Highcleeve Limited

Horton House Residential Care Home

Inspection report

Horton House Residential Care Home
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Gloucester
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Tel: 01452524615

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11 January 2017

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Ratings

Overall rating for this service	Good
Is the service effective?	Good

Summary of findings

Overall summary

This was an unannounced inspection which took place on the 11 January 2017. Horton House Residential Care Home provides accommodation for up to 23 older people. At the time of our inspection there were 23 people living there. Of these people 20 had been assessed as unable to make decisions about their care and support.

Horton House is a family run home. People in 12 bedrooms had en-suite facilities. They also had access to a shared bathroom and shower room as well as living and dining areas. A conservatory at the rear of the home provided additional space for activities and to meet with visitors. The grounds around the home were accessible to everyone.

There was a registered manager in post. 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.

We carried out an unannounced comprehensive inspection of this service on 5 January 2016. A breach of legal requirements was found. After the comprehensive inspection the provider wrote to us to say what they would do to meet legal requirements in relation to the breach.

We undertook this focused inspection to check that they had followed their plan and to confirm they now met legal requirements in relation to a breach of regulation 13. This report only covers our findings in relation to this requirement. You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Horton House on our website at www.cqc.org.uk"

At the comprehensive inspection of this service on 5 January 2016 a breach of legal requirements was found. After this comprehensive inspection, we asked the provider to take action to:

• ensure that people who had been deprived of their liberty had the appropriate authorisations in place.

At this inspection we found action had been taken to submit authorisations to the supervisory body for people who were unable to make decisions about their care and support and whose liberty had been restricted. There was evidence that wherever possible the least restrictive solution was found. Bed rails were not used instead people were provided with beds which could be lowered and crash mats were placed on the floor. People who liked to go out for walks could walk freely in the secure rear garden or go out with staff. The registered manager had developed a monitoring tool so that she could monitor when each person's Deprivation of Liberty Safeguard needed reviewing.

The provider had displayed the rating for this service on their website and in the home.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service effective?

Good

The service was effective. We found action had been taken to ensure the service was effective. People who were unable to make decisions about their care and support and who were deprived of their liberty to keep them safe had the appropriate authorisations in place. Wherever possible the least restrictive solution was found.

Horton House Residential 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.

We undertook an unannounced focused inspection of Horton House on 11 January 2017. This inspection was done to check that improvements to meet legal requirements planned by the provider after our comprehensive inspection on 5 January 2016 had been made. We inspected the service against one of the five questions we ask about services: is the service effective? This is because the service was not meeting some legal requirements.

The inspection was undertaken by one inspector and was unannounced. Prior to the inspection we reviewed information we have about the service including notifications. A notification is a report about important events which the service is required to send us by law.

As part of this inspection we spoke with the registered manager over the telephone and spoke with senior carers at the home. We reviewed the care records for eleven people focussing on deprivations of liberty. After the inspection the registered manager sent us a monitoring tool they used to oversee the submission and authorisation of deprivation of liberty safeguards.

Good

Is the service effective?

Our findings

At our inspection of 5 January 2016 we found people who had been deprived of their liberty did not have the appropriate authorisations in place. This meant the provider was not acting within the Mental Capacity Act 2005 Deprivation of Liberty Safeguards. The provider sent us an action plan telling us how they would address these issues.

At our focused inspection on 11 January 2017 we found the provider had taken action to address these issues.

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 in their best interests and as least restrictive as possible. People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

People who had been assessed as unable to make decisions about their care and who were deprived of their liberty had authorisations either in place and authorised by the supervisory body (local authority) or applications had been submitted. People's care records included copies of authorisations to deprive them of their liberty. Of the three authorisations we looked at no additional conditions had been made in relation to these. In total four authorisations had been agreed and the registered manager had notified the Care Quality Commission of the outcome of these. Another 15 applications had been submitted to the supervisory body which were awaiting assessment. The registered manager monitored the status of each person's DoLS through a spread sheet which also highlighted when reviews were needed.

People's records confirmed the least restrictive solution was sought when placing restrictions on them to keep them safe. For example, one person loved to go for walks but was at risk of getting lost due to memory problems. They were able to walk around the rear garden which was safe and secure and staff supported them when they accessed their local community. People who were at risk of falling out of bed had been provided with beds which could be lowered with crash mats on the floor, instead of using bed rails.