Barchester Healthcare Homes Limited

Henford House

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?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Henford House is registered to provide nursing care to 58 people. The home is a detached, two storey building set in its own grounds on the outskirts of Warminster. At time of our inspection, 44 people were living at the home.

The inspection was unannounced and took place on the 13 and 14 December 2016.

The service had a registered manager who was responsible for the day to day running of the home. 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 told us they felt safe living at Henford House and were happy with the care they received. Relatives told us the home was friendly and welcoming.

Systems were in place for the storage, administration and disposal of medicines; however the ordering and delivering of prescriptions were not completed in a timely way. This meant some people's prescribed medicines were not available.

Where people did not have the capacity to make the decisions themselves, mental capacity assessments were in place and records showed that decisions had been made in line with best interests, however we found mental capacity assessments were not always decision specific.

We have made a recommendation that the service seek advice on the implementation of the MCA 2005.

There were sufficient staff to meet people's basic care needs; however people who remained in bed or their rooms did not receive much interaction from staff, other than care provision. This increased the risk to their emotional well-being and social isolation.

Staff had the knowledge and confidence to identify safeguarding concerns and act on them to protect people.

Care records showed that people's individual needs were assessed before admission into the home and where risks were identified appropriate guidance was in place to minimise potential risks.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals.

The provider had quality monitoring systems in place. Accidents and incidents were investigated and

discussed with staff and at team meetings to minimise the risks of reoccurrence.

Arrangements were in place for keeping the home clean and hygienic and to ensure people were protected from the risk of infections. During our visit we observed that bedrooms, bathrooms and communal areas were clean and tidy and free from odours.

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 always safe.

There was sufficient staff to meet people's basic needs, however people's emotional well-being needs were not always met.

People were kept safe by staff that recognised the signs of potential abuse and knew what to do when safeguarding concerns were raised.

Systems were in place for the storage, administration and disposal of medicines; however people's prescribed medicines were not always available.

Risks to people's safety had been assessed and plans were in place to minimise these risks.

Is the service effective?

Requires Improvement

This service wasn't always effective.

Staff told us they received training and support to provide people's care effectively.

People had sufficient to eat and drink to maintain good health and were supported to have their health care needs met.

People were supported to make choices and decisions about their daily living. Mental capacity assessments where people lacked capacity to make certain decisions, were not always decision specific.

Is the service caring?

Good

This service was caring.

People were treated with kindness and compassion in their day to day care and support.

Staff knew the people they were caring for including their preferences for how they would like to receive care.

People and their relatives were given support when making decisions about their preferences for end of life care.

Is the service responsive?

Requires Improvement

This service was not always responsive.

People and/or their relatives said they were able to speak with staff or the managers if they had any concerns or a complaint. Most people were confident their concerns would be listened to and appropriate action taken.

People had care plans that detailed how they would like to receive care and support. Care plans were reviewed but people's involvement in the reviews was not always evident.

Changes in people's health and care needs were not always consistently shared during handovers.

People were encouraged and supported to take part in activities within the home. There were limited opportunities for people going on outings and people who remained in their rooms were at risk of social isolation.

Is the service well-led?

Requires Improvement

This service wasn't always well-led

The registered manager had a vision to improve the service further and to integrate the service more with the community.

Management systems were used to regularly review the service and identify where to prioritise action; however the registered manager relied on the provider and deputy manager for quality assurance and completion of internal audits.

Most staff felt supported by the management team and could raise concerns and seek guidance.

Henford House

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.

We carried out this inspection over two days on the 13 and 14 December 2016. The first day of the inspection was unannounced. One inspector and two experts by experience carried out this An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before we visited, we looked at previous inspection reports and notifications we had received. Services tell us about important events relating to the care they provide using a notification. We reviewed the 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 used a number of different methods to help us understand the experiences of people who use the service. This included talking with 14 people and 14 visiting relatives about their views on the quality of the care and support being provided.

We looked at documents that related to people's care and support and the management of the service. We reviewed a range of records, which included four care and support plans, daily records, staff training records, staff duty rosters, personnel files, policies and procedures and quality monitoring documents. We looked around the premises and observed care practices.

We spoke with the registered manager, deputy manager (clinical lead), three care staff, an agency nurse, housekeeping staff, staff from the catering department, maintenance and the activities coordinator. We received feedback from one health and social care professional who worked alongside the service.

Requires Improvement

Is the service safe?

Our findings

People we spoke with told us they felt safe living at Henford House and staff were always available to help them. Comments included "Yes I feel safe, never really thought about being safe", "Yes I do, the staff make me feel safe and I like X who helps me with my gardening." and "Oh yes. Very safe. There's always help, the staff are so good." One relative said "most of the time they felt X [family member] was safe but often no staff are visible and then had concerns."

The service used its 'dependency indicated care equation' form (DICE) to work out nursing and care staffing levels. There were sufficient staff to meet people's basic care needs; however people who remained in bed did not receive much social interaction from staff, other than care provision. This increased the risk to their emotional well-being. Speaking with relatives they said "There are not really enough staff, they always seem to be rushing around and because of the wait for two carers to be available together to assist X it can be quite a long time." And "Y doesn't wear a call button; he wouldn't know what to do with it anyway, so how does he call for help when he needs it if I'm not here. It relies totally on staff coming in and visiting and I don't know if that happens. I do worry about what happens when I'm not here." We saw records kept about people's emotional well-being were only reflected for those involved in activities and didn't record those who declined or were unwell.

Staff had the knowledge and confidence to identify safeguarding concerns and act on them to protect people. They had access to information and guidance about safeguarding to help them identify abuse and respond appropriately if it occurred. Staff told us they had received safeguarding training and we confirmed this from training records. Staff were aware of different types of abuse people may experience and the action they needed to take if they suspected abuse was happening. They said they would report abuse if they were concerned and were confident senior staff in the organisation would listen to them and act on their concerns. Staff were aware of the option to take concerns to agencies outside the service if they felt they were not being dealt with.

Care records showed that people's individual needs were assessed before admission into the home and where risks were identified appropriate guidance was in place to minimise potential risks. For example, the provider had carried out assessments in relation to falls prevention, malnutrition and the safe moving of people. Personal emergency evacuation plans had been completed for people using the service. Staff explained that where risks had been identified assessments still promoted people's independence whilst maintaining their safety.

When people had accidents, incidents or near misses these were recorded and monitored to look for developing trends. We observed staff responding quickly when a person had a fall during our inspection, however there was about a ten minute delay in supporting the person off the floor as staff could not allocate a hoist.

Safe practices for storing medicines were followed. All medicines were stored safely and in a locked cupboard and fridge, and disposed of safely in a locked returns box when no longer required. Where people

were prescribed medicines to be taken 'as required', there were clear procedures in place to inform staff when they should support the person to take the medicine.

We reviewed the MAR (medicines administration record) for people and saw that they were mostly being completed properly and signed by the competent person administering the medicines. However, we found that for a new admission, the person had not received some of their medicines for two days and there were gaps on the MAR sheet, which staff did not seem to be aware of when questioned. There had also recently been another medicine error, which the clinical lead was investigating. We found there were concerns regarding prescriptions being ordered and delivered in a timely way, which meant some people did not have their prescribed medicines available. For example creams and convenes ran out, increasing people's risk of skin breakdown. A relative told us their family member's skin condition flared up after their creams had run out. A relative said "X has to be creamed twice a day but the creams are not always replaced and so they run out - this has happened a few times. We are checking all the time to make sure things are there for him - but is it really our job, shouldn't the home be doing this." The clinical lead told us this had been a historical complaint and they now ensured they had a large supply available.

Where the GP had made changes to medicines during their weekly round, these changes were not effectively communicated during handover, which increased the risk of medicine errors occurring. For example where the dose of a person's medicines was lowered, the nurses supporting that person continued to administer the higher dose causing the person confusion. We discussed these concerns with the clinical lead, who informed us they were aware of these concerns and were looking at ways of improving communication during handovers across all staff. Communication books were in place in the nurses stations and daily diaries were used and encouraged for passing on information. They had already started using an online system, which enabled them to order prescriptions online as well as sending messages to GP's. This provided a more stream lined system for the management of medicines and ensuring the delivering of prescriptions in a timely way.

The service had maintenance systems in place to monitor the premises and equipment, for example testing of fire alarms weekly and monitoring of equipment such as hoists and standing aids. The maintenance manager told us they were also responsible for checking water temperatures, thermostats and general maintenance of the home. We found that wheelchairs, which were provided by people and not the service, were not included in the maintenance. This meant that the safety of the wheelchairs was not checked, for example we found one person's wheelchair had defective brakes with only one side working. This increased the risk of an accident occurring especially as the hand brake on both sides was not working either.

We found that some fire doors were left open, while it was labelled to keep the door shut and closed at all times. One of these doors was for a kitchenette, which the registered manager explained was used by the people and if the door was shut, they would not be able to access it. The registered manager explained that in case of a fire, the door would automatically close. Since our inspection the registered manager had taken action and changed the signs to "fire door, keep clear" and had ordered more signs for the rest of the Home to be placed in appropriate areas. Another door for a linen cupboard was also unlocked, while clearly labelled it should be closed and locked at all times. The registered manager told us they did not have a key for this door, but would be discussing this with maintenance. Other doors to the maintenance room and hair salon were unlocked at times, which meant people could have free access to equipment, increasing the risk to their safety. Since our inspection the registered manager had taken action and changed the signs to "fire door, keep clear" and have ordered more signs for the rest of the Home to be placed in appropriate areas. The door to the linen cupboard now had a key to be locked and the maintenance team ensured they locked their office door when they were not in the room. All equipment in the hair salon was put out of reach.

We saw safe recruitment and selection processes were in place. We looked at the files for four of the staff employed and found that appropriate checks were undertaken before they commenced work. The staff files included evidence that pre-employment checks had been made including written references, satisfactory Disclosure and Barring Service clearance (DBS) and evidence of their identity had been obtained. The DBS helps employers to make safer recruitment decisions by providing information about a person's criminal record and whether they are barred from working with vulnerable adults. Records seen confirmed that staff members were entitled to work in the UK.

We found the service to be clean and homely. Staff were able to explain how standards of cleanliness were maintained and cleaning schedules were in place to record that all areas of the home were being cleaned.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (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 legally authorised under the MCA. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS).

We found that where people were not able to consent to a specific decision, the service had completed capacity assessments and recorded best interest decisions. For some mental capacity assessments it was not always clear what the decision related to, for example a decision to consent to living at Henford House while the discussions were around consenting to the administering of medicines. The registered manager had identified a number of people who they believed were being deprived of their liberty. They had made DoLS applications to the supervisory body and were awaiting assessment.

Some people had given others lasting power of attorney (LPA) in relation to either their finances or their care and welfare. This gave them the power to take decisions on behalf of the person if they lacked mental capacity. The service had obtained details of LPAs where people had them, however this was not consistently recorded in people's care records.

Staff told us they had the training and skills they needed to meet the needs of the people they were supporting. New members were supported to complete an induction programme when they started working at the home and were able to shadow more experienced members of staff before working independently. There was a training matrix in place which recorded the training staff had completed and staff said they were supported to refresh their training as required. Training undertaken by staff included safeguarding of vulnerable adults, fire safety, infection control and moving & handling.

Staff told us they received regular supervisions (one-to-one meetings) which supported them in their role. The registered manager told us not all staff had received an annual appraisal yet, but they are in the process of completing these. There was a matrix in place which detailed when staff had received their supervision. These meetings were used to discuss progress in the work of staff members; training and development opportunities and other matters relating to the provision of care for people living in the home. These meetings would also be an opportunity to discuss any difficulties or concerns staff had.

Most people we spoke to were complimentary about the food. Comments included "The food is very nice and I get a good choice.", "Yes food is acceptable and I get a choice and if I don't like it they will find something else for me to eat." and "The food is good to eat. Yes usually we get a good choice. If I got hungry at night I think you can always get a sandwich." Some people felt the portion sizes were small. They said "Food here is poor. We get small amounts and the food is very bland.", "The food is a bit sparse and portions on the small side but some of the meals are what I would choose." And "The food is enjoyable but quite

small portions." A relative told us they were not confident that information handed over to the kitchen, would be acted on. For example a person had requested a cooked breakfast, but the request had been missed. The chef told us that food orders were taken table by table and should be individually, but if more than one person at the same table had the same meal, preferred portion sizes were sometimes given to the wrong person. We informed the registered manager of the concerns and were told they would be reviewing the ordering of food as well as the recording of people's preferred choices, for example this would be evidenced on a new form, which would be kept with the chef.

We observed lunchtime on both days of the inspection and saw people had a choice of two main meals. There was also a choice of puddings. People ordered what they wanted at the table and some people found it difficult to make a choice and may have benefitted if they were given a visual choice. If people did not like what was on the menu, they could have an alternative, however they had to wait until the end of service before the chef was able to make an alternative. Following our inspection staff now advise people daily of the meals on the menu so they could make a choice prior to lunch, ensuring if there had been any changes, chef was aware and where people wanted an alternative, they would receive this the same time as other people. We observed that when people had finished eating, their plates were removed without staff asking if they had enough or if they wanted more. A relative said "Someone from the family visits every day to make sure X is okay, as I don't have total confidence in her eating properly if one of us isn't here". The person needed prompting with eating and the relative didn't feel the person would receive appropriate support.

People's health care needs were monitored and any changes in their health or well-being prompted a referral to their GP or other health care professionals. We saw for example where people had diabetes; discussions with various health professionals such as the GP, diabetic nurse specialist and pharmacist were recorded.

We recommend the service seek advice on the implementation of the MCA in relation to carrying out assessments of people's capacity to make decisions when necessary and making a record of LPAs where people had them.

Good

Is the service caring?

Our findings

Most people told us they were happy with the care they received. They said staff attitude were generally good, but one person said "Some are brilliant but some are rubbish." And speaking to a relative they said "The staff are very good here, I feel he is quite safe and the standard of 90% of the carers is very high." We observed staff talking to people in a kind and compassionate manner.

People received care and support from staff that had got to know them well. Staff said "It's not about us, but about the residents". The relationships between staff and people receiving support demonstrated dignity and respect most of the time. Comments included "Yes they treat me with respect." and "The staff treat me with respect when they wash me and I have an assisted shower once or twice a week and I get a strip wash every day. They always close the curtains and the door." We observed some peoples' privacy and space wasn't always respected as staff didn't always knock before entering a person's room. People said "No they don't always knock on my door, only sometimes. But if I'm in the shower and the door is shut, they knock on my shower door and if I don't answer they come in." and "Sometimes they knock on my door and sometimes not, they just walk in on me."

Speaking with relatives they said "Staff support the family as well as the resident and that's nice", "The home has a caring atmosphere and is so welcoming. They are very flexible about things, and staff are very accommodating", "Residents are treated with dignity and respect and their privacy is always respected - the carers try very hard to do the best they can.", "The carers are always polite, cheerful, very courteous and sympathetic." and "Because mum was not looking after herself properly before, with better food and cleanliness she is actually better now than she was when she first came in."

Staff knew people's individual communication skills, abilities and preferences. Where people were not able to communicate their needs, staff told us they knew what to look out for, for example a person's body language or facial expression. There was a range of ways used to make sure people were able to say how they felt about the caring approach of the service. People's views were sought through care reviews and annual surveys. People were also invited to residents' meetings which were an opportunity for people to talk about things that mattered to them.

Staff were knowledgeable about things people found difficult and how changes in daily routines affected them. For example staff knew that one person did not like to have a wash and preferred to stay in bed. The person would hit out if staff attempted to support with personal care. Staff told us they would leave and go back at a later time. They also knew that the person liked a cup of tea and would always offer one.

People's bedrooms were personalised. People were surrounded by items within their rooms that were important and meaningful to them. This included such items as books, ornaments and photographs. The home was spacious and allowed people to spend time on their own if they wished. The registered manager told us the home had recently been refurbished as part of Barchester's "WOW" project, which was a project across Barchester services to improve the interior of services. For example new furnishings, bedrooms repainted and an extension in the dining area.

People and their relatives were given support when making decisions about their preferences for end of life care. Services and equipment were provided as and when needed. The registered manager told us they had links with local Hospices and hospitals, which also provided staff with training in end of life care and death and dying.

Requires Improvement

Is the service responsive?

Our findings

Care plans were personalised and each file contained information about the person's likes, dislikes and people important to them. Care plans included information that enabled the staff to monitor the well-being of the person. For example where people had lost weight, were at risk of dehydration or skin breakdown, we saw that food, fluid and repositioning charts were completed. However, the information recorded wasn't always meaningful, for example some people's progress and evaluation records stated "Food and fluid intake is good" or "food and fluid intake is poor." However it didn't provide information on what "good" or "poor" was for that person. We also saw that where some care plans had been updated, it had conflicting information. For example in the nutrition and hydration care plan, it stated as the person was palliative; there was no food and fluid chart in place. However, in the plan of care needs to maintain adequate nutritional intake, it stated "Although eating and drinking fairly well, is losing weight and at high risk of malnutrition. X is assisted with all meals and fluids, which is charted." This could be confusing for staff who did not know the person well.

The repositioning charts were not always consistently completed and we found that when people were repositioned, it wasn't recorded if a drink was offered or if any other care was provided. The clinical lead told us they were developing a new document for care given and visual checks, for example if the person is comfortable, asleep, if a drink, food or mouth care was given. These forms would be especially beneficial for people who were unable to use their call bells in providing anticipatory care. These forms were put in place soon after our inspection.

Where a person's health had changed it was evident staff worked with other professionals, for example tissue viability nurses, neurological occupational therapist or diabetes nurse specialist. We saw a multi-disciplinary meeting was held during our inspection to discuss concerns about a person's complex health and care needs. We also saw where needed a referral was made to dermatologists, opticians and dentists.

People and relatives told us they were also involved in the on-going review of their care needs. A relative said "As X's needs have changed, the home have changed to support her more as she needed it". Where care profile reviews had been completed, we didn't always see evidence of the person's involvement, for example the discussion recorded was with a relative or representative and did not represent the person's views.

People told us staff responded to their needs quickly the majority of the time, but there could be a wait in the morning during personal care. People said "It depends on how busy they [staff] are to how quick they come" and "Yes it's around my neck and yes I have used it and they come very quickly. If I can't press my call bell I can always shout."

The registered manager told us when people pressed the call button; the response time was usually no longer than three to four minutes. If staff took longer than this, an emergency alarm went off. We saw evidence that some people frequently used the call bell. For one person this could be up to seventy times a day for various reasons, but staff still responded in a timely way. The registered manager had been working with the community mental health team and relatives trying to resolve the person's anxieties.

Handover between staff at the start of each shift ensured that important information was shared, acted upon where necessary and recorded to ensure people's progress was monitored. However because of the use of agency nurses, there was at times a lack of information sharing, resulting in a lack of clarity about any changes in people's care. A health care professional stated that communication between GP surgeries and staff at Henford House was inconsistent. The clinical lead told us they were working with GP surgeries to improve the level of communication. The regional director held a meeting with the GPs and steps had already been taken to address the issues. Some of the difficulties caused were partly because some GPs didn't always visit on their scheduled day, which meant a detailed list of people requiring a visit from the GP that day, was not available.

People's concerns and complaints were encouraged, investigated and responded to in good time. People told us that the service was open and responsive to complaints. Relatives commented "I did have a concern. I took it to the manager and it was dealt with satisfactorily." And "If we have a concern we go to the manager – both she and all the staff are very approachable." And "I do see the manager and deputy manager sometimes, they are both very approachable. I did have to raise a concern, it was about the creams and it has been better since I mentioned it."

People had a range of activities they could be involved in. People were able to choose what activities they took part in and suggest other activities they would like to complete. In addition to group activities people were able to maintain hobbies and interests, staff provided support as required. Comments from people included "I like to read and watch TV but that's it for me. And in the summer they take us out into the garden centre and go into the garden." And "Yes I play scrabble and pottery on a Wednesday, gardening in the summer – I do everything. And we're going to do Christmas cake decorating and anything else I can do." People told us they would like to go on outings more, but Henford House did not have their own mini-bus and shared one with another Barchester service nearby. That meant opportunities to use the mini-bus were limited for example to once a month at times.

Whilst group activities were on offer daily the activities coordinator told us they offered people 1:1 social stimulation throughout the week, for example nail and beauty treatments in their rooms. We observed during our two days of inspection that some people remained in their room because of complex health needs. Those who remained in their rooms were only visited when staff were providing a care task. This put people at risk of social isolation. Relatives told us they felt staff were able to meet people's basic care needs, but did not have time to spend talking to people. Staff told us they were rushed in the morning and didn't get time to sit down talking to people until the afternoon.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in post who was responsible for the day to day running of the service. The registered manager was supported by a deputy manager who was the clinical lead and had been new in post. The registered manager told us it had been a challenge as they did not have a clinical background and the service had been without a clinical lead for six months. They had also struggled to recruit and retain registered nurses, which meant they had to make use of agency nurses. The registered manager had a vision of recruiting a stable care team to ensure continuity for people using the service. The registered manager said "Staff have people's best interest at heart".

The registered manager told us they could now focus on developing the service further as they had the support from the clinical lead in improving the clinical governance of the service. This meant they had more time focussing on making Henford House part of the community as the location could be isolating. The registered manager wanted to make it a place where people wanted to come to. They recognised that staff were not always able to spend one-to-one time with people and wanted to create more volunteering opportunities within the service.

Most staff told us they felt supported by the management team. Comments included "The manager is approachable. Makes me feel they take on board what I am saying" and "X is brilliant as a manager." Staff had monthly meetings and told us these were opportunities to talk about things that were going well and any areas of improvement.

We found that the registered manager relied on the provider for quality assurance of the service and the deputy manager was responsible for clinical governance. Internal audits and two monthly provider visits had been undertaken. On the first day of our inspection we saw a mattress audit was in process to ensure the mattresses were clean and in good condition. Other audits included monthly medicines and health and safety audits. We found the provider also completed quality first visits and the provider had identified some of the concerns raised during our inspection, for example the management of medicines.

The registered manager told us any risks or concerns identified were recorded on a centralised action plan and any shortfalls were responded to. The action plan was reviewed by the regional manager to ensure proposed actions were put in place. The registered manager also had support from regional support teams, who visited the service and provided advice on areas such as hospitality, dementia care and learning and development. The registered manager had made links with the local community. They told us some people from the local community came to Henford House for day care. They had links with local churches, British legion, local schools, library and the Army as a lot of service men were based in Warminster. The service also provided placements for students from the local college to support them in their Health and Social care award.

The registered manager kept up to date with current practices and legislation through attending meetings such as monthly general managers meetings and quarterly provider's meetings. The registered manager received a weekly general manager's bulletin with any updates, which they also circulated to staff with any

relevant information. The deputy manager told us all staff were now on Barchester e-mail and they were able to circulate information more effectively.