Care Quality Commission

Alliance Care (Dales Homes) Limited

Houndswood 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 well-led?	**Requires Improvement**

Summary of findings

Overall summary

About the service
Houndswood House Care Home is a residential care home providing personal and nursing care to 37 people aged 65 and over at the time of the inspection. The service can support up to 50 people.

Houndswood House Care Home accommodates up to 50 people across two units, both of which has separate facilities and adjoining communal areas.

People's experience of using this service and what we found
People told us they felt safe and happy living at the service. However, two relatives raised concerns regarding the actions of specific members of staff. A safeguarding referral was made following the inspection in relation to these concerns. The registered manager took action to mitigate the potential risks posed to people whilst an investigation is completed.

There were several shortfalls and inconsistencies in the completion of the records used to record incidents, accidents and falls. This meant that all events had not been included in the reviews of risks to people's health, safety and wellbeing. Pressure relieving mattresses were found to be incorrectly set for people's recorded weights and repositioning of people at high risk of pressure damage was not completed in accordance with care plans and risk assessments.

Processes followed to recruit new staff were not always fully completed. Staff files lacked information to demonstrate references provided had been checked and verified and reasons for leaving previous employment explored.

Checks and audits had been completed on all aspects of the service. However, these audits were not effective and did not identify the shortfalls found at this inspection. The quality assurance report submitted to the provider contained inaccurate information and was inconsistent with the findings of this inspection. This meant that appropriate action may not be taken to address any shortfalls or drive improvements at the service.

There was a consistent number of staff on duty. People received care in a timely manner and staff were attentive and able to respond promptly to requests from people. Medicines were being managed well and staff followed good infection control practices.

People and relatives felt the service was well-led. They knew who the registered manager was and said they were approachable, supportive and responsive to their needs. The registered manager and staff were responsive to suggestions and observations made during the inspection to improve practice. Staff received regular support for their role to ensure they had up to date knowledge for their role and felt involved in the development of the service. Regular meetings were held for people, relatives and staff.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was Good (published 20 January 2018).

Why we inspected
We received concerns in relation to the management of incidents and accidents and people's safety. As a result, we undertook a focused inspection to review the Key Questions of Safe and Well-led only.

We reviewed the information we held about the service. No areas of concern were identified in the other Key Questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those Key Questions were used in calculating the overall rating at this inspection.

The overall rating for the service has changed from Good to Requires Improvement. This is based on the findings at this inspection.

You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Houndswood House Care Home on our website at www.cqc.org.uk

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We may meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-Led findings below.	**Requires Improvement**

Care Quality Commission

Houndswood House Care Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was completed by two inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
Houndswood House Care Home is a 'care home'. People in care homes receive accommodation and nursing or personal care as single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We used all of this information to

plan our inspection.

During the inspection
We spoke with seven people who used the service and four relatives about their experience of the care provided. We spoke with seven members of staff including the area manager, registered manager, senior care workers, care workers and housekeeping staff.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data, people engagement records and quality assurance records.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse
● Most people told us they felt safe at the service, however concerns were shared with us regarding the behaviour of specific staff members. One relative told us, "Majority of staff are really keen to offer top level care, but we had a one staff member being on occasion abrupt and bordering rude, poking my [relative] in her tummy saying she is fat now. I don't know if that's supposed to be some kind of joke or something else, but it didn't sit with me well. Once my relative told me…. (I was) pretty upset." Another relative shared a concern regarding a conversation that they had overheard between their relative and a member of staff.
● The registered manager confirmed they had knowledge of the first incident and had taken action to address this. However, they had not recorded the concern or the action they had taken in response. In addition, they had not given consideration to this being a potential safeguarding issue.
● We raised a safeguarding referral with the local authority regarding the second concern. The registered manager took action to safeguard people, once informed, while an investigation is completed.

Systems in place were not effective in identifying potential safeguarding concerns and ensuring prompt action was taken and recorded. This placed people at risk of harm. This was a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they understood how to recognise and report concerns or abuse. Staff received training in safeguarding and felt confident to raise concerns.
● Information regarding safeguarding and how to report concerns was displayed in the service.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong
● Risks to people were identified and plans were in place to minimise those risks. Regular reviews took place and records were maintained. However, incidents, accidents and falls were inconsistently recorded. This meant that these reviews did not always consider events that had occurred. This had an impact on the accuracy of the assessments which meant people might not receive appropriate, safe care.
● Regular checks were carried out on the pressure relieving equipment being used by people, however we found that several mattresses were set incorrectly for people's weights. For one person, this inaccuracy was more than 30kg. The registered manager took immediate action to address this.
● We also found that one person identified as being at high risk of developing pressure ulcers was not being supported to reposition at the frequent intervals as recorded in their care plan and risk assessment. We also found that this person was not being repositioned in alternating positions and was spending long periods of time on their back.

● We found inconsistencies with the reporting and recording of incidents, accidents and falls. Staff completed reports where a person had been involved in an incident or accident, but these were inconsistent in where they were recorded and not all had been entered into the computerised system or seen by the management team.
● Records did not demonstrate information was shared amongst the staff when things went wrong. For example, following the completion of an audit or following an incident.

Systems in place were not robust enough to demonstrate safety was effectively managed. This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staffing levels were seen to be consistent and people told us they were happy with the availability of staff.
● Staff were attentive and able to respond promptly to requests from people.
● Throughout the inspection we observed call bells were answered in a timely manner. Staff were observed spending time chatting to people and care was not rushed.
● Systems were in place to ensure people were protected as far as possible from being cared for by unsuitable staff, recruitment checks included Disclosure and Barring Service (DBS) checks, written references, health declarations and proof of identity. However, we found that some references received had not been verified and the reasons for people leaving a previous position in health and social care had not been explored or recorded.

Using medicines safely
● Medicines systems were organised, and people received their medicines when they should. The provider was following safe protocols for the receipt, storage, administration and disposal of medicines.
● Audits were completed regularly. Where mistakes were identified, these were followed up and action taken.

Preventing and controlling infection
● Systems were in place to prevent the spread of infection and maintain a safe and clean environment.
● Staff had received training and procedures were in place. Housekeeping staff carried out a range of regular tasks to ensure the service was clean.
● Personal Protective Equipment (PPE) was available throughout the service. Staff were seen to use PPE appropriately when supporting people.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to Requires Improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong

● There was both a registered manager and deputy manager to support staff in their roles and staff told us they understood what was expected of them. However, we identified areas where improvement was needed regarding quality performance and safety.
● Quality monitoring systems were in place, but they were not always effective. Audits undertaken had failed to identify the issues we found on inspection.
● Some risks to people's safety had not been mitigated, including safeguarding, people's pressure care and accident and falls.
● Systems had not identified where recruitment processes had not been fully followed.
● Quality reports completed by the registered manager and submitted to the provider organisation, as part of the provider oversight process, contained inaccurate information.

The auditing of the service had not always been effective. The failure to effectively monitor and improve the service was a breach of Regulation 17 (Good governance) of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The registered manager told us they understood their responsibilities and regulatory requirements. They had notified CQC when it was required of events which occurred at the service.
● Policies and procedures to promote safe, effective care for people were available to staff.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics; Working in partnership with others

● People and some relatives felt the service was well-led. They knew who the registered manager was and said they were approachable, supportive and responsive to their needs. One person said, "I know both the manager and deputy. I think they are both doing a great job. I have no problems how this place is run and would not like to change anything." A relative told us, "[Registered manager] simply wants to do best for people who are here, and really listens. [Registered manager] is very present in this place. "
● People, relatives and staff were involved in planning care and support. The registered manager regularly spoke to people and involved them in decisions about the service. This included regular meetings with

people and relatives. These meetings were used to provide information and seek feedback on different aspects of the quality of care.
● Staff told us they had opportunities to attend team meetings to discuss the service and raise any issues.
● Staff sought advice and worked in partnership with others such as the local authority and health care professionals to promote the best possible support for people.

Continuous learning and improving care
● The registered manager and staff were responsive to suggestions and observations made during the inspection to improve practice.
● Staff received regular support for their role to ensure they had up to date knowledge for their role.
● An on-going improvement action plan was in place to continually develop and improve the service. However, all actions were marked as complete. This is inconsistent with the inspection findings.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Systems in place were not robust enough to demonstrate safety was effectively managed. Incidents, accidents and falls were not consistently reported or recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Systems in place were not effective in identifying potential safeguarding concerns and ensuring prompt action was taken and recorded.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance The auditing of the service had not always been effective. Quality assurance processes did not identify the concerns found on this inspection. Information sent to the provider as part of the quality assurance and monitoring of the service contained inaccurate information.