Care Quality Commission

Avery Homes Hinckley Limited

Hinckley 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?	Good
Is the service well-led?	Requires Improvement

Overall summary

We carried out our inspection on 12 May 2015. The inspection was unannounced.

The service provides accommodation for up to 60 older people. The service is located in a residential area of Hinckley. Hinckley House is a modern purpose built residential care home. Accommodation is on three self-contained floors. Each has a dining room, lounges and communal areas. The home has landscaped gardens. At the time of our inspection 50 people were using the service.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run. A registered manager left the service in March 2015. Interim management arrangements were in place pending the appointment of a newly recruited registered manager.

Summary of findings

Staff understood and put into practice the provider's procedures for safeguarding people from abuse and avoidable harm. People using the service knew how to raise concerns. The provider was recruiting staff in order fill vacancies and address issues caused by under-staffing by permanent staff. People usually received their medicines at the right time. The provider had effective arrangements for the safe management of medicines.

People using the service were supported by staff who had received relevant and appropriate training. Staff felt supported through effective training but they had not had regular supervision. Senior staff understood the relevance to their work of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, but care workers we spoke with had only a basic awareness of the legislation.

Staff supported people with their nutritional needs. However, as a consequence of a lift being out of order, people on the second and third floors were not provided with the same quality of meals as people on the ground floor during a two week period.

People were supported with their healthcare needs and could access healthcare services when they needed them. However, during the period the lift was out of use two people's hospital appointments were cancelled because staff believed it was unsafe to attempt to transfer people to the ground floor. One of those cancellations was unnecessary.

People using the service told us that staff were considerate and caring. People were able to enjoy a variety of meaningful activities that reflected their hobbies and interests. People were usually supported by care workers who understood their needs, but we saw agency care workers who were not fully attentive to people's needs. People were involved in the assessments of their needs and in reviews of their plan of care. People were provided with information about their care and support options and were involved in decisions about their care and support. Care worker's respected people's privacy and dignity but we saw an instance of an agency care worker who hadn't done so.

People's plans of care were centred on their specific needs. Those plans had agreed aims and objectives which care workers helped people to achieve. People knew how to raise concerns if they needed to. People we spoke with were very pleased with the care and support they had experienced.

The provider had effective procedures for monitoring and assessing the quality of service that promoted continuous improvement. The provider had managed the impact of the lift being out of use and scale of disruption to service was less than it might otherwise have been. However, the absence of continuous and consistent management had been felt by staff. The management team were not fully aware of some decisions care workers and other staff had taken, for example cancellation of a person's hospital appointment and that people on the upper floors were served improvised meals.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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.

Staff were aware of their responsibilities of how to keep people safe and report concerns.

Sufficient staff were not always available or deployed appropriately to meet people's needs.

People received their medicines safely.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had received relevant training and development to be able to meet the needs of people using the service, but care workers had limited awareness of the Mental Capacity Act and Deprivation of Liberty Safeguards. People were supported to maintain their health and access health services when they needed to, but during a period of over two weeks when a lift was out of action people on the second and third floors were supported to attend only urgent hospital and other appointments.

Is the service caring?

Requires Improvement

The service was not consistently caring.

Permanent staff understood people's needs and developed caring and supportive relationships with people. However, agency care workers were not as attentive to people's needs. People were encouraged to express their views and be involved in the planning and delivery of their care.

Is the service responsive?

Good

The service was responsive.

People received care and support that met their individual needs. Staff supported people to lead active lives based around their hobbies and interests. The provider sought people's views and acted upon their views.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

At the time of the inspection the service did not have a permanent registered manager. People's views and experience were used to develop the service but staff had fewer opportunities to do so. The provider had procedures for monitoring and assessing the quality of the service and managing temporary difficulties but actions identified by them had not always been carried out as planned.

Hinckley 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.

The inspection took place on 12 May 2015. The inspection was unannounced.

The inspection team consisted of an inspector and an expert by experience (ExE). An ExE is a person who has personal experience of caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also looked at information we held about the service.

We spoke with eight people who used the service at the time of our inspection and relatives of five other people. The interim manager of the service was away but we spoke with the service's regional manager, a senior care worker and two care workers. We looked at the care records of four people who used the service, information about training that staff had attended and documentation from the provider's quality monitoring processes.

Is the service safe?

Our findings

People told us they felt safe. A person told us, "Yes I feel safe the staff here are alright." Another person told us, "I feel safe because the staff are kind." However, people also told us that at times they had to wait for a long time before staff attended to their needs. A person told us, "Sometimes it takes a long time for them [staff] to respond when I call them [using call alarm]." Another person told us they felt that not enough staff were available. A relative told us they felt there were enough staff were available and explained, "I've not seen anything happen to suggest there are not enough staff." However, a relative of another person told us their parent had been quite distressed when having to wait for their bedtime medication recently. They said their parent went to bed at 8pm and rang for their tablets several times but did not have his medicines until 10pm.

Early in our inspection we learned that only seven of the expected 10 staff were on duty. One had left due to feeling unwell and two had not arrived for work. Staff we spoke with felt that not enough staff were available. One expressed their concerns about a lack of staff on shift, saying, "One gentleman is still in bed and I haven't finished the medications yet." Another told us they were unable to do their usual job due to the lack of staff. We found that a medication round that should have been completed by 11.15am had still not been completed an hour later because staffing resources were so stretched. That delay had not compromised people's health but they had not had their medicines at times they expected. Staff told us that one person who required support of two staff had waited two hours to receive routine personal care because not enough staff were available.

Another person who liked to be supported to get up by 10.30am each morning waited until 10.50am before they were helped. Staff we spoke with told us that while staffing issues were particularly acute on 12 May and that the extent of the staffing situation that day was not typical, staff shortages were a regular occurrence. One employee told us, "It [staff shortages] happens quite often. There are not enough staff. Sometimes there are more agency staff than permanent staff." Another employee told us, "Yesterday [11 May 2015] four people had to have breakfast in bed because there were not enough staff to get them up." A relative told us, "The last time I was here, I had a bad taste about the place, no staff when I visited, just like today. What if [person using the service] wanted to go to the toilet, no one is around." We saw from a record of a relatives meeting that relatives had raised concerns about staffing levels. This showed that staffing issues were not isolated to the day of our inspection.

Before we arrived for our inspection arrangements were made to bring in care workers from another home and agency staff were brought in. However, for the greater part of the morning only seven care staff were available to provide care and support for 50 people. People's personal care and support had been delayed as a result. After sufficient care staff were on duty later in the day we saw care staff spending time washing dishes after people had their lunch. A relative of a person using the service told us, "When staff are in the lounge they seem more interested in the dishes than people." At 2.35pm we saw that a person was asleep in an armchair but their movement was restricted because a meal tray with unfinished lunch was still positioned over their upper legs. Care staff had not been effectively deployed to meet people's needs and provide appropriate support such as checking that people were comfortable.

At the time of our inspection the service had 12 unfilled vacancies. The regional manager told us that the service was in the process of recruiting additional care staff to fill those vacancies. Five new care workers were expected to join the week after our inspection. However, during our inspection we found that there were not sufficient numbers of staff to meet people's needs.

These issues and others described later in this report were a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People felt secure at Hinckley House. A person told us, "I am secure and my belongings are safe." Another told us, "I feel safe and comfortable when staff provide my personal care." However, when we arrived for our inspection we were able to access the home without waiting to be allowed inside. The reception area was unstaffed. We could have accessed any area used by people using the service. Later in our inspection we saw a visitor walk straight into the home during a period the reception was again unstaffed. The security of the home was therefore lax on the day of our inspection.

Staff we spoke with had an understanding and awareness of abuse. They were able to describe what signs they

Is the service safe?

looked for to identify abuse. For example, they were alert to changes in a person's mood and behaviour and if they identified any bruising or injury they reported it using the provider's safeguarding procedures. Staff we spoke with told us they were confident that any concerns they raised would be taken seriously and acted upon. Staff knew how they could report concerns through the provider's whistleblowing procedures or to external agencies including the local authority and Care Quality Commission.

People's plans of care included assessments of risks associated with their care and support. This meant staff were aware of how to support people safely. We saw staff using equipment to support people with their mobility and they did so safely. Risk assessments were reviewed if people had accidents. The reviews identified why accidents had occurred and actions were taken to reduce the risk of similar incidents happening again. For example, staff increased the frequency of observations they made of people who were at risk of falls.

The premises were maintained to ensure the safety of people using the service, visitors and staff. The provider had ensured that hoists and other equipment had been serviced and maintained. The service's lift was maintained by the manufacturer, but at the time of our inspection the lift had been out of use for a week and was expected to be out of use for up to a further week and a half. The provider had arranged for chair lifts to be installed on stairways. However, it was apparent that people requiring the assistance of a hoist would not be able to access the chair lifts and therefore would have to remain on the second and third floors until the lift was repaired. This meant that there were temporary restrictions on people's freedom of movement because they could not leave the floor they lived on, for example to use the garden or to socialise with other people on other floors.

The provider had effective recruitment procedures. People using the service and their relatives could be confident that staff employed were suitable to work in the service. Applicants for positions at the service underwent a rigorous selection process. Successful candidates did not start work until all required pre-employment checks had been successfully carried out.

When we spoke with people about their medicines they told us they had their medicines on time. We found that had not been the case on the day of our inspection because of staffing issues. Only staff who were trained in medicines management gave people their medicines. Staff made accurate records of medicines that had been administered. The provider's arrangements for ordering medicines and safe storage and disposal of medicines were effective.

Is the service effective?

Our findings

People using the service told us that they felt staff understood their needs most of the time. However, a person using the service told us, "The staff don't always understand what I need. They don't always understand why I find it difficult to move." A relative of another person told they felt staff were well trained to understand the needs of her mother, they added, "I can't praise them too highly." Our observations were that permanent staff were better informed about people's needs than agency staff were.

The Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) exist to protect the rights of people who lack the mental capacity to make certain decisions about their own wellbeing. These safeguards are there to make sure that people in care services are looked after in a way that does not inappropriately restrict their freedom. A person should only be deprived of their liberty when it is in their best interests and there is no other way to look after them, and it should be done in a safe and correct way. Senior staff had a good awareness of MCA and DoLS. Care workers had training about MCA and DoLS but two care workers we spoke with could not explain what the relevance of the MCA was. They both told us they had "never heard" of the DoLS. Both were aware, however, that any form of restraint could only be used if legally authorised. After we discussed with the regional manager what staff had told us, refresher training about MCA and DoLS was scheduled to take place for staff in the remainder of May and in June 2015.

We saw a record made by staff which highlighted that they did not understand about consent and use of restraint. The record was of an incident that occurred six weeks before our inspection. In it staff wrote that a person screamed and shouted whilst being transferred by hoist so they could receive personal care. Staff recorded that `we carried on regardless of the situation.' That person's capacity to consent use of the hoist had not been assessed. This meant that staff had not acted in accordance with the requirements of the MCA. After we brought this to the attention of the regional manager immediate action was taken to arrange a DoLS application so that whether the use of a hoist to transfer the person was in their best interests.

These matters were a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff told us about the training they'd had and training records we looked at confirmed what they told us. They told us they had found the training helped them to carry out their roles and responsibilities. A care worker told us, The training was good. It went into a lot of depth. It's helped me do my job." Another care worker told us about the induction training they had. They told us it included training about how to support people with their mobility. That was important as many people using the service required such support.

All care staff we spoke with told us that they felt well supported through training but that they had not had regular supervision and annual appraisal meetings. One care worker told us, "I've not been told anything about supervision meetings." Supervision meetings are intended to provide staff with support in the form of one to one discussions with their line manager where they can discuss their role and performance, including any concerns. The regional manager told us that supervision and appraisal meetings were in arrears because of the temporary absence of a permanent registered manager.

Staff exchanged relevant and appropriate information about people they supported. Staff exchanged information verbally at `handover' meetings that occurred in between shifts. They also used a handover sheet in which information about people's care and welfare was recorded for staff to refer to. Staff communication about people's needs meant that people experienced a continuity of care irrespective of which care worker supported them.

People using the service told us they enjoyed their meals. One person referring to the lunch they had told us, "There is not much choice, but I like what I had." People normally had a wide choice of meal. However, since the home's lift was out of action people with accommodation on the second and third floors of the building had limited choice. That was because there was no suitable equipment in which to carry hot meals (and preserve hot food temperatures) from the ground floor kitchen. Warm food carriers were ordered and arrived on 19 May 2015, two weeks after the lift was first out of use. Whilst people's meals on the ground floor were unaffected by the situation, people upstairs had soup and a sandwiches to choose from. People that required hot soft food were taken that

Is the service effective?

food in thermos flasks as a temporary measure until the correct type of containers were delivered. People using the service on the upper floors were informed why their food choice was temporarily limited.

People's care plans included details of their nutritional needs. People's food and drink intake was monitored using a nutritional screening tool called MUST. This is used to identify people who are at risk of under nutrition or obesity. One measure is to weigh people. We saw from a record that a person had lost 4% of their body weight in the space of a month after maintaining the same weight for 15 months. Their weight loss was recorded but the MUST record was inaccurately completed and consequently no action was taken until we brought the matter to the regional manager's attention to identify the reason for weight loss and appropriate response.

We saw from records that people were supported access health services in the period before our inspection. Staff had arranged for a doctor or a nurse to visit people when they required medical attention. A doctor who visited the service at the time of our inspection told us that staff were attentive to people's health needs and acted on advice they had given staff.

The situation with the lift meant that there was no safe way of transferring people with limited mobility from the second and third floors to the ground floor. Those people could not access the garden or meet people from the other floors. Ordinarily, when the lift was in use, people were supported to attend hospital and similar appointments with at a variety of health services. However, two people with bedrooms on the upper floors had hospital appointments cancelled because staff felt they could not be moved safely to the ground floor. However, one of those people could, with support, have used the chair lift. Their relative told us they had become anxious because of the appointment had been cancelled.

Is the service caring?

Our findings

People using the service told us that staff were caring. A person told us, "The staff are very friendly." Another person said, "It's like home here." We spoke with a person who said that it was important to them that they attended faith services when they wanted. They told us that staff supported them to do that. This showed that staff helped people to feel they mattered.

A relative of a person using the service told us, "Staff are attentive and responsive; I can't praise them too highly". They added, "[Person using the service] has everything they need." Our observations were that staff employed by the provider were mostly attentive to people's individual needs. They provided care and support in a more caring and considerate manner than agency staff we saw. For example, permanent staff were attentive to people's comfort and they engaged in meaningful conversations with people. They could do so because they understood people's needs and were familiar with people's care plans. By contrast, although agency staff supported people with kindness and consideration they were more task-orientated. For example we saw an agency worker patiently support a person from a dining area to their room where they helped them sit comfortably, but they omitted to ensure that the person's drinks were within easy reach. The provider was recruiting more permanent staff with a view to ending reliance on agency workers.

The quality of care was compromised by the shortage and deployment of staff. During the afternoon on at 2.45pm we saw three people were still seated at the tables were they had eaten lunch which they had finished an hour before. One was resting on the table and asleep. Two staff were in the room, one loading a dishwasher whilst another wrote notes. A person in an armchair called out, "I want the toilet" a few times but none of the staff acknowledged them. Another person appeared confused. They said, "Could you help me I don't seem to have had anything to eat. I would like a cup of tea, can't remember the last time I had one. No one has done my hair." No staff reassured them because they were pre-occupied with other work.

People using the service and relatives who were affected by the situation with the lift were told what the impact would be. People we spoke with on the second and third floors tolerated the situation. People and relatives were involved in decisions about their care and support. A person using the service told us they knew they could discuss their care plan with staff. A person's representative told us, "My friend has been here two weeks, she has settled really well, as she has no family we were involved in her care. No problems, no concerns."

People's privacy was respected. The last survey of people who used the service showed that people felt staff respected their privacy. Staff only entered people's rooms after knocking and being invited in. Staff knew which people liked to spend time alone reading, listening to a radio or watching television. Those people were not disturbed by staff, although staff made discrete observations to ensure they were comfortable. However we did see an agency worker wake a person by tapping on the person's leg to ask if they wanted a drink. The person reacted with alarm to the agency worker. This was another illustration of how agency staff were less aware of how to treat people with courtesy and dignity.

We discussed with the regional manager the differences between permanent staff and agency staff. They immediately took steps to ensure that in future agency staff were informed of the standards of care expected of them.

People's relatives were able to visit without any undue restriction. The visitor's signing-in book had many entries that showed relatives visited throughout the day. Receiving visitors was important to some people. They told us that they looked forward to visits from their relatives.

Is the service responsive?

Our findings

People using the service contributed to the assessment of their needs but those we spoke with hadn't contributed to the planning and delivery of their care. They told us they left such matters to their relatives. One person told us, "My sons and daughters keep an eye on things" which was representative of what five other people told us. A relative we spoke with told us they had been involved. They had made suggestions to staff about how to support their mother, for example to provide cutlery that was easier for her mother to use, which staff had acted upon. They knew they could attend residents / relatives meetings to discuss more general things about the service. Another relative we spoke with knew about the meetings. They told us, "There are residents / relatives meetings; the minutes are on the notice board." We saw that to be the case. Relatives found out about the meetings from information that was posted on notice boards. Few relatives attended the meetings, but those that had made suggestions that were acted upon. For example, relatives asked if they could have a session to inform them about dementia. The acting manager was in the process of arranging one.

We discussed the low attendance at residents / relatives meetings with the regional manager who told us that in future, all relatives would be invited by letter to the meetings as they thought more might attend.

People using the service told us they knew they could give their views or express concerns to staff and the manager if they wanted to. A person told us, "I know it's a good idea to speak with staff [about how they support them] because they might better understand me." They felt that at times staff did not appreciate why they found it difficult to move their arms, for example when they wanted to reach things. We saw that to be the case when an agency worker did not place a drink within the person's reach. They told us would tell their daughter if they had any concerns.

People were supported to follow their interests and take part in social activities. A few days before our inspection the service's activities co-ordinator had arranged for animals to be brought to the home which people told us they enjoyed. Other recent social occasions included Victory in Europe commemorations. People participated in flower arranging sessions, quizzes, sing-a-long sessions with entertainers who visited the service. Aromatherapy sessions, coffee mornings, film nights and day trips out had been taken place. On an individual level, the activities co-ordinator supported people with activities that interested them, for example reminiscence sessions were they spoke with people about their past and things that were of interest to them. People with faith needs were support to attend faith services. We saw people playing games, reading newspapers and having conversations with other people and staff. Most social activities took place on the ground floor which meant that people on the second and third floors had not been able to attend and participate because of the situation with the lift. The activities co-ordinator had tried to arrange activities on the upper floors but their time to do so had been restricted because they had spent more time supporting people with personal care during periods when fewer staff than required were on duty. That meant people who had been used to activities had not had as many during the period the lift was out of use.

The provider sought relative's views through survey cards. We saw an analysis the results of the most recent survey which had been carried out in May and June 2014 and in which 15 people out of 29 participated. The results were positive. Most respondents said their personal needs were met, though a very small number rated that aspect of their care and support as poor. Similarly, most people enjoyed the activities, but some thought they were poor.

People and relatives we spoke with knew how they could raise concerns or make complaints. The provider had a complaints procedure which had been used. The procedure had clear aims and objectives of focusing on how to improve the service. However, the last survey of people using the service showed that 20% of people were not aware of the complaints procedure.

Complaints were investigated by the manager. We saw that the regional manager had on occasions been involved in complaints resolution and had spoken or met with the person making the complaint. Complaints we saw were thoroughly investigated and we saw that action had been taken arising from complaints, including disciplinary action where appropriate and the re-training of staff.

Is the service well-led?

Our findings

People using the service had opportunities to be involved in developing the service through participation in surveys and residents / relatives meetings. Some people had participated in the most recent survey. People told us that they felt comfortable about making suggestions and that they had been listened to, for example in relation to the types of activities provided. A relative told us, "We are able to give our views at relatives meetings and at any time we visit."

Staff were supported and encouraged to raise concerns about what they felt to be poor or unsafe practice. Staff we spoke with told us they were confident about both raising concerns and that their concerns would be taken seriously. The provider had a whistle-blowing procedure that staff were aware of and knew how to use. Staff rooms had notice boards with information about how staff could raise concerns directly with the local authority safeguarding team, the police and us. Staff we spoke with told us they knew how to raise concerns with those bodies.

Staff meetings took place were staff had opportunities to raise concerns or contribute ideas for the development of the service. However, some staff we spoke with felt that their concerns about low staffing levels and the impact it had on them had not been taken seriously. For example, staff felt that low staffing levels meant they could not meet people's needs.

The service had not had a permanent registered manager in place since March 2015. However, an experienced registered manager of another service operated by the provider managed the service three days a week from 9 March 2015. They were supported by a full time deputy manager. A new permanent full time registered manager was expected to start in June 2015.

The interim management team were aware of the responsibilities of a registered manager. They had ensured that we were kept notified of events at the home and they had made the necessary statutory notifications to us. The team had put an action plan in place to manage what had become an escalating challenge caused by the lift being out of action. The plan was adapted to meet changing circumstances and this had meant that the disruption to the quality of services had been kept to a minimum after a difficult first few days.

The management team and staff at all levels had taken reasonable action to mitigate the temporary loss of the lift. Chair lifts were installed for people and visitors who could use them. Risk assessments had been made of the impact of the lift being out of action and staff had improvised how people were provided with meals for a few days until warm food containers were delivered. However, the management team were not fully aware of how staff had responded to some of the challenges brought about by the lift being out of use.

The management team kept people using the service and their relatives informed of events that affected the service. For example, all relatives had been sent a letter that explained about lift being out of action and what was being done about it.

The provider had procedures for monitoring and assessing the quality of service. Each month the manager sent a report to head office reporting on a wide range of aspects concerning the service. The manager's reports were subject to critical and objective scrutiny by the regional manager. Parts of the quality assurance were in arrears. For example an action plan to address areas that had been identified as requiring improvement from the 2014 survey of people who used the service had not been developed. In addition, staff supervision and appraisal which provided staff with formal opportunities to contribute to the development of the service were also in arrears. However, plans were in the process of being developed address those matters.

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	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not being met. The service had not deployed suitably qualified, competent, skilled and experienced staff to meet people's care and treatment needs.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met. The service had not ensured that people's consent had been sought or where they lacked capacity to give consent that staff acted in accordance with the Mental Capacity Act 2005.