Horizon Transitional Care Ltd

Himley House

Inspection report

40 Himley Crescent
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Wolverhampton
West Midlands
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Tel: 01902218702

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

Summary of findings

Overall summary

This inspection was unannounced and took place on the 17 February 2017. This was the first inspection of Himley House which began offering a service to people in September 2016. Himley House is registered to provide accommodation and personal care for up to four adults who have an autistic spectrum disorder and / or a learning disability. At the time of our inspection the service was supporting one person.

People using the service are supported by staff on a twenty-four hour basis. Each person has their own bedroom and bathroom. A kitchen, lounge and dining room are also located on the ground floor. There are gardens at the back of the house for people to use, and parking outside.

At the time of the inspection there was no registered manager. The previous registered manager had left the home in May 2016 and a new manager was in the process of applying to become registered. 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 were not supported by a service that was operating effective systems or processes to assess risks, and to monitor and improve the quality and safety of the services provided.

People's rights were not being consistently protected in line with the Mental Capacity Act.

People using the service were seen to follow their preferred routines and lifestyle and interactions between staff and people were positive, responsive to need and caring. The care provided was personalised in some areas but did not enable people to live as independently as possible. The providers' management of complaints procedure had not been followed and had failed to ensure that any complaints received had been responded to appropriately.

People were supported to choose their meals and make their own drinks and snacks, with staff support. Staff had good knowledge of people's likes, dislikes and routines in respect of food, drinks and meal times.

Staff knew how to protect people from abuse and to keep them safe. The registered provider had policies in place to safeguard people from abuse and staff had completed training in this key area.

People were supported to receive their medicines. They were administered safely within the home but not when people were in the community. People had contact with their GP and health professionals as required.

Staff had been appropriately recruited to ensure they were suitable to work with vulnerable adults. We saw there were enough staff on duty to support people as needed in the home.

People using the service took part in a variety of activities in the community.

You can see what actions we told the provider to take as 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.

Peoples may have been at risk as plans of care had not been updated when their needs changed.

People were not kept safe from errors with their medicines when away from the service.

Staff told us they felt people were safe.

Is the service effective?

Requires Improvement

The service was not always effective.

Practices did not ensure that people would consistently be supported in their best interests.

The advice from healthcare professionals to meet people's care needs was not effectively shared with all staff.

Staff had received induction and training to support them in their roles.

Is the service caring?

Requires Improvement

The service was not always caring.

People's privacy and dignity was not always respected by staff.

People were not supported to promote their independence.

People were at risk of not being supported how they wanted because staff did not consistently use their preferred style of communication.

Staff were kind and considerate.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People could not be assured their complaints would be handled in line with the provider's complaint's policy.

People were not involved in their care and support.

People were supported to engage in activities they enjoyed in the community.

Is the service well-led?

Requires Improvement

The service was not always well led.

People were not supported by a service that was effectively ensuring compliance with all the regulations and managing risks.

The provider had not notified the commission of incidents and events as they are legally required to do so.

Staff told us they felt supported by the management.

Himley 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.

The inspection took place on 17 February 2017 and was unannounced. The inspection was undertaken by one inspector.

During our inspection we used a number of different methods to help us understand people who lived at the home. This was because the people who lived there communicated in different ways and we were not always able to directly ask them their views about their experiences.

Before the inspection, we asked the provider to complete 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. They did not return a PIR and we took this into account when we made the judgements in this report.

We also checked if the provider had sent us any notifications. These contain details of events and incidents the provider is required to notify us about by law, including issues such as unexpected deaths and injuries occurring to people receiving care. The provider had not sent us any notifications.

During our inspection we observed how people, who due to their specific conditions did not communicate verbally, were supported to express their views and interact with staff. We observed how people spent their time and if they appeared engaged and happy. We spoke individually with the manager, the provider and three care staff.

Each person has their own bedroom and bathroom. A kitchen, lounge and dining room are also located on the ground floor. There are gardens at the back of the house for people to use, and parking outside

We looked at a range of records including people's care plans. This enabled us to judge how well the service

met people's care needs and managed any risks to people's health and well-being. We also looked at other records including the provider's policies and procedures, two staff files, minutes of meetings, complaint and safeguarding records, medication records, staff training, maintenance and audit documentation.

After the inspection visit we also spoke with four health and social care professionals on the telephone and one relative.

Requires Improvement

Is the service safe?

Our findings

Peoples risks had been assessed by the manager but the risk assessments were not always robust. Whilst we saw that care plans were detailed and had been regularly reviewed, we noted that risk assessments had not been updated in response to changes in people's needs and behaviours. For example one person's plan of care around how they needed to be supported with their personal care, differed significantly from their risk assessment related to this area of care and support. This placed the person at risk from receiving inconsistent support that they needed to keep well. Staff we spoke with about this issue gave us inconsistent accounts of how they should be supported with personal care. A professional spoke with us about staff at the home and said, "They are soaking up information, which is good, but for [the people] with high levels of need, they don't know enough." A lack of consistent care and absence of consistent information about how people required supporting put people at risk of receiving unsafe or inappropriate support.

People had received appropriate support when they had been involved in any accidents or incidents, and we saw that the service maintained clear records of any accidents or incidents that happened within the home. Staff told us about the importance of reporting incidents or accidents that occurred. We noted that while the records were up to date there had not been any analysis of them. This meant that opportunities for protecting people from the likelihood of accidents and incidents reoccurring were missed.

People received most of their medicines safely and when they needed them when they were in the home, however this was not the case when they were out in the community with staff. Staff we spoke with were not aware of how to provide medicines safely for people when they were outside of the home. For example, staff told us, and professionals confirmed, that when people went into the community that medicines for one person were removed from the original packaging and were carried unlabelled. This placed the person at risk of receiving the wrong medicines.

We saw that medicines were kept in a suitably safe location, although the provider was not monitoring the temperature at which the medication was kept. Very high or low temperatures may affect the effectiveness of some medicines. The medicines were administered by staff who were trained and assessed as competent to do so. Where medicines were prescribed to be administered 'as required', there were instructions for staff providing information about the person's symptoms and conditions which would mean that they should be administered. We sampled the Medication Administration Records (MARs) and found that they had been had been correctly completed. A count of people's medicines balanced with the amount of medication which had been recorded as administered. This indicated that people had received their medication in the home as prescribed.

The deputy manager told us that every time they came on shift they visually checked the medication recording and addressed any errors or concerns at that time. Records of these checks were not available to us on the day of our inspection to confirm this. The home's medication policy was not available for staff on the day of our inspection.

Staff we spoke with felt the home was safe, one member of staff said, "[People are] absolutely safe; we are always there for them." We saw people were confident to approach members of staff if anything concerned them. We saw staff spent time with people to reassure them. Staff we spoke with felt confident and able to recognise and respond to different types of abuse to protect people from the risk of harm. A member of staff spoke to us about safeguarding people and said, "I would tell someone, I have whistle blown before at a different home, I know what to do." We found that staff had up to date knowledge and training in relation to keeping people safe from abuse.

People were kept safe from fire. In the event of a fire emergency evacuation plans were in place for each person which detailed their support needs. Staff we spoke with were consistent in their response as to what action to take in the event of a fire or an emergency situation. This reduced the risk of harm to people during an emergency.

We saw and staff told us that there were sufficient numbers of staff available to support and meet people's care needs. Staffing levels meant that people could be supported very quickly and this helped them stay safe and well. All the staff we spoke with confirmed this. Throughout the inspection we saw staff were able to spend time with the person supporting their different care needs or interests. For example, when the person wanted to go out in the car, staff facilitated their request very quickly. We saw that the manager had sufficient systems in place to manage staff absence, for example there were other staff available who were not on duty who could cover any staffing issues at short notice.

People were supported by staff who had been safely recruited. Recruitment processes in place had been followed to help minimise the risks of employing unsuitable staff. We reviewed staff recruitment files and saw that the registered provider's recruitment process contained the relevant checks before staff worked with people. One member of staff said, "I had my police check and references before I started."

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 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). 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.

The provider had approached the local DoLS authority when there was a risk that the care provided could result in restricting a person's freedom. We found that the provider had appropriately applied for any deprivation of liberty safeguards that were needed and had a system in place that ensured that were reviewed. However the provider had failed to notify CQC that the authorisation had been granted.

Staff we spoke with told us they gave people day to day choices such as what food to eat. One member of staff said, "We show [the person] things and they choose." Where decisions were needed about bigger issues, there were no formal processes in place to ensure that such decisions were made in keeping with best interests procedures. Where a person had been deemed to lack capacity, the manager had not applied the law to ensure others who had an interest in the person's welfare had been involved in deciding any actions which were in the person's best interest.

For example we found that the provider had made a decision to restrict visitors to the home without agreeing the reasons through the MCA decision making processes. They had not considered if less restrictive options were available, or when people lacked the mental capacity to agree to this decision, taken any action to involve others to identify what was in people's best interests. This meant that the key elements of the Mental Capacity Act had not been fully understood or implemented by the service. They did not respect the person's right to a family life and placed them at risk of unnecessary psychological distress.

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

During our inspection we noted that the home used some physical restraint techniques to support people to keep themselves and others safe. The home had a clear restraint policy. We saw a protocol for each person was in place and staff all knew what restraint should be used and when. Staff clearly described restraint as a method of last resort after other ways of supporting people had not worked. All the staff who took part in restraint people had received appropriate training to do so safely. We saw that records had been maintained detailing occasions when restraints had been used and we noted that the frequency of restraints for one person had reduced since they began living at the home.

People in the home were supported to make use of the services of a variety of mental and physical health professionals including psychiatrists. We saw that people had health action plans in place that gave information about who was involved in each person's care and support. The manager told us they involved other professionals promptly and the advice that had been given had been cascaded to the staff team verbally either at 'hand over meetings' or within team meetings. Records were not available to us on the day of our inspection to demonstrate this. We noted that people's care records did not consistently include any verbally cascaded information, and that some support was being delivered in an inconsistent manner. For example information from health professionals had not been recorded in relation to a safe method of bathing and staff were not supporting the person consistently with this activity. This meant that people did not receive consistent healthcare support as advised by their healthcare professionals.

All the staff we spoke with said they felt they had the knowledge needed to support the people in the home. Staff told us and records confirmed that all staff had received induction training when they first started to work in the home. We saw that this included the Care Certificate. The Care Certificate is an identified set of induction standards to equip staff with the knowledge they need to provide safe and compassionate care. Staff also received additional training when necessary to meet people's needs including guidance from health professionals about people's specific conditions. One member of staff told us, "I do my training." We saw that the provider had a system for monitoring and recording when staff needed to have refresher training to make sure they maintained relevant skills and knowledge.

Staff confirmed they had good access to advice and guidance when necessary from senior staff. We saw a matrix that was used to monitor and ensure that all staff received informal and formal supervision from the manager on a regular basis. There were staff meetings to provide staff with opportunities to reflect on their practice and agree on plans and activities. Staff felt supported to develop their knowledge and skills.

People were offered food staff knew they liked. Staff told us people were supported to be involved in selecting menu items, and we saw photographs and objects of reference that were given to people to help them make an informed choice about the food they wanted that day. One staff member said, "We give [people] the actual food [which is available] so that they can choose." We noted that people had their weight regularly monitored to identify if there were any adverse health effects when people chose not to eat.

Requires Improvement

Is the service caring?

Our findings

People's privacy and dignity was not always maintained. One person liked to spend time on their own in their room and we saw staff would check on the person to make sure they were safe and well. We noted however that one person had a small window in their door to allow staff to monitor them discreetly to keep them safe. However this window remained uncovered when not in use by staff which enabled visitors to also view the person in their room from the entrance hallway of the home.

The culture of the service did not include promoting people's independence. Staff we spoke with did not have a clear understanding of how to promote people's independence to enhance their dignity and self-esteem. One member of staff said, "We don't really do anything to promote independence." The manager told us that the home did not have a plan or method of promoting independence in any structured way for the future but advised that on occasion people had taken part in some activities within the house. We saw photographs of a person taking part in various household activities. We found that people had occasionally been supported in some areas such as preparing food, but this was not part of people's care plans. Staff told us some people had needed time to settle into their new home, which delayed a focus on promoting independence.

People were not always supported to express their views and be involved in making decisions about their care. Staff had not supported one person to use their preferred communication style, Makaton, for some months after moving into the home. There had been a delay in using Makaton to assist the communication of people. This had significantly reduced the person's ability to express their views of the service and to specify what support they needed or wanted. This meant that the person was unable to be involved in their care and support as much as they otherwise could have been. At our inspection the manager told us that Makaton training had been sought for staff and they were now beginning to use it.

We saw that staff expressed a kind and a caring attitude to the people within the home. Everyone we spoke with talked of the person with respect and empathy. All the staff we spoke with said that they thought the home offered caring and kind support to the people who lived there. One staff member said, "We are all concerned about [the people] and care about them."

We saw staff checking and asking people what support they wanted from staff or where they wanted to be in the home. We saw that there were clear records of how people wanted to be addressed by staff and what they liked to do. We observed staff addressing people by their preferred names. Staff were keen to encourage people to take part in activities they knew people would enjoy and offered reassurance when people became upset. People received very timely support when needed, and we saw that practical steps were taken promptly to relieve people's distress. For example when one person started to become anxious staff responded positively as an activity was organised very quickly to ensure that the persons distress was of short duration.

Requires Improvement

Is the service responsive?

Our findings

People could not be assured that their complaints would be responded to effectively. The service had a comprehensive and up to date complaints policy but this was not always followed by staff. Although the manager told us that the service had not received any complaints or concerns, records confirmed that formal complaints had been received. We noted these had not been responded to in line with the provider's complaints policy.

We found that people and their relatives had not been given access to guidance about how to raise a complaint including information about how to take the matter further if they were not satisfied with how their complaint had been responded. We brought this to the attention of the manager who was not aware of their responsibility to operate within a formal complaints process or of their responsibilities under the duty of candour to provide an open and transparent complaints process.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The home had gathered some background information about people, but this lacked detail and did not ensure that people received their care and support in a way they preferred. A professional we spoke with told us they felt the people who lived at the home were, "not at the centre of what [the home] does." For example one person whose history showed that they liked to have short hair had not been supported to have a haircut for many months. The manager had not sought available information from professionals and relatives about how to do this in a way the person preferred. As the available information had not been used, the persons care had not been given in a way they preferred. While many health and social care professionals had been involved in developing and planning the care for people, the care people received from the service did not always put people at the centre of their support.

People were not involved in the development of their care plans to ensure they reflected their preferences. We spoke with both the manager and staff and found that no action had been taken to ensure that care and support plans had been developed to support people to be involved and to help them understand care options available to them. The manager advised that they had no plans to begin involving people in a meaningful way. The manager told us that care plans had been devised based on information received from other professionals. One professional confirmed that that no staff had tried to involve a person using the service to be involved in development of their care plan The provider had not tried to do everything reasonably practicable to involve people in agreeing their care and support that was to be provided.

Staff we spoke with told us about the activities that people enjoyed and we saw that staff supported people to choose what they did each day. Staff told us and records showed that people were supported to engage in activities they liked. Staff made judgements about the type of activity each person might enjoy at any specific time. People had been supported to return to education on a part time basis and were beginning to benefit from the regular input from their school. We noted that people preferred to be supported by care staff of their own gender and this had been arranged by the provider.

Requires Improvement

Is the service well-led?

Our findings

At the time of the inspection there was no registered manager at Himley House. The previous registered manager had left the home in May 2016 and an acting manager was in post at the time of our inspection. The acting manager told us they intended to apply to become the registered manager of the service.

Organisations registered with the Care Quality Commission have a legal obligation to notify us about certain events. The provider had not ensured that effective notification systems were in place and CQC had not been notified of events as required. This included not being notified of the previous registered manager leaving the service and not alerting the local authority or notifying CQC of safeguarding events when people were put at risk if harm. At the time of inspection the service had been without a registered manager for over eight months, without notification being made advising of the arrangements to manage the service in the absence of a registered manager.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009.

We found that the registered provider was not operating effective systems or processes to assess, monitor or improve the quality and safety of the services provided. The provider told us that they visited the home on a weekly basis to review records and speak with staff. The provider also told us that they reviewed the environmental safety of the home at that time including water temperature checks, general maintenance and smoke alarm tests. Records of these visits were noted in a daily log book but no records were available in relation to any findings, improvements or actions the provider may have taken as a result of these visits. The manager told us that spot checks had taken place with night staff and care records were reviewed on a regular basis. There were no records to evidence this and the manager could not provide us examples of how the service had improved as a result of this monitoring. There was no trends analysis of any information within the home, for example in relation to accidents or incidents. Formal audits of medication had not taken place. Shortly after the inspection we were advised that steps had been taken to improve this situation.

The systems in place to assess, monitor and manage the home were not effective and had failed on occasions to identify issues that needed to be addressed. For example the manager told us that information and advice about how to support people had been received from external health professional. This information had been verbally cascaded to the staff team. However care plans and risk assessments had not been updated to reflect this advice. We found that external advice and guidance had not been effectively implemented within the home and that information sharing was inconsistent. Systems to monitor this had been ineffective.

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

Before the inspection, we asked the provider to complete 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. They did not return a PIR within the time frame required.

The provider had made decisions that may have impacted negatively on people and had not taken into consideration the principles of the Mental Capacity Act to protect people's human rights, specifically in relation to relatives visiting people at the home.

The provider had a complaints process which had not been implemented or followed.

We found that the leadership of the service was very reactive to input from other professionals, but was not proactive in managing risks, or seeking ways to be more person centred and to put people at the centre of their care and support.

Not all staff understood their responsibilities or their roles within the home such as how to promote peoples independence, or to ensure they supported people in a way that kept them both safe and well.

The home had been registered for less than one year and so formal surveys had not yet taken place. However there were no other methods being used to seek feedback from people, their relatives or professionals to improve the service. The manager could not tell us of their plans to introduce this. We found that quality assurance was not an integral part of the homes culture.

Feedback we received from the majority of professionals described the home as not consistently providing a high quality service. Comments included, "There's no co-ordinated approach." Another professional commented on witnessing poor knowledge and negative attitude from the management which they had found to be unhelpful.

Staff told us felt supported by management and were recruited safely. Staff received training and supervision regularly. Staff meetings took place and staff were given a verbal handover of information at the change of every shift. Staff told us that a manager was available to them if they needed support.

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	Regulation 18 Registration Regulations 2009 Notifications of other incidents Statutory Notifications had not been completed or returned to CQC as required.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Key elements relating to Best Interests of the Mental Capacity Act had not been fully understood or implemented by the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had not operated within their own complaints procedure. Complaints received were not investigated and responded to in line with regulations.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The providers systems had not been effective in assessing, monitoring and driving up quality improvements within the home.