Methodist Homes

Horfield Lodge

Inspection report

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Ratings

Overall rating for this service	Requires improvement
Is the service safe?	Good
Is the service effective?	Requires improvement

Overall summary

We carried out a comprehensive inspection of Horfield Lodge on 16 December 2014. Three breaches of the legal requirements were found at that time. These related to safeguarding, the Mental Capacity Act 2005 and record keeping. After the inspection, the provider sent us a report of the actions they would take to meet the legal requirements.

We undertook a focused inspection on 28 May 2015. This was to check the provider had followed their plan and to confirm they now met the legal requirements.

This report only covers our findings in relation to these specific areas. You can read the report from our last comprehensive inspection, by selecting the 'All reports' link for 'Horfield Lodge' on our website at www.cqc.org.uk.

Horfield Lodge is a care home with nursing for up to 75 people. Care is provided for older people, some of whom are living with dementia.

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.

At our focused inspection on 28 May 2015, we found some good practice in relation to record keeping; however more needed to be done to ensure consistency and enable effective monitoring of the support that people received. This was particularly in relation to the support provided to people to reposition when they were at risk of developing pressure damage to the skin.

Summary of findings

There was good practice in relation to the monitoring of some wounds to the skin, with photographs being used to document how the wound was progressing. We also found good recording in relation to the monitoring of people's weight and the action taken when concerns were identified.

Progress had been made in ensuring that appropriate action was taken to safeguard people from potential abuse. When unexplained marks or bruises were found on a person, these were reported to the safeguarding team accordingly. There was also evidence that when a person returned from another establishment with unexplained marks on their body, then enquiries were made in order to establish how the marks occurred. This would help ensure that people were safe and action taken to protect them when necessary.

Progress had also been made in ensuring the people's rights were protected in line with the Mental Capacity Act 2005. Where a person was found to lack capacity to consent to the use of bedrails, a specific capacity assessment was in place and a best interests decision documented.

As a result of the findings of this inspection, the rating for the key question 'is the service safe', has been changed from 'requires improvement' to 'good'. Overall the rating for the service remains as 'requires improvement'. We found one breach of regulation at this inspection. 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?
Action had been to ensure that safeguarding processes were followed when concerns about a person's welfare were identified. This ensured that people were protected from the possibility of abuse.

Good 

Is the service effective?
There was some good practice identified in relation to how the care and support provided to people was recorded; however more needed to be done to ensure that recording was consistent and enabled staff to effectively monitor people's care.

Requires improvement 

Horfield Lodge

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.

We undertook a focused inspection of Horfield Lodge on 28 May 2015. We checked that the improvements planned by the provider after our comprehensive inspection on 16 December 2014 had been made.

We inspected the service against two of the five questions we ask about services: is the service safe and is the service effective. This was because the breaches found at the last inspection were in relation to these questions.

The inspection was carried out by one Inspector.

Before carrying out the inspection, we reviewed the information we held about the home. This included the report we received from the provider which set out the action they would take to meet legal requirements. We looked at the notifications and any information of concern we had received. Notifications are information about important events which the provider is required to tell us about by law.

As part of our inspection, we spoke with the registered manager. We viewed the care records of six people.

Good

Is the service safe?

Our findings

At the inspection of Horfield Lodge on 16 December 2014 we found that procedures were not always followed to ensure that people were protected from harm. This was because we identified one person for whom potential concerns had not been followed up or reported.

This was a breach of Regulation 13 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection on 28 May 2015 we found that steps had been taken to address this breach of regulation and systems were in place to investigate and report potential concerns.

We found examples of when unexplained marks or injuries had been identified on a person and suitable action taken in response. In each case, the concerns had been reported to the safeguarding team in the local authority in order for them to make a decision on whether they needed to investigate under safeguarding procedures. Relevant documentation was also completed by staff to show where on the body the mark had been identified. Photographs of the mark were taken so that the development of the mark could be effectively monitored.

In the case of one person who had returned to the home from another establishment, marks were noted on the person's body. There were clear records to reflect that the establishment had been contacted to enquire about the marks on the person and an explanation was provided.

These examples demonstrated that action had been taken to ensure people were protected and concerns reported to the relevant authority. As a result of the improvements that had been made, the rating for this section of the report has been changed from 'requires improvement' to 'good'.

Requires improvement

Is the service effective?

Our findings

At the inspection of Horfield Lodge on 16 December 2014 we found that people's rights were not always protected in line with the Mental Capacity Act 2005. This was because where people potentially lacked capacity to make a decision about the use of bedrails, procedures weren't followed to ensure that a decision was made in their best interests.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We returned to the service in May 2015 and found that action had been taken to ensure that appropriate procedures were followed when bedrails were in use. Where people were being supported with the use of bedrails, there was a documented mental capacity assessment in place. If the person was found not to have capacity to be able to consent, then a best interest decision was made. Records documented that relevant people were consulted when making the decision, including the person's relatives where appropriate. These steps helped ensure that the person's rights were protected and care was provided in a safe way.

However, we did find other examples of care where it wasn't clear that the principles of the Mental Capacity Act had been followed. A number of people had sensor mats in place to alert staff when the person moved from their bed and was therefore potentially at risk of falling or injuring themself. Staff told us that relatives had been consulted when a decision was made to use the sensor mats. However there were no clear records to show that the person's capacity to consent had been assessed or whether a best interest decision had been made to fully consider all aspects of using the sensor mat, such as the impact on a person's privacy.

At our inspection on December 16 2014 we also found that people's support plans did not always accurately reflect the care and support they required.

This was a breach of Regulation 17 2(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our focused inspection in May 2015 we found there was good practice in relation to recording the care that people had been given; however more needed to be done to ensure that this was consistent and effective.

Good examples of recording, included the monitoring of some wounds, where photographs were used to show how well the wound was healing. However in one case, we found that a wound had been noted but there was no further recording to reflect the care provided following this; although staff confirmed verbally that the wound had healed.

Further examples of good practice included the monitoring and recording of people's weight. Records showed that where concerns had been identified, these had been discussed with the person's GP. The person's support plan was then updated to reflect changes in need, such as if food supplements were required. This ensured there was clear information for staff to follow when supporting people.

Some people were identified as requiring support to reposition in order to prevent pressure damage to their skin. On the floor for people with nursing needs, we were told that specific charts were not used to record when a person had been supported to reposition unless they had a pressure sore that was being treated. In other cases, support to reposition would be recorded in a person's daily notes. We checked the daily notes for two people who had been identified as requiring support to reposition. It was not possible to check from the recordings in these notes that people had received the support set out in their plan. For example, we saw gaps in recording of several hours where it was not clear what support had been provided. In other cases, there were recordings of care being provided but it wasn't clear whether this had included support to reposition. There was no clear recording to enable staff to monitor people's care and support effectively.

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 17 HSCA (RA) Regulations 2014 Good governance This was a breach of Regulation 17 2(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Records relating to people's care and support were not always accurate or complete.