# 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 Inspection: 14 May 2013

Date of Publication: June 2013

We inspected the following standards as part of a routine inspection. This is what we found:

| | |
|---|---|
| **Care and welfare of people who use services** | ✓ Met this standard |
| **Meeting nutritional needs** | ✓ Met this standard |
| **Management of medicines** | ✗ Action needed |
| **Requirements relating to workers** | ✓ Met this standard |
| **Assessing and monitoring the quality of service provision** | ✓ Met this standard |

## Details about this location

| | |
|---|---|
| Registered Provider | Methodist Homes |
| Registered Manager | Dr. Sarah Batchelor |
| 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<br>Diagnostic and screening procedures<br>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

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

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 14 May 2013, observed how people were being cared for and talked with people who use the service. We talked with carers and / or family members and talked with staff.

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 found when we last visited the home in March 2013. During our visit, we found that improvements had been implemented and systems were being developed so that the manager was able to monitor the service provided.

People living in the area of the home for people with dementia were unable to speak with us directly. However, we carried out a structured observation and saw examples of people reacting positively to staff interactions and people enjoying time in the lounge listening to music.

We saw that improvements had been made in relation to the quality and quantity of food provided for people. People were able to make choices about the food they wanted and were able to have more if they wished. Staff told us that there were drinks rounds for people between main meals, with cakes and biscuits on offer.

A pharmacist inspector formed part of our inspection in order to look at the recording and administration of medicines. We found shortcomings in the obtaining, recording and safe administration of some medicines.

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

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** ✓ Met this standard

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

### Our judgement

The provider was meeting this standard.

People experienced care, treatment and support that met their needs and protected their rights.

### Reasons for our judgement

At our last inspection, we found that information held in people's care files was insufficient to support staff in meeting the needs of people, particularly in the area for people with dementia. We also found that information was not regularly reviewed and it wasn't always clear how people's health needs had been managed.

When we visited in May 2013, we were told that effort was being made since the last inspection to improve care plans and ensure that they were reviewed regularly. We looked at three people's records on the nursing floor. Care records evidenced that people's needs had been assessed and then care records developed to meet these needs. One person's file we looked at showed that this person had recently been diagnosed with diabetes, we saw that blood sugar records were taken daily as per a request by the GP. We viewed five care records in the area of the home for people with dementia. Overall we saw that progress had been made in reviewing the information held in these files and ensuring the information was relevant and sufficiently detailed. However, the provider might like to note that we did find some lapses in information. For example, one care file that we looked at had not been reviewed since initially being written in October 2012. A further file had not been reviewed in the month of April.

People were assessed for the risk of developing pressure sores. Where risks were identified care plans were put in place to manage these risks. For example people were provided with pressure relieving mattresses and supported to change position at regular intervals. One person's care records explained that the person did not like the pressure relieving mattress and found it uncomfortable. We noted that this person's views had been respected and they had a normal mattress in place but were encouraged to change position regularly and regular checks on the condition of this person's skin were carried out and recorded.

We spoke with four people on the nursing floor of the home. People told us that they liked living at the home and that things had improved recently. Two people we spoke with told us that when they moved into the home things were very good then it had deteriorated,

especially the food but this was getting better.

People in the area of the home for people living with dementia were not able to talk to us directly about their experiences. We carried out a Short Observational Framework for Inspection (SOFI). This is a tool that is used in inspection to help us understand the experiences of people who are unable to communicate with us directly. During our half hour observation, we saw that people were enjoying listening to music by singing along and mouthing the words. Staff interactions were positive and people smiled in response. One person who was sleeping received attention from staff by having a cushion place under their arm to make them more comfortable. Our observation showed evidence that people in this area of the home benefitted from positive relationships with staff.

People told us that the home had a regular programme of activities and they were kept informed of what was going on at the home. During the afternoon of our inspection there was a history group and people told us that they enjoyed this. We observed an exercise activity taking place in the area for people with dementia and saw that people were engaged and taking part.

We saw evidence that care was planned in a person centred way which meant that people's individual needs and preferences were identified. For example, we read that one person enjoyed listening to music and that this could 'lift their spirits' when in a low mood. It was noted for another person that they enjoyed having their nails painted and wearing perfume.

**Meeting nutritional needs** ✓ Met this standard

**Food and drink should meet people's individual dietary needs**

## Our judgement

The provider was meeting this standard.

People were protected from the risks of inadequate nutrition and dehydration.

## Reasons for our judgement

When we visited the home in March 2013, we found that there was risk that people's nutritional needs were not being met because there were insufficient quantities of food. Relatives had reported that the quality was poor. When we returned to the home in May 2013, we found that improvements had been made. We spent time observing a mealtime in both the area of the home for people with dementia, and the floor for people with nursing needs.

We spoke with three members of care staff in the area of the home for people with dementia and they all reported improvements in the food provided for people. We also spoke with the chef who showed us information about people's likes and dislikes and any particular dietary requirements that they had. This information had been reviewed since our last inspection and meant that kitchen staff had up to date information about people's nutritional needs.

During the lunch time meal time in the area of the home for people with dementia, we saw that there was fresh fruit available on the table for people when they arrived. We observed several people taking the fruit whilst waiting for their main meal. The senior carer told us that it had been a positive step in providing this fruit as people enjoyed it and it didn't appear to prevent them from eating their main meal. Staff took food over to people on trays with the various options available so that people could see and easily make a choice. Staff noticed when people were reluctant to eat and offered appropriate support and encouragement.

We observed lunch on the nursing floor and were told by the deputy manager that they had just introduced a new system of serving meals that the staff were not totally familiar with yet. This led to the meal serving being quite disorganised. However, all the people received the food that they ordered and told us that it was nice. People told us that they had choices about what they wanted to eat. The choices were made in the morning for what they wanted for that day. Staff also told us that if people changed their mind they would be able to have an alternative.

We saw that care plans were in place in relation to nutrition and these described the support that people required. For example one person required small portions but offered frequently. We were told that a box of 'finger food' was supplied for this person in their room so that they had access to snacks as and when they required it. We were told that

this was working well. However, the provider might like to note that care plans did not always reflect the person's current support. For example, in two care plans that we viewed, it was documented that food and fluid charts were to be used, however we were told that these were no longer required.

On the nursing floor of the home, where people were assessed as being at risk of malnutrition or dehydration, food and fluid charts were put in place. We saw that these were completed correctly and staff were aware of the amounts of fluids that people should be drinking.

We saw that people's weights were monitored on a monthly basis and we discussed with senior staff about what would trigger a referral to other professionals such as dieticians. On the nursing floor of the home, we saw that people were referred to Speech and Language therapists if there were concerns about their eating and drinking. Staff were aware of the therapist's advice. This meant that people were protected from the risks associated with eating and drinking and from poor nutrition.

**Management of medicines** ✖ Action needed

**People should be given the medicines they need when they need them, and in a safe way**

## Our judgement

The provider was not meeting this standard.

People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the obtaining, recording and safe administration of some medicines.

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

People living in the care suites on the top floor of Horfield Lodge had varying degrees of support with their medicines depending on their needs and choices. People we spoke to were satisfied with the arrangements in place. One person was able to look after some of their own medicines and found it easier for staff to manage others. They told us they had 'no problems' with this. Another person told us that staff arranged for the supply of their medicines and they then looked after them. Staff had checked they were able to safely look after their own medicines. Staff looked after and gave most medicines used in other areas of the home. One person told us that they had been happy to hand over their medicines to the staff to look after for them.

We saw staff giving some people their medicines in the morning. People were given their medicines in a safe and respectful way. We heard staff asking some people if they needed medicines that had been prescribed to be given 'when required'. One person had refused the medicine when first offered it but later changed their mind and was able to take it then. This meant that these people were able to choose when they needed these medicines.

Suitable arrangements were in place in relation to ordering medicines. These arrangements had been changed during March 2013. During this change over period the provider had told us that a number of people had missed some doses of their prescribed medicines. Staff giving people medicines told us that the supply of medicines had improved since that time. The manager told us that they received daily information which allowed them to check that people had received their medicines correctly. We saw examples of information from 2 days in the previous week. These showed five medicines throughout the home had been unavailable on one day and two on another day. Three medicines administration records we looked at showed that people had missed at least one dose of medicine because it was unavailable. This meant that arrangements in place did not work on some occasions and this could harm people's health.

Arrangements were in place in relation to the recording of medicines. Records were made electronically and could be viewed on the computer. All the staff we spoke to told us that they had received training in using this new system and were familiar with its use. The two daily information summaries we looked at showed that no items had been missed. This meant that staff had recorded that people had been given their medicines or had recorded the reason if they had not been given. We looked in detail at one person's medicines administration record. A five day supply of an antibiotic had been received but staff had recorded that the medicine was given for eight and a half days. This meant that this record may not have been accurate. This person may not have been given their medicine as prescribed which could have made it less effective.

Some people had been prescribed medicines to be given 'when required'. Dose instructions for these medicines included how often they could be given. On the ground floor staff showed us an example of the additional information available for staff which would help them to give the medicine in a safe way. On the first floor we looked at records for a person prescribed a medicine 'when required' to treat a particular medical condition. There was some general information about treating this medical condition. This was not specific to this person and did not include any information about how and when the medicine should be used. Another person was prescribed a medicine for mental health, to be given when required. Staff told us when they would use this medicine. We saw a care plan relating to this person's mental health. This did not include information about using this medicine. A lack of written information in these cases increased the risk that people would not always benefit from the safe use of these medicines.

Suitable arrangements were in place for storing medicines safely on each floor of the home. Medicines fridges were available and records showed that these were kept at a safe temperature. Trolleys were available for transporting medicines around the home securely.

Suitable storage was available for controlled drugs which need additional security. However we saw that records for these medicines had not always been completed as required. Records on one floor showed that staff regularly checked the stock balance for one medicine but had not recorded when they had given a dose to the person concerned. The record did not correspond exactly to the person's medicines administration record so it was not clear whether they had received their pain relieving medicine as prescribed for them. On another floor records for several medicines used in 2012 did not show that they had been disposed of safely when no longer needed. The manager told us that she would investigate this.

**Requirements relating to workers** ✓ Met this standard

**People should be cared for by staff who are properly qualified and able to do their job**

## Our judgement

The provider was meeting this standard.

People were cared for, or supported by, suitably qualified, skilled and experienced staff.

## Reasons for our judgement

When we visited the home in March 2013, we found that some people had been recruited without all the relevant checks being undertaken.

When we revisited the service in May 2013, we looked at four staff files to check that all relevant information was in place. One member of staff was in the recruitment process but had not started working. A criminal records check had been obtained and the application form was completed. The file contained a signed copy of the job description stating that the person understood the job role. There had been two references obtained by the home. However, these references only confirmed that the person had worked in these jobs for the period stated and included no information about the person or the quality of their work. The home had also not applied for a reference for the previous job that involved supporting vulnerable adults. We spoke to the acting manager about the references and they said that they would attempt to get a reference from the most recent employer. They also said that it was getting harder to get employers to write references other than standard references that confirmed the period they worked there for.

In another file, we saw that the person had completed relevant checks but only had one reference on file and in the last file, we saw evidence that a criminal records check had been applied for but there was no records of the disclosure number.

The manager told us that they had identified shortcomings in the recruitment inspection prior to our visit. We were told that administration staff were working through everyone's recruitment records and working to ensure that all shortcomings were being acted on. We spoke with the admin staff who showed us records of people's files that they had checked and what they were doing to ensure that everyone's recruitment records were up to date. Even though we found lapses in staff files, we were assured that the manager and admin had identified these issues through their own monitoring and were addressing them.

**Assessing and monitoring the quality of service provision** ✓ Met this standard

**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 meeting this standard.

The provider had an effective system to regularly assess and monitor the quality of service that people receive.

## Reasons for our judgement

During our visit, we looked at what systems were in place to monitor the quality of the service provided. The manager present during our inspection had been supporting the service since our last inspection in March and was in place until a permanent manager could be recruited. The interim manager for the service showed us the audits that they had undertaken and talked to us about how they were listening to the views of people using the service and their relatives.

We were told that all homes run by MHA were expected to audit a selection of care plans each month. The manager told us that they aimed to audit eight plans each month. We viewed the audit tool used for this purpose and saw that it was comprehensive and if used appropriately would help protect people using the service because it checked that risk assessments and care plans were up to date. The last audit was carried out in April 2013 and showed that each of the eight plans looked at were below the standard required by the provider. Reviewing care plans has been an ongoing process since our last inspection and we saw evidence that work was being done to improve the quality of support files. We have referred to this under 'Care and Welfare of people who use Services'.

Other information that we viewed included a record of accidents for the month of April 2013. The record identified how the incident had occurred and the action that had been taken. We viewed audits for 'pressure ulcers' and weight for the month of April. This would benefit people using the service as it would support staff in identifying when input from other professionals may be required. We discussed for example when people might be referred to the fall clinic or to a dietician.

We asked the provider about how they monitored call bell waiting times and we were shown a computer screen that identified which calls were a priority in relation to how long the person had been waiting. We were told that the manager monitored the screen to help ensure that calls were answered promptly. The provider might like to note that this system of monitoring calls could be developed further to ensure that it is monitored at all times, in the absence of senior staff with particular reference to busier times, such as evening and early mornings.

We saw that there was opportunity for people using the service to express their views and opinions on the service they received. Since our last inspection highlighted concerns with the quality of food within the home, we were told that a 'food forum' had been set up. We viewed the minutes of the last meeting of this group from April 2013 and saw that people had been able to put forward their likes and dislikes and their opinions on the quality of the food.

We also viewed minutes of the last two residents'  meetings. These showed that people living in the home were able to raise issues of concern, such as call bell waiting times and use of agency staff. There was a formal complaints procedure in place and we saw that records of complaints were kept and responses provided.

**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<br><br>Diagnostic and screening procedures<br><br>Treatment of disease, disorder or injury | **Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010**<br><br>**Management of medicines**<br><br>**How the regulation was not being met:**<br><br>People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place for the obtaining, recording and safe administration of some medicines. (Regulation 13) |

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 28 June 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.<br>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.<br>We monitor the implementation of action plans in these reports and, if necessary, take further action.<br>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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|---|---|
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