Four Seasons (Bamford) Limited

Hornegarth House Care Home

Inspection report

204 Walsall Road
Great Wyrley
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Tel: 01922701702

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected this service on 17 February 2016. This was an unannounced inspection. Our last inspection took place in May 2014 and we found no concerns with the area's we looked at.

The service was registered to provide nursing for up to 37 people. At the time of our inspection 32 people were using the service, a further three people were in hospital.

The service did not have a registered manager. There was a new manager in post. The new manager confirmed they had started with the organisation the previous week. They confirmed they had started the process to register with us and showed us evidence of this. 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.

There were not enough staff available to ensure people were safe, we observed that people had to wait to be provided with support. Risks to people were not manged to ensure people were safe from avoidable harm. Medicines were not stored in a safe way and therefore we could not be sure they were safe to administer. We found that medicines were not administered as prescribed. People's rights to privacy and dignity were not always upheld. There were limited opportunities for people to participate in activities they enjoyed.

When people were unable to consent to their care, capacity assessments had been completed and decisions had been made and recorded in people's best interests. When people were being restricted in their best interest, this had been considered and applications and authorisations for this were in place.

Staff received an induction and training which was relevant to meeting people's needs. We saw when specialist equipment was used; it was maintained and used in a safe way. People had individual plans for emergency situations and staff were aware of these.

People were offered food and drinks which they enjoyed. People were offered choices at mealtimes and about their day. We saw drinks and snack were offered throughout the day. When people required specialist diets we saw this was provided for them. We saw that staff interactions with people were caring and staff knew people well.

Quality monitoring systems were in place. The provider sought the opinions of people who used the service and relatives to bring about changes. There was a new manager in post. There were a complaints procedure in place and when complaints were made the provider dealt with these in line with their policy.

We found 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.

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 were not enough staff to meet people's needs in a timely manner and people had to wait for support. Checks that were put in place to keep people safe were not always maintained. Risks to people were not always managed in a safe way. Medicines were not always managed to ensure they were safe to use. Staffs understanding of safeguarding were inconsistent. There were procedures in place to manage safeguarding incidents. Equipment was used and maintained to ensure people were safe. Pre-employment checks were completed to ensure staff were suitable to work within the home.

Is the service effective?

Good

The service was effective.

The principles of the Mental Capacity Act 2005 were followed. When needed, capacity assessments were completed and decisions made in people's best interest. When people were subject to restrictions authorisation had been made and were in place for these people. Staff received training and an induction that helped them support people. There were sufficient food and drink for people to access. People had access to healthcare professionals when needed.

Is the service caring?

Requires Improvement

The service was not always caring.

People's right around privacy and dignity were not always upheld. People and relatives were happy with the staff and were treated in a caring way. Visitors were free to visit throughout the day.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were not always offered activities that provided

stimulation. Accurate information was not always relayed to maintain people's care needs. There was a system in place for managing complaints. Staff had prompts available to identify people's preferences.

Is the service well-led?

Good

The service was well led.

Quality checks were in place to bring about improvements to the service. The provider sought the opinion off people and relatives to being about improvements. There was a whistleblowing procedure in place and staff felt confident these concerns would be dealt with.

Hornegarth 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.

This inspection took place on the 17 February 2016 and was unannounced. The inspection was carried out by one inspector 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.

We checked the information we held about the service and the provider. This included notifications the provider had sent to us about significant events at the service and information we had received from the public.

The provider completed 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 spent time observing care and support in the communal area. We observed how staff interacted with people who used the service. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us.

We spoke with one person who used the service, five relatives, five members of care staff, two registered nurses, and the activity coordinator. We also spoke to the regional manager the previous registered manager and the new manager. We did this to gain people's views about the care and to check that standards of care were being met.

We looked at the care records for five people. We checked that the care they received matched the

information in their records. We also looked at records relating to the management of the service, including quality checks and staff files.

Requires Improvement

Is the service safe?

Our findings

We found there were not always enough staff to ensure people's needs were met in a timely manner. We observed people were still in bed and waiting to get up at midday. People were unable to tell us about this but a relative said, "There are not enough staff here especially at breakfast time, they get up so late, the dinners have been getting later as not everybody is out of bed for lunchtime". One member of staff told us, "People are still waiting to get up, we can't get to everybody, there are not enough of us". Another member of staff said, "We can be later than this supporting people to get up, it's not fair they have no choice". At lunchtime we observed people had to wait for support with their meals. We observed and staff confirmed there were eight people in one lounge that all required support with their meal. We saw there were two staff available to support these people. One person had to wait for over an hour before they were supported to eat their meal.

Some people remained in their bedrooms, they did not have access to a call system due to their capacity, so staff told us they provided regular safety checks. We observed these checks were not always provided. Staff confirmed they could not ensure these checks were completed as there were not enough of them. One staff member said, "We just haven't got the time". Staff told us and the manager confirmed that a member of staff should be in the communal area's at all times. One member of staff told us, "Anything could happen; people could stand and fall or choke, anything really". We observed for periods throughout the morning the communal areas were left unsupervised.

This is a breach of Regulation 18 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

We observed that people's medicines were not always administered in line with their prescriptions. We saw a tablet that should have been administered on the 15 February 2016 was still in the medicines pack. We checked the medicines administration record (MAR) for this and it had been signed as administered. We also saw a further medicine should have been administered the previous day. There was no signature on the MAR to confirm whether this medicine had been given. We discussed this with the manager who confirmed this should have been identified by the next person administering medicine, they confirmed this had not. This demonstrated we could not be sure that medicines were administered as prescribed.

We saw there were medicines that were stored in the fridge. These had a recommended storage temperature range as identified by the manufacturer. The fridge temperatures were monitored and recorded by staff. We saw the temperature had dropped below the recommended storage range on several occasions. We spoke with staff about this who told us it was during the period when the fridge had broken and a new one was ordered. Staff confirmed that medicines had been continued to be stored in the fridge and were administered. This was over a five week period. This meant the provider could not be sure this medicine would be effective and was safe to administer.

This is a breach of Regulation 12 of the Health and Social Care Act 2008. (Regulated Activities) Regulations 2014.

Medicines were administered to people in a safe way and staff spent time with people to ensure they had taken them. We saw staff explained to people what the medicines were and gained consent from the person before giving it to them. When people were administered covert medicines we saw that protocols for this were in place and reviewed. Covert administration is when a medicine is hidden in food or drink and the person is unaware they are taking this. When people were prescribed 'as required' medicines there were protocols in place with clear guidance around administration of these.

Risks to people were not always managed in a safe way. For example, one person had rolled out of bed twice in one month. There was a risk assessment in place for this however no review had taken place since either incident. The risk assessment stated the person was to have a 'crash mat' next to their bed to reduce the impact if they rolled. We spoke with the staff about this. One staff member said, "No, I don't think [person] uses that anymore". Another member of staff told us, "I would have to check about that". We were unable to speak with the person about this due to their capacity. The written information recorded demonstrated that risks were identified but may not be managed as they should be.

The staff's understanding of safeguarding people was inconsistent. Some staff told us they had not received safeguarding training. One member of staff said, "Is it keeping people safe?" Another told us, "I think its well-being". Staff did confirm if they were concerned about anything they would report it to the nurse in charge. One staff member said, "I'm not sure about safeguarding but any abuse I would be straight in the office". We spoke with the regional manager about this who confirmed staff had received this training. They advised this was an area they would revisit with staff to ensure their understanding. We saw information was displayed around the home on safeguarding and procedures to follow. Procedures were in place to ensure any concerns about people's safety were reported appropriately. We saw when needed these procedures were followed to ensure people's safety.

People were supported in a safe way. For example, some people needed to be transferred with the support of specialist equipment. We saw staff using this equipment safely and in line with the person's care plan. This equipment had been maintained and tested to ensure it was safe to use.

Staff we spoke with were aware of people's emergency plans and the levels of support they would need to evacuate the home. We saw these plans provided guidance and the levels of support people would need to be evacuated from the home in an emergency situation. The information recorded was individual and specific to people's needs.

We spoke with staff about the recruitment process. One member of staff told us, "I had to wait for my police checks and references before I could start here". We looked at two staff files and we saw pre-employment checks had been completed before staff were able to start working in the home. This demonstrated the provider ensured the staff were suitable to work with people who used the service.

Good

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 in their best interests and as least restrictive as possible.

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 and hospitals are called the Deprivation of Liberty Safeguards (DoLS).

Some of the people living in the home lacked capacity to make important decisions for themselves. We saw when needed people had mental capacity assessments in place. When people were unable to make decisions we saw decisions had been made in people's best interests. Staff we spoke with understood the importance of gaining consent from people before offering support. Staff explained how they would gain consent from people. One member of staff explained they watched the person and how they reacted, what their facial expressions were like and what the person did. We saw staff gaining consent from people. For example, one member of staff asked if the person would like to sit down, they held out their hand for the person to take it, but the person pushed it away. The staff member said to the person, "That's fine, you keep walking then". This demonstrated that staff understood people and the importance of gaining consent from people.

The provider had considered when people were being restricted unlawfully and applications when needed had been made to the local authority. There were DoLS authorisations in place for four people and a further 29 application had been made. Some staff told us they were unsure about DoLS. One staff member said, "I'm unsure on that, I haven't had any training ". Another member of staff said, "Not sure it's about people not being able to go home". Staff were able to tell us about the codes on the doors and how these were in place to keep people safe and that some people wanted to go home but were unable to. Some staff were aware that people had authorisations in place. We spoke with the manager about this who confirmed this was something that would need revisiting with staff.

We saw that referrals had been made to health professionals when needed. For example, one person had been identified as needing support with eating and drinking, we saw a referral had been made to the relevant professional. This professional had completed an assessment and made recommendations for this person. We saw staff supported this person to eat and drink in line with these recommendations. We saw when one person was unwell the nurse contacted the doctor and later they made a visit to the home to see this person.

Staff told us they received training and an induction that helped them support people who used the service. One member of staff told us about their induction. They told us they had shadowed other staff for two weeks. They said, "It was great, it helped me to learn people's ways and personalities". Staff told us they had

received moving and handling training and this was important for them to support people. One member of staff said, "I wouldn't trust what I was doing was right if I hadn't had that". This demonstrated that staff received training that was relevant to meeting people's needs.

People we spoke with told us they enjoyed the food. One person said, "This is lovely". We saw people were offered a choice at mealtimes. There was a meal planner displayed in the dining room offering a choice of meals. People were offered drinks and snacks throughout the day. When people had specialist diets this was provided for them. A relative told us, "The food is lovely; I often have my lunch while I'm here, and the cooks are great they don't mind".

Requires Improvement

Is the service caring?

Our findings

People were not always supported to maintain their privacy and dignity. For example, we observed one person had an injection administered in a communal area while other people were present. This involved the person's shirt being lift up and their body being exposed. We also saw that when a person was hoisted their lower clothing was not adjusted so that their dignity could be maintained. During a doctor's visit we saw a person was also physically examined in the communal area, this involved the person's clothes being pulled up in front of other people.
A relative told us about when they had a meeting, which involved other professionals. They explained there was nowhere private for this meeting to take place and it was held in the dining area. They said, "There is just nowhere private to sit". This demonstrated that staff did not always respect people rights to privacy and dignity.

People and relatives told us they were happy with the staff. One person said, "Oh she's a great one". A relative told us, "The staff are very devoted, more than I've seen in other homes". Another relative said, "The staff seem caring without a doubt". We saw staff joking with people and the atmosphere was relaxed and friendly. We heard a person said they felt unwell and we observed that staff sat with this person, stroking their hand and offering reassurance to them. This showed us that people were treated in a caring way.

Staff supported people to make choices about their day. For example, some people went to the dining area for lunch and others stayed in the lounge. We spoke with a member of staff about this, they said, "[Person] likes the quiet so that's why they stay here, occasionally they go into the lounge but as soon as it gets noisy they want to come back". We saw staff ask people where they would like to sit and if they wanted to stay in the dining area or move to the lounge.

Relatives and visitors we spoke with told us staff were welcoming and they could visit at any time. One visitor said, "They always find me a seat and get me a cuppa". Another told us, "We visit every day, we visit at different times and there is a nice atmosphere". We saw relatives and friends visited throughout the day. This demonstrated that visitors were welcomed by staff

Requires Improvement

Is the service responsive?

Our findings

There were mixed views about the activities with in the home. One relative told us, "There is not enough stimulation here". We saw there was an activities board displayed in the communal areas. The display stated there was a 'cake sale today'. This activity did not take place. There was a full time activity coordinator in post. They explained that monthly entertainment came to the home and this included a singer and the 'memory man'. They told us that today was reminiscence in the morning and a pamper session in the afternoon. The activity board confirmed this. We saw these activities taking place on an individual basis with some people. We saw one person had some large dominoes in front of them, we saw these remained unopened and the person was not offered support. We observed throughout the day that most people were asleep and did not participate in any activities or pastimes.

There were daily arrangements in place to keep staff informed about people's needs. We observed a handover, which identified that one person was 'not safe in the hoist, so needed to stay in their bed'. We saw this person was in their chair and the staff we spoke with confirmed the person had been hoisted earlier that morning. This demonstrated that information that was handed over was not always accurate.

Staff understood how people wanted their care to be delivered. We saw information in people's files about their preference and likes and dislikes. There were prompt sheet around the home with information, for example on how people liked their drinks. Outside people's rooms there was a life history of the person. This meant staff had information available to them to remind them of people's needs.

Relatives told us they had been involved with reviewing their relatives care. One relative explained how they had held a meeting to discuss their relatives care. Another said, "Yes, I am involved". We saw in people's files that when decisions were made in people's best interests meeting had been held and relatives had been involved with this. We were unable to talk to people about this due to their capacity.

Visitors told us if they had any concerns or complaints they would be happy to raise them. A relative said, "I would speak to someone". Another relative gave an example of a complaint they had made and how this had been dealt with. The provider had a complaints policy in place and systems to manage and monitor complaints. We saw that when complaints had been made the provider had responded to them in line with their policy.

Good

Is the service well-led?

Our findings

There was a new manager in post. The new manager confirmed they had started with the organisation the previous week. They confirmed they had started the process to register with us and showed us evidence of this. Relatives told us the new manager had introduced themselves and they felt they were approachable. A relative said, "From the top down the staff are approachable". The provider understood their responsibilities of registering with us. They had reported significant information about events in accordance with their requirements of the registration.
Staff confirmed they felt positive about the new manager and were optimistic they would be listened to in the future. The new manager told us they would be arranging a staff meeting and supervisions with all staff in the future.

Quality checks were completed by the manager and the provider. These included checks in relation to health and safety and safeguarding incidents. Where concerns with quality had been identified we saw an action plan had been put in place and action taken. For example, it was identified that a error had previously occurred. We saw this had been identified through an audit. We saw an action had been set to discuss this with the staff member. We saw evidence this had been discussed with the staff member and no further errors by this person had been identified. We saw and the regional manager told us they used the information from the audits of the service to look for trends and patterns, to bring about improvements. This showed us when concerns were identified action was taken to bring about improvements.

Resident and relatives meeting were held. We saw information from these were used to bring about improvements. For example, we saw one person had requested a flu jab for their relative. Records confirmed this had now been actioned. There was also a request by a relative that improvements were made to the garden. The manager told us that the garden had now been improved with additional seating area and planters. We saw this was in place. There were I pads available in the entrance area so relatives and visitors could provide feedback. This demonstrated that the provider sought opinions of people and relatives to make positive changes.

We saw the provider had a whistle blowing policy in place. Whistle blowing is the procedure for raising concerns about poor practice. Staff we spoke with understood about whistle blowing and said they would be happy to do so. One staff member said, "It's there to protect these vulnerable people if the care isn't right". Another member of staff told us, "I would be happy to do this, I'm sure if it was about the residents I would have the managements support". This demonstrated that when concerns were raised staff were confident they would be dealt with.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not stored in a way to ensure they were safe to use. medicines were not administered as prescribed.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to meet peoples needs in a timely manner and people had to wait to receive support. safety checks were not always completed to ensure people were safe from harm.