Care Quality Commission Inspection Report

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

Horfield Lodge

Kellaway Avenue, Horfield, Bristol, BS7 8SU

Tel: 01179166630

Date of Inspections: 13 October 2013
10 October 2013

Date of Publication: November 2013

We inspected the following standards in response to concerns that standards weren't being met. This is what we found:

Standard	Outcome
Care and welfare of people who use services	✗ Action needed
Safety and suitability of premises	✓ Met this standard
Staffing	✗ Action needed
Supporting workers	✓ Met this standard
Records	✗ Action needed

Details about this location

Registered Provider	Methodist Homes
Overview of the service	Horfield Lodge is a location of Methodist homes which provides accommodation for up to 75 people. The accommodation is purpose built and is arranged over three floors.
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'.

	Page
Summary of this inspection:	
Why we carried out this inspection	4
How we carried out this inspection	4
What people told us and what we found	4
What we have told the provider to do	4
More information about the provider	5
Our judgements for each standard inspected:	
Care and welfare of people who use services	6
Safety and suitability of premises	8
Staffing	9
Supporting workers	11
Records	12
Information primarily for the provider:	
Action we have told the provider to take	13
About CQC Inspections	15
How we define our judgements	16
Glossary of terms we use in this report	18
Contact us	20

Summary of this inspection

Why we carried out this inspection

We carried out this inspection in response to concerns that one or more of the essential standards of quality and safety were not being met.

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 10 October 2013 and 13 October 2013, 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 and talked with staff.

What people told us and what we found

We received information from a number of sources as part of this inspection and issues of concern were highlighted to us; these were predominantly in relation to the nursing floor of the home. We also received communication from families who wanted us to know about the positive experiences of their family members. We received some comments from people living in the home, such as staff are "alright to me". We met another person in their room who was making their own bed who said that "I don't mind doing it to help them, the staff are ok just not enough of them".

Observations that we made showed that people weren't always supported in a person centred way and that they didn't always receive adequate support. For example, we found evidence that people weren't always supported with their food and drink. At other times, we saw that staff were caring and kind and offered support to people when they were withdrawn or upset. Staff told us that staffing levels were inadequate and that this had an impact on how well they could deliver care. The observations that we made supported this view.

Staff received training to support them in their roles and this included training particular to the needs of people living in the home. We found significant concerns in relation to record keeping. Records relating to personal care and food and fluids were not being consistently completed by staff. This presented a risk that staff would not be able to monitor to care that people received.

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 05 December 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where we have identified a breach of a regulation during inspection which is more serious, we will make sure action is taken. We will report on this when it is complete.

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

Care and welfare of people who use services ✖ Action needed

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

Our judgement

The provider was not meeting this standard.

Care was not always delivered in a way that ensured people's safety and welfare.

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

As part of our inspection, we spent time in all areas of the home making observations and speaking with staff and people using the service to look at how their care needs were being met. Relatives also contacted us following the inspection to tell us about their experiences. We heard both positive experiences and other issues that were concerning. We heard from two families who had contacted us specifically for the purpose of telling us about how well their relatives had been well cared for. These families appreciated the support that they and their relatives had received during some very difficult times and gave us examples of some good care. For example, one person told us that a member of staff had arranged for soft food to be provided for their relative, following an appointment with the dentist. Another person commented that their relative "always looks well cared for and seems happy and cheerful".

We made some observations of good care, particularly in the area of the home for people with dementia. We noted that one person on the day of our inspection appeared withdrawn. A member of staff sat with this person and offered reassurance by holding and gently rubbing their hand. We saw other exchanges between staff and people living in this area of the home, which showed that staff were understanding of people's needs. We also observed an organised activity in the lounge area of the home for people with dementia. Staff supported a number of people to join in and we saw that they were animated and engaged. Staff involved with the activity noticed when people needed support to join in and offered their support accordingly.

We viewed a selection of records relating to activities for people in the dementia area of the home and saw that people were supported to take part in a range of events such as music therapy, dance therapy, skittles and cookery club. We spoke with the manager about the activities programme and we were told that staff from another home were coming in to help improve the activity programme and ensure that activities were on offer

throughout the week, including weekends.

Staff working on the nursing floor of the home told us that due to other factors, such the staffing levels, they weren't always able to offer support to people according to their individual needs and preferences. One member of staff told us that at times when staffing was 'short', people may have to be left in their rooms until after lunch. This member of staff was concerned about the impact of staffing on the care people received. Relatives and representatives also raised concerns about the lack of activity and stimulation. This meant that staff on the nursing floor of the home were predominantly focused on completing care tasks rather than delivering a person centred approach to caring for people.

Observations that we made as part of our inspection demonstrated that people on the nursing floor of the home didn't always receive the support that they required. This reflected the views of staff and some relatives that care was not delivered in a person centred way. This was particularly evident at meal times when people weren't being supported to ensure that they received adequate nutrition and fluids. For example, we observed one person in their room with their breakfast in front of them at 10 am. The breakfast was uneaten and cold and was still in the person's room uneaten at 11am. We also observed people being supported with their breakfast late in the morning, which meant that there would only be a short space of time until lunch. We saw that on both days of our inspection, the medication round took between 2-3 hours to complete. This meant that there was a risk that people would not receive their medication at the appropriate or preferred time, due to the timescales required between doses. Following our inspection, we were provided with information from the provider that suggested the average time for medication rounds was less than 2-3 hours. This meant that the length of time taken to complete the round was variable. We noted some pleasant interactions between staff and people living in the home, however care was not always delivered in way that would ensure people's safety and wellbeing.

Safety and suitability of premises ✓ Met this standard

People should be cared for in safe and accessible surroundings that support their health and welfare

Our judgement

The provider was meeting this standard.

People who use the service, staff and visitors were protected against the risks of unsafe or unsuitable premises.

Reasons for our judgement

Prior to our inspection, we had received information that there were some areas of the home that were in need of maintenance. We checked communal rooms in both the area of the home for people with dementia and the nursing floor. We found no issues of concern during our inspection. We noted that there was a member of staff on duty on the day of our inspection who was responsible for maintenance issues within the home and was attending to issues during our visit.

We asked to view records relating to maintenance and saw that systems were in place to identify and act upon issues to ensure that people were cared for in a safe environment. For example, we saw certificates for a fire alarm inspection and gas safety inspection dating from June and September 2013. We also saw that PAT (Portable Appliance Testing) testing took place. We saw that areas of risk within the environment were checked on a regular basis. We saw records to show that window restrictors and bedrails were checked on a monthly basis.

The provider might find it useful to note that the design and layout of the building did not provide a dedicated and private area of the home for staff to complete their care records. Staff used communal areas of the home to complete these duties.

Staffing ✖ Action needed

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was not meeting this standard.

There were insufficient numbers of suitably skilled and qualified staff to ensure that people's individual needs could be met at all times

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 discussed staffing levels with staff in the home and heard a range of views in relation to whether staffing was sufficient to enable people's individual needs to be met. The concerns that we heard related predominantly to the nursing floor of the home. We received comments such as "every weekend we are short staffed here" and "we are short staffed here all the time". Staff working in the area of the home for people with dementia told us that staffing levels were sufficient but occasionally staff would be asked to cover staff absence in other areas of the home, meaning they were short staffed.

We asked to see records such as staffing rotas and sign in sheets to establish whether expected staffing levels had been met. This was difficult to determine from the information we had because all staff, including ancillary staff were included on the same sign in sheet so it was not immediately clear which staff had direct caring responsibilities for people in the home. The staff rotas didn't indicate on which floor people were working, so we could not determine whether there were shortages in any particular area of the home. Without this information being clear and readily accessible, it would be difficult for senior staff to monitor how well staffing needs were being met in the home and assure themselves that they were sufficient.

On the second day of our inspection, we discussed people's dependency levels on the nursing floor with the nurse in charge. We were told that 13 people required two care assistants to support them with their personal care. The nurse confirmed that five people were nursed in bed and there were two others in bed at the time of our inspection. This meant that people had high levels of dependency and required high levels of support throughout the day to ensure that their needs were met. Four care assistants were on duty plus one nurse on the day of our visit (and 1 further care assistant who was a 'floater' and allocated to work in the area of the home where the need was greatest).

We made observations that supported the views of staff that staffing levels were insufficient to meet the needs of people on the nursing floor. For example, on day two of our inspection, we noted that some people were receiving support with their breakfast late

in the morning, which meant that there was only a short break of an hour and a half until the lunchtime meal. We also noted that the medication round on both days of our inspection, took between 2-3 hours. This meant the nurse was unable to support other care tasks during this time. Following our inspection, we received further information from the provider about medication round times, as outlined under 'care and welfare of people who use services'.

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 were supported to deliver care and treatment safely and to an appropriate standard.

Reasons for our judgement

We received a mixed response from staff in relation to how well supported they felt. A number of staff commented on how approachable senior staff were and how well supported they were. One member of staff told us they appreciated the support they had received with an issue outside of work. Other staff were clearly anxious and worried about the possible repercussions of raising issues of concern with us.

It was not clear why there was such a disparity in the views of staff. However the provider might find it useful to note that it is important that all staff feel able to raise issues of concern in order that there is an atmosphere of transparency and concerns can be addressed.

We made observations that showed staff were caring and had the skills to care for people in the home, even if other factors, such as staffing levels meant they weren't always able to provide care to the standard that they would like to. For example, we observed staff in the area of the home for people with dementia notice when people were appearing withdrawn and offering appropriate support. Staff were supportive during an organised activity and helped ensure that people were engaged and enjoying the task. This showed that many staff were skilled and caring.

We looked at the overall training matrix for staff and saw that staff received training to help ensure that they were able to carry out their roles effectively and safely. For example, we saw that safeguarding training was refreshed on a yearly basis to help ensure that staff had the knowledge to be able to identify and act upon concerns about abuse. Manual handling and infection control training was also provided on a yearly basis. Other topics relevant to the needs of people in the home were covered, for example, we saw that the majority of staff had received training in both dementia and the Mental Capacity Act 2005.

We asked to see information relating to formal supervision. We were told that there was no overall plan but that the expectation was that staff would receive formal supervision every two months. The provider might find it useful to note that an overall plan of supervision would help senior staff monitor that all staff were receiving supervision on a regular basis.

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 fully protected from the risk of unsafe care because accurate records were not always maintained.

We have judged that this has a major impact on people who use the service. This is being followed up and we will report on any action when it is complete.

Reasons for our judgement

During our inspection we found that records relating to people's care were not completed consistently. This meant that there was a risk that people would not receive the care and support they required in line with their individual needs, arising from a lack of accurate records being kept.

We viewed records relating to all aspects of people's care and support and found examples of where people's support plans did not reflect their current needs. One person's support plan for nutrition stated that they were able to enjoy finger foods independently. Staff confirmed that this was not the case and therefore the plan was inaccurate.

We also found a number of examples of where people's daily records were not completed accurately and this presented a risk of unsafe care. For example, we looked at the food and fluid charts relating to a person who was identified as being at risk of developing pressure sores. We saw a number of occasions when fluids had not been totalled for the day and there were significant gaps in recording times of fluids being offered and/or taken. The nurse we spoke with confirmed that these charts should be completed and totalled each day. This meant that there was a lack of clear information about the total amount of fluids this person had drunk and whether it was sufficient to ensure they were cared for safely.

In the care records of other people using the service, we found a lack of recording in relation one person's PEG (Percutaneous Endoscopic Gastrostomy) tube. This person's support plan stated that daily cleaning and checks were required. However, the recording charts had a number of dates not ticked so it could not be confirmed from these records if the care had been delivered. This meant that there was a lack of clear and accurate information about this person's care. We also found gaps in two other people's personal care records.

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 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services** **How the regulation was not being met:** Care was not always delivered in a way that ensured people's safety and welfare.

Regulated activities	Regulation
Accommodation for persons who require nursing or personal care Diagnostic and screening procedures Treatment of disease, disorder or injury	**Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010** **Staffing** **How the regulation was not being met:** There were insufficient numbers of suitably skilled and qualified staff to ensure that people's individual needs could be met at all times

This section is primarily information for the provider

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 05 December 2013.

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.

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 other services less often. 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.

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. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). 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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