and staff supported them to wear make-up and nail polish. Their relative said; “Their clothes and make-up are always perfect. Particularly their clothes”. Another person liked holding a soft toy and we saw this was provided. A relative who visited every day said; “The staff know what (person) likes”. This showed that care staff felt that people’s wishes and preferences mattered.

Within the younger person’s unit we observed that there was a relaxed and friendly atmosphere. We saw that there was positive, friendly interaction between staff and the people that lived there. We saw staff took account of people’s views and involved people in decisions about their lifestyle. For example people chose their food, the times they got up and went to bed and how they spent their time. One person told us that they get on with the staff and found them to be supportive.

We saw that people’s privacy and dignity was promoted. One care plan we examined stated; “Be respectful in your approach and not patronising”. We observed that when people needed personal support this was done in a discreet and sensitive manner. One relative said; “I have observed staff supporting people to have their personal care attended to in a manner that was done quietly and without fuss”.

During the inspection we witnessed an incident when one person became angry with another person and saw that staff intervened in a manner that showed the people respect and promoted their dignity. Staff told us, and we saw that they knocked on people’s bedrooms doors before entering.

The home had recently implemented the 6 C’s approach. This is a national approach to providing care that is based on values that include compassion, caring, courage and commitment. Staff we spoke with were enthusiastic about the programme.

Is the service responsive?

Our findings

Relatives and staff told us, and we observed that people did not have enough stimulating things to do. Records confirmed that approximately once a month entertainers came in and there were some trips out. We also saw that a hairdresser visited weekly and there was a religious service every month. Most activities were impromptu and were fitted in between other tasks as staff said they did not have time to organise things for people to do in advance.

On the residential unit we saw that there was nothing available for people to do. We also saw that staff were very busy and had little time to interact with people. Everyone we spoke with said they could not remember when the last time anything had been organised for people to do. On the nursing unit we saw a few people had things to do. For example we observed one staff member throwing a balloon to people and then encouraging people to take part in a sing-a-long. We also saw that there were some objects for people to pick up and handle such as handbags and scarves. Also one person had a doll and another a soft toy. There were some other sensory objects but these were not provided to people during our visit. We were also told that film nights took place. We noticed there were significant periods when people were sitting or walking around with no stimulation. The guidelines of the National Institute of Clinical Excellence (NICE) emphasises that the well-being of people living with dementia is promoted when they engage and interact with other people and have the opportunity to take part in leisure activities. This meant that there was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We also saw that the home was not responding to the cultural needs of a very small number of people. For example one person's plan stated they enjoyed a specific type of food. We were told that the home had not been able to meet this need and the family now brought in food to make sure they had at least one appropriate meal a week. The home also stated that they did not have the facility to provide appropriate hair care for some people. This meant that the care these people received was not taking into account their wishes and preferences. This meant that there was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Six relatives told us they felt that their family member received the personal care and support they needed. They told us that they were involved in reviews about their relatives and in on-going discussions about their care. One relative told us that their family member was recently assessed due to changes in their care needs. They said they had been fully involved in the process to discuss how their relative would receive the additional support they needed.

We saw that plans of care were available to staff that related to all aspects of people's care needs. These were comprehensive and provided information about how each person should be supported to make sure their needs were met. This included people's specific communication needs as well as individual preferences and interests. Records confirmed that plans were regularly evaluated and reviewed. This meant that information about people's needs was kept up to date to enable staff to provide appropriate care.

We saw examples of care that meet people's specific needs and preferences. For example, staff were aware of things that people liked to do. One person was supported to go out for a walk and another person was encouraged to read a newspaper. A relative told us that their family member needed bed rest after lunch due to having a fragile skin and confirmed this was always provided. Another person did not sleep well at night and their relative told us that the staff made sure they were well supported throughout the night and had access to food and drink. We also saw and heard of examples when people's care was not individualised and their individual needs were not met and their wishes not fully taken into account. For example one relative told us there were times when their relative did not wear their own clothes.

In the younger person's unit people chose the activities they wanted to do. One person we spoke with told us they went regularly to the village and was going to the library the following day.

The service had a complaints procedure in place. A record was kept of complaints they received. Our check of records confirmed that these were responded to appropriately. Four relatives we asked told us they would raise any concerns they had. They told us that the staff and the manager were very approachable and felt that concerns

Is the service responsive?

were acted upon. One person told us that prompt action had been taken when they raised a concern about their relative's care. This meant that the home was listening to people's views.

Is the service well-led?

Our findings

We saw that the company had systems in place to review and monitor the quality of the service. This included a range of audits covering medication, health and safety issues, care plans and staff supervision and staff records. We saw evidence that a number of these had been completed and where shortfalls had been identified an action plan had been put in place. When we checked the action plans there was no evidence to confirm that the actions had been acted upon. For example audits had been completed on the environment and on the content of plans of care. The manager was unable to show us that the shortfalls they had identified in care records had been acted upon to improve the care people received. We observed that there was no effective system in place to monitor and check that staff training and staff supervision was completed. The manager therefore did not know which staff had completed the required training. This meant that people's care could be provided by care staff who did not have the necessary training and knowledge to keep them safe.The manager confirmed that this was an area that needed to be addressed. This meant that there was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

We observed that Hunters Lodge had an open culture. Relatives told us they felt welcomed to the home and several visited daily and assisted with their relative's care. One relative visited at different times and told us the unit was no different whenever they visited. They told us that they felt at ease and felt that staff welcomed their involvement. We observed that there were friendly relationships between staff and relatives. Staff we spoke with also said they felt that the manager was supportive and was available to talk with at any time.

As part of the home's 6c's approach to care the manager had recently implemented a monthly award for the staff member who had best demonstrated caring values in their support to people. This meant that the service was keen to improve the quality of care it provided to people.

Relatives we spoke with told us they had the opportunity to complete a satisfaction survey. These had recently been completed but the service had not yet completed an analysis of the outcome. The home was unable to provide us with a copy of the outcome of the previous year's survey. However information in their Provider Information Return stated that previous survey had identified concerns over the quality of the laundry service. They told us they had acted upon this. This meant that they had taken action in response to people's feedback about the service.

The home had no registered manager in post. The current manager was due to stand down and a new manager had been appointed. The operational manager and the current manager told us that they were aware that there were improvements needed to the way the service was led and managed.

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 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	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services People were not protected against the risks of receiving unsafe or inappropriate care because the provider was not ensuring that the delivery of care met people's individual needs and ensured their welfare and safety. The registered provider was not providing care that reflected published guidance by professional and expert bodies as to the good practice in respect of people with dementia care needs. **Regulation 9(1)(b)(ii)(iii)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People were not protected against the risk of unsafe or inappropriate care because the provider did not have an effective system in place to regularly assess and monitor the quality of the service. **Regulation 11(1)(a)(b) & (2)(a)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse The registered person must make suitable arrangements to make sure that people are safeguarded against the risk of abuse by identifying the possibility of abuse and responding appropriately to any allegation of abuse.

This section is primarily information for the provider

Action we have told the provider to take

	Where any form of control of restraint is used the provider must have suitable arrangements in place to protect people against the risk that such actions are unlawful or excessive. **Regulation 11(1)(a)(b) & (2)(a)(b)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010 Respecting and involving people who use services The provider must have suitable arrangements in place to ensure that people's care takes account of their cultural needs. **Regulation 17 (2)(h)**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment The registered person did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users in relation to the care and treatment provided for them in accordance with the Mental Capacity Act 2005 and the Deprivation of Liberty safeguards. **Regulation 18**

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person did not have suitable systems in place to ensure there were sufficient numbers of suitably qualified, skilled and experiences persons employed. **Regulation 22**

Regulated activity	Regulation

This section is primarily information for the provider

Action we have told the provider to take

Accommodation for persons who require nursing or personal care	Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff The registered person did not have suitable arrangements in place to ensure that staff received appropriate training to deliver care and treatment safely and to an appropriate standard. **Regulation 23(1)(a)**