Care Quality Commission

Speciality Care (REIT Homes) Limited

Houndswood House Care Home

Inspection report

Houndswood House Care Home
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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**

Overall summary

This inspection was carried out on the 7 January 2016 and was unannounced. It was a focussed inspection in response to concerns we had received about the standards of care at the home. The concerns related to poor care and a lack of appropriate response to people's health needs. We considered the information and concerns and concluded that we should focus on two of the key questions: Is the service safe? Is the service well-led?

Houndswood House provides accommodation for up to 50 people who require nursing and personal care, including people living with dementia. There are two separate units in the home, Magnolia Lodge for people living with dementia and Primrose House for people who require nursing care. At the time of our inspection there were 43 people living at the home.

The home had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Summary of findings

CQC had received information relating to five recent safeguarding concerns at the home. However these had not been reported to us by the provider and therefore we had not been informed in a timely way and this had delayed our involvement and response to the concerns.

Most people looked groomed and it was evident that they had been assisted with personal care. Some of the people who lived at Houndswood house were sitting around in various lounges and other people were being assisted to get ready for the day or had chosen to stay in their bedrooms.

We observed staff to be caring in their approach to people. Feedback from four relatives was extremely positive and complimentary and relatives raised no concerns about the standards of care. Relatives in particular were complimentary about the staff. One relative told us “I have always been happy with the care my ‘Relative’ has received. Another told us “My ‘relative’ likes it here and if they are happy, so am I” They went on to say “The staff are wonderful”.

We noted that records and paperwork was not always consistent and not always kept up to date. For example records relating to fluid intake, weight monitoring and ‘must’ scores were not always maintained accurately and the registered manager was arranging a staff meeting to address this imminently.

The home was due to be refurbished at the end of 2015; however the registered manager told us the refurbishment had been put on hold for approximately 9 months. This was a decision taken by senior managers and the registered manager did not know why the refurbishment had been put on hold.

We noted storage of equipment was an area of concern, and this was referred to the manager to address, as we observed this to be a hazard.

We saw that people’s daily care file records were located in the doorways or on window sills in the corridors, therefore not protecting or maintaining people’s privacy/ confidentiality.

The manager told us they were short staffed and this meant that they and the deputy manager had to cover some of the nurse shifts. This impacted on their ability to concentrate on the ‘management type issues’ and they told us they were often behind with completing paperwork and other tasks.

The ‘call bell system’ was not working correctly apart from to alert staff that people needed help The time and date settings were found to be incorrect and no records or historic data were available. So they could not be monitored effectively.

Medicines were found to be administered safely by staff who had been trained. Staff competency was checked and medicines were only administered by the nurses.

Staff were able to demonstrate they understood fully the safeguarding procedure, what constituted a concern, how to report concerns and how to escalate these if required.

The registered manager had systems in place to monitor the quality of the service. However these were not always effective in identifying issues or concerns or in putting timely remedial actions in place.

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? The service was not consistently safe. People were not always kelp safe, and staff did not always follow the safeguarding process appropriately. Risk assessments were in place but there were concerns about the effectiveness of these. The home was not always maintained to a sufficient standard to protect people from the risk of cross infection. Staffing levels were not always adequate to meet people's needs in a timely way.	**Requires improvement**
Is the service well-led? The service was not consistently well led. The service had a registered manager. There were systems in place to monitor the quality of the service. However they were not always effective. Records and documentation was not consistent and not always maintained effectively.	**Requires improvement**

Houndswood 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2014 and 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 7 January 2016 and was carried out by two inspectors. The inspection was unannounced and had been brought forward in response to concerns received at the CQC. Before our inspection we reviewed information we held about the service including statutory notifications relating to the service. Statutory notifications include information about important events which the provider is required to send us.

During the inspection we spoke with four people who lived at the service, four relatives, a visiting health care professional, four members of staff, the deputy manager and registered manager. We received feedback from health and social care professionals who visited the home. We viewed six people's support plans and looked at safeguarding records, monitoring records and audits, cleaning schedules and accident/incident records. We observed staff interactions with people and saw how care was provided to people.

We used the Short Observational Framework for Inspection (SOFI). SOFI is a specific way of observing care to help us understand the experience of people who could not talk with us due to complex health needs.

Requires improvement

Is the service safe?

Our findings

People were not consistently safe. CQC had recently received information of concern relating to poor care. There were safeguarding investigations on going at the time of our inspection. One allegation had been partially substantiated.

People were not always kept safe from risks within the service. Although there were risk assessments in place they were not always followed. For example we observed people being hoisted and saw that the staff interaction was kind and there were always two staff supporting the person. However we found that the slings used with the hoist were being shared which increased the risks of cross infection. The manager told us that people did have their individual slings and that these should be kept in people's rooms and should only be for used for the person who had been assessed for use of that particular sling. When we spoke to staff to check where they found the information to inform them about the use of equipment, for example which slings to use,staff were unable to tell us where they would find this information. This lack of knowledge placed people at risk, especially when being transferred using a hoist.

We saw that wheelchairs, foot plates, and slings were all stored in the corridors. In one corridor there were eight wheelchairs the entire length of the corridor. In addition we saw four sets of footplates and approximately seven slings draped over furniture and on the back of doors. These items of equipment presented a trip hazard and also in the event of an emergency greatly restricted the speed at which people could move along the corridor. We told the manager about this and they told us the home lacked storage space. However when we detailed the risk impact the manager agreed that they would address this.

This was a breach of regulation 12 of the Health and Social Care Act 2014 because the provider failed to ensure that risks that were identified and mitigated.

We saw that staff were kept busy at all times, with little time to spend time with people other than when assisting them with tasks. The manager told us they used a dependency tool to assess staffing levels. We observed that three people sitting in the small lounge were left alone without any staff present for 15 minutes in the morning and while staff were assisting people to the dining room for lunch staff were also not present for 25 minutes. We reviewed rotas for a period of four weeks and saw that there were usually four care staff and one nurse on duty on Primrose unit and five care workers and one nurse on duty on Magnolia unit. However at times this varied, and staff told us that they often only had four care staff on each unit. Staff told us that when there was only four staff on duty they were very stretched and because several people required the assistance of two staff it took much longer to get around to assist people with personal care. People we spoke to did not tell us they had to wait too long for assistance. However staff did say that people had to wait to be assisted with washing and dressing.

We also noted that there were odours in the main lounge and staff were not always able to assist people when they required assistance. We saw that staff were still assisting people to get ready for the day at 11am. However these were people living with dementia and they were unable to tell us if they were happy to wait until this time to be assisted. However one person was sitting in their pyjamas and only had slippers on their feet another had a nightdress on with an outside jacket over the top. This was undignified for them as the room had nine other people sitting in it. We reviewed two care plans for these people and they did not specify support was required later in the morning. Staff did tell us that these two people had been given breakfast in their bedrooms earlier so that it would not impact on their lunch which was served at 12.30. Staff told us they felt that they could do with more staff especially on Magnolia where people required close monitoring and supervision. Staff told us they 'encouraged' people to come downstairs to one of the lounges as they were able to keep an eye on them, where as if they were in their bedrooms it was not so easy to observe them so frequently. This feedback suggested that people were not always being supported in a timely way but were reliant on the availability of staff, to meet their needs when they were free to do so.

Medicines were managed safely, and were only administered by trained nurses. There had been no medicine errors since our last inspection. We saw that nurses underwent annual 'competency' checks to ensure good practice was maintained.

Requires improvement

Is the service well-led?

Our findings

We found that the service was not consistently well led. The home had not been maintained to a sufficient standard and the audits and checks that were in place were not effective in identifying and addressing the shortfalls.

The manager confirmed they had not notified us about the safeguarding concerns as they did not realise they had to. They had also failed to notify us of a serious injury to a person who used the service, at the point at which they became aware of the injury, which was after the person had been admitted into Hospital.

This was a breach of regulation 18 (2) of the Health and Social Care Act (Regulation Activities) 2014 Regulations because the provider failed to notify us of accidents which resulted in an injury to a person who was using the service.

The registered manager told us the refurbishment of the home had been put on hold for up to nine months. However after we pointed out some areas that needed immediate improvements the manager told us they had been given authorisation to proceed with changing the carpets.

People knew who the manager was and told us they were seen out 'working' on the floor. Relatives also told us they were able to speak with either the manager or deputy most times.

There were some systems in place to monitor the quality of the service. However these were not always effective. For example the cleaning schedule, although we saw that they had been completed regularly they were not checked and were non-specific. For example, we asked how the manager knew that mattresses on beds had been checked and were told this would be done as part of the 'resident of the day' checks. However this was not recorded and therefore staff could not be challenged if the task remained uncompleted. This also meant that the manager could not satisfy themselves that people were receiving safe and appropriate care if there was no evidence that people's mattresses were being checked.

We spoke with senior staff on the nursing unit to ask how they ensured that the correct sling size was being used when transferring people using a hoist as we had identified this as a area of concern. They stated that they knew people's sizes but could also check in the moving and handling section of people's care plans. However, we reviewed these and found that this information was not recorded there. This meant that staff may not have had access to correct and current information and this put people at risk of poor moving and handling practices.

We saw records were not consistent and not checked to ensure they had been completed correctly. We found the food and fluid monitoring charts had been duplicated causing confusion for staff and inconsistent records. We saw that in one persons care plan both forms were being completed by some staff, while others were completing food intake on one form and fluid intake on another. This meant that the records were inaccurate and inconsistent. This also meant that the manager could not satisfy themselves that people were receiving safe and appropriate care if there was no evidence that people's food and fluid intake were being monitored correctly.

We saw that people's MUST scores were not always accurate or up to date. MUST is a recognised malnutrition screening tool. This meant that we could not be assured that people were receiving appropriate care. We also saw that daily care files were propped up in the door way of people's bedrooms or on window sills in the corridors. The records were accessible to anyone visiting the service and this was a breach of confidentiality.

We looked at quality assurance processes for falls, mobility, medicines, dementia care and skin integrity. Again, we saw that records were not always accurate. For example one person had sustained a fall and subsequently the matter was referred to safeguarding for investigation. There were two different dates recorded for when the incident occurred. This meant that we could not be assured people were receiving appropriate care and support. We also saw there was a process for recording and monitoring accidents and incidents. However the maintenance of records and documentation required improvements

This was a breach of regulation 17 (c) of the Health and Social Care Act (Regulation Activities) 2014 Regulations because the provider did not have adequate systems in place to maintain the accuracy and security of records.

The manager was visible throughout our inspection and staff confirmed they felt they could approach the manager with any concerns they had. At the time of the inspection there had been a couple of emergencies and the manager was seen responding to these as well as staff. We observed

Requires improvement

Is the service well-led?

good responses from staff when responding to emergencies. This demonstrated that staff did not assume that other people would deal with the problem but responded as part of their role.

We spoke to a visiting health care professional who told us they felt it was a good home and that staff responded appropriately to people's needs and arranged for visits when required. They told us they found that staff were efficient in taking and recording basic observations of people.

Staff received support from managers and told us this was regular and they always discussed ways of improving the service.

At night there were two nurses and three care staff. At times of peak demand care staff 'floated' between the two units to give support where required. Call bells were answered efficiently during our inspection. However we were unable to check any historic records as the system did not provide historic data. This meant that the response times to call bells could not be monitored effectively. The manager told us they were short of nurses and both they and the deputy manager had to cover nurse's shifts on a weekly basis. This meant that while they were covering nurses shifts their 'management responsibilities were put on hold.

The manager told us they completed daily spot checks to see that staff responded efficiently to the call bell system. The registered manager told us they went into various areas in the home and activated the call bell and then waited to see how quickly staff responded. However the system did not have the correct date and time, and the registered manager told us they checked the response times on their watch. This was an unreliable way of checking response times, and these checks were reliant on the registered manager being available and on site to complete these but did not serve much purpose to support any investigations for example. However there were three 'emergencies' on the day and they were dealt with super efficiently when staff were alerted by a continuous ringing of the alarm.