Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Holbeche House Care Home

Wolverhampton Road, Wall Heath, Kingswinford,
DY6 7DA

Date of Inspection: 22 October 2012

Date of Publication: November 2012

We inspected the following standards to check that action had been taken to meet them. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✗ Enforcement action taken
Safeguarding people who use services from abuse	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✗ Enforcement action taken
Records	✗ Action needed

Details about this location

Registered Provider	Four Seasons (Bamford) Limited
Registered Manager	Ms. Diane Williams
Overview of the service	Holbeche House care home can provide accommodation for up to 49 people who require nursing or personal care.
Type of service	Care home service with nursing
Regulated activities	Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

We carried out this inspection to check whether Holbeche House Care Home had taken action to meet the following essential standards:

- Respecting and involving people who use services
- Care and welfare of people who use services
- Safeguarding people who use services from abuse
- Supporting workers
- Assessing and monitoring the quality of service provision
- Records

This was an unannounced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 22 October 2012, observed how people were being cared for and checked how people were cared for at each stage of their treatment and care. We talked with people who use the service, talked with carers and / or family members, talked with staff and talked with stakeholders.

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.

What people told us and what we found

We carried out this inspection to follow up concerns we identified from our previous inspection on 28 June 2012. There were 36 people living at the home on the day of the inspection, including 22 people in the dementia unit. We spoke with two people, five staff, the deputy manager, the home manager, and the regional manager.

We found that improvements had been made in the way people were offered choices One person said, "I get a choice for what I want to eat."

We continued to find that people were not receiving appropriate care in a timely manner. People's care records were not always accurate and updated regularly. This meant that improvements had not been made to ensure people received care that met their needs.

We found that improvements had been made in the way that staff reported safeguarding concerns and in the way that people's finances were being managed.

We found that improvements had been made in supporting staff with regular supervision and training. One staff said, "It is better now than before."

We found that the registered provider and the registered manager had failed to make necessary improvements following our previous inspection, where we identified concerns.

We found evidence to show that concerns had not been addressed appropriately to ensure better outcomes for people.

We found that records were inaccurate, incomplete, and unclear which continued to pose a risk of people not receiving the care they needed.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 08 December 2012, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

We have referred our findings to Local Authority: Commissioning and Local Authority: Safeguarding. We will check to make sure that action is taken to meet the essential standards.

We have taken enforcement action against Holbeche House Care Home to protect the health, safety and welfare of people using this service.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Respecting and involving people who use services ✓ Met this standard

People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run

Our judgement

The provider was meeting this standard.

People were offered choices and their dignity was being maintained.

Reasons for our judgement

Our inspection of 28 June 2012 found that people's care records relating to their choices and preferences had not always been completed and people's dignity was not always maintained. The provider sent us an action plan to tell us that people's documentation would be completed and that staff would be reminded to use dignity blankets when people were being transferred using the hoist.

During this inspection, we found that staff had completed documentation relating to people's preferences to ensure they were aware of people's likes and dislikes. We saw staff using dignity blankets throughout the day when people were transferred from one place to another using a hoist.

We found that people could choose what they wanted to eat from the menus. One person said, "We just choose what we want from the menu every time." We saw that the home had pictorial menus, although we did not see them being used on the day of the inspection. We saw people being offered choices during mealtimes. This meant that improvements had been made in the choices that were being offered to people living at the home.

Care and welfare of people who use services ✖ Enforcement action taken

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

People did not experience care, treatment and support that met their needs and protected their rights.

We have judged that this has a moderate impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

Our inspection of 28 June 2012 found that care was not always planned and delivered in a way that met people's needs or in a way that ensured people's safety and welfare. The provider sent us an action plan telling us that people who went to live at the home would have their care records completed within seven days. We were informed that care plans were updated regularly, risks were identified and managed, and activities would be taking place particularly in the dementia unit.

During this inspection, we found that improvements had not been made to ensure that care was planned and delivered in a way that met people's needs or in a way that ensured people's safety and welfare. We looked at four people's care records.

We looked at one person's care records who had recently gone to live at the home. The care records indicated that staff had identified that the person had sore skin at admission. The person's care records stated that they should be encouraged to walk around the home to improve circulation in their feet. We observed that staff did not carry this out throughout the day appropriately. This meant that the person's needs were not met to manage their health condition. We found that this person did not have all aspects of their care plan completed although they had been at the home for over seven days. For example, there was no information about how staff should communicate with the person. It was important for staff to know this as the care plan stated that staff should prompt the person to walk frequently. This meant that the action the provider had told us they had taken, had not been completed.

We looked at another person's care records and found that they had sore skin of a serious nature. We found instructions in the care records that staff should turn the person in different positions every two hours to relieve pressure in the area of the sore skin. We looked at the charts, which showed how often the person was turned and what position they were turned to. We found that records for some days indicated that they were turned on the side, which they should not have been turned on and in other instances, there were gaps, which indicated that the person might not have been turned. We spoke with different

staff about the care the person should have received and we found that all staff gave us different information about this. This meant that people might not receive care that met their needs. One person told us, "Care is OK."

One person's care plan about their continence needs, mentioned that they had poor vision. We could not find any other information in the person's care record about their vision and how this might affect the delivery of care. We asked the home manager about the reason for poor vision, who informed us what this was but also stated that there was no treatment for this. We spoke with staff about this person and two out of three staff were aware that the person had poor vision. This meant that we cannot be assured that consistent care was delivered and that the correct care was being provided in the absence of further information relating to the condition.

We saw that the television was on although this was not loud enough and people were not watching it. We continued to see lack of stimulation and activities, especially in the dementia unit. We found that improvements we had seen at the previous inspection were not being followed during this inspection, like people playing instruments. This meant that the improvements made previously were not consistent to ensure that people had a stimulating and meaningful lifestyle.

We saw one registered nurse administering medicines to one person using their finger, which they put in the person's mouth. They then continued to cut another person's food using their hands. The staff member did not follow procedures to wash their hands to minimise the risk of spreading infection.

In the afternoon, we heard music was playing in the background. However, people were agitated, and distressed in the dementia unit. We found two senior staff in the staff room writing in people's care records, one staff sitting on a chair not interacting with people, and another staff holding a person's hand without realising they needed support with their care needs. We had to ask the staff to help the person they were sitting with and another person who needed help and support in the same longue. In one instance, we saw people at the home supporting and reassuring each other. We saw that there was little or no interaction between staff and people. This meant that staff did not respond to people's needs in an appropriate and timely manner.

Safeguarding people who use services from abuse ✓ Met this standard

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was meeting this standard.

People who use the service were protected from the risk of abuse, because the provider had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening.

Reasons for our judgement

We spoke with people living at the home but their feedback did not relate to this standard.

Our inspection of 28 June 2012 found that staff were not appropriately referring safeguarding concerns to management. During this inspection, we found that staff had knowledge about the actions they needed to take to safeguard people. Since the previous inspection, we found that staff had appropriately referred a safeguarding concern to management in the absence of the home manager. This meant that staff took action to keep people safe.

Our inspection of 28 June 2012 found that people's finances were not being managed appropriately. During this inspection, we looked at two people's money records and balances. We found that the home did not keep people's money individually although there were individual records for people's finances. We found that there was a floating balance, which included several people's money. We checked this balance and found that it was accurate. We found that there was an effective system and that all debit transactions were accompanied with receipts, which were checked by two staff. The home manager was also checking the balances and receipts on a regular basis. This meant that suitable arrangements were in place to ensure that people's money was safeguarded appropriately.

Supporting workers ✓ Met this standard

Staff should be properly trained and supervised, and have the chance to develop and improve their skills

Our judgement

The provider was meeting this standard.

People were cared for by staff who received supported to deliver care.

Reasons for our judgement

We spoke with people living at the home but their feedback did not relate to this standard.

Our inspection of 28 June 2012 found that staff did not receive appropriate professional development through training, supervision, and appraisals. During this inspection, we found that staff had progressed significantly in their training. The manager had displayed some statistics on the wall of the office to show this progress. Staff we spoke with told us they had been completing their training. One staff said, "I have done so much training recently, but its good." This meant that staff received appropriate training to develop their skills.

We saw a supervision matrix, which indicated that 21 staff had supervision with their manager in the month of September. We spoke with five staff about supervision, all of whom told us they had received this recently. Staff told us they felt supported and used supervision to talk about their progress, training needs and their performance. This would enable staff to get feedback and improve working practices.

We looked at minutes for staff meetings, which gave staff feedback following our previous inspection and areas of concern so that improvements could be made. Staff were aware of our inspection findings and areas of non compliance. This would enable staff to understand shortfalls and make improvements where possible. We found that staff appraisals had not been completed. The manager told us that this would be carried out for staff. The provider may find it useful to note that all should receive regular appraisals to ensure that they get an opportunity to identify and work towards their goal and develop their skills.

Assessing and monitoring the quality of service provision

✖ Enforcement action taken

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system to regularly assess and monitor the quality of service that people receive.

We have judged that this has a major impact on people who use the service and have taken enforcement action against this provider. Please see the 'Enforcement action' section within this report.

Reasons for our judgement

We spoke with people living at the home but their feedback did not relate to this standard.

Our inspection of 28 June 2012 identified that a number of the issues raised from our previous visit of 9 May 2012 had not been addressed. We had also identified continuing concerns in the home that the registered manager or registered provider failed to improve. Following the previous inspection, the provider sent us an action plan to tell us that the regional manager would be providing support, audits would be completed to identify shortfalls, and action would be taken to address this, which would be tracked.

During this inspection, we found that the registered manager and the registered provider had again failed to make necessary improvements for better outcomes for people living at the home. We found that actions that the provider had told us were completed had not been completed. For example, the action plan stated that the regional manager had identified that some records were not completed appropriately. However, we continued to find instances during this inspection where records were not completed. In one instance, a senior manager had audited one person's care record in July 2012 and September 2012 and found similar gaps. We looked at the person's care records and found that the gaps had still not been addressed. This meant that systems were not in place to ensure action was taken once shortfalls were identified.

Our inspection of 28 June 2012 found that not all accidents and incidents were being reported. The provider sent us an action plan to tell us that all incidents would be reported electronically and analysed monthly to review changes. We found that not all incidents we identified from one person's care records were reported electronically. The manager was unable to use the system to find out how many incidents one particular person was involved in over the month. We saw a monthly print out of the incidents with a description of the incident, which would identify trends. However, we were unable to see how this information was used to minimise risks and make improvements.

We found that the home was failing to identify concerns and make improvements across

other regulations that we inspected.

Records ✖ Action needed

People's personal records, including medical records, should be accurate and kept safe and confidential

Our judgement

The provider was not meeting this standard.

People were not protected from the risks of unsafe or inappropriate care and treatment because accurate and appropriate records were maintained.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with people living at the home but their feedback did not relate to this standard.

Our inspection of 28 June 2012 found that records were not accurate, complete, or accessible. During this inspection, we looked at people's care records and found that there was contradicting information about the location of sore skin. One document stated it was the right foot and other document stated it was the left foot. The deputy manager told us she might have written the wrong location in the notes. We found another person had two entries describing their sore skin for the same date, although both descriptions were different. This meant that records were not always an accurate reflection of people's care needs and conditions.

We looked at people's food and fluid intake charts, which tell us how much people have had to eat and drink throughout the day. We saw that these were not completed to show what people had to eat and drink. In one instance, we were made aware that the deputy manager had given a person fluid and asked another staff member to record this, which was recorded incorrectly by the staff. This would provide inaccurate information about how much the person has had to drink. Staff must ensure that they record entries in people's care files that they have delivered.

We found that staff did not always complete all sections in people's care records, as they should. For example, in one person's repositioning records, staff were not recording the mattress setting which is important in the healing of sore skin. We found that although this had been highlighted, staff continued to complete documentation incorrectly. We found that many entries in people's care records were not clear and legible. In some instance, we had to ask staff or the regional manager to read records for us. This meant that records were not accurate, complete or clear which continued to pose a risk of people not receiving the care they needed.

We will be taking action to address continued non compliance of this Regulation through Regulation 10, outcome 16.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010** **Records**
	How the regulation was not being met: The provider was failing to meet Regulation 20(1)(a) to ensure people were protected against the risks of unsafe or inappropriate care and treatment arising from a lack of proper information about them.

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 08 December 2012.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

This section is primarily information for the provider

✖ Enforcement action we have taken to protect the health, safety and welfare of people using this service

Enforcement actions we have taken

The table below shows enforcement action we have taken because the provider was not meeting the essential standards of quality and safety (or parts of the standards) as shown below.

We have served a warning notice to be met by 07 December 2012 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
Diagnostic and screening procedures Treatment of disease, disorder or injury	**How the regulation was not being met:** The provider was failing to comply with Regulaton 9(1)(b)(i) and 9(1)(b)(ii), which states that people should be protected against the risks of receiving care or treatment that is inappropriate or unsafe, by planning and delivering care and treatment that meets individual needs, and ensures the welfare and safety of people.

We have served a warning notice to be met by 07 December 2012 This action has been taken in relation to:	
Regulated activities	Regulation or section of the Act
Accommodation for persons who require nursing or personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**
Diagnostic and screening procedures	**How the regulation was not being met:** The provider was not complying with Regulation 10(1)(a) and (b) and 10(2)(b) and (v) to assess and monitor the quality of the service to protect people against the risks of inappropriate care.

This section is primarily information for the provider

Treatment of disease, disorder or injury	The provider was failing to to identify, assess and manage risks, and have regard to reports prepared by the Commission.

For more information about the enforcement action we can take, please see our *Enforcement policy* on our website.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of dentists and other services at least once every two years. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times but we always inspect at least one standard from each of the five key areas every year. We may check fewer key areas in the case of dentists and some other services.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. We make a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation) from the breach. This could be a minor, moderate or major impact.

Minor impact – people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact – people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact – people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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