Caring Homes Healthcare Group Limited

Hulcott Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

About the service
Hulcott Nursing Home is a home providing personal and nursing care to up to 49 people. The service provides support to older people and people with dementia. At the time of our inspection there were 24 people using the service, in one adapted building.

People's experience of using this service and what we found
We found concerns about infection prevention and control practice, which could put people at risk of harm. This included inconsistencies in mask-wearing and contamination risks associated with management of laundry.

People were potentially placed at risk of harm as the home could not demonstrate there were effective fire drills to rehearse what to do in the event of a fire or other emergency. Additionally, we found two fire exit routes were obstructed, which could have impeded safe evacuation.

It was not clear whether people received the support they needed to keep well-hydrated. Records showed varying amounts of fluids offered to people from day to day and sometimes only small amounts had been drunk. We observed some people had multiple, sometimes untouched, drinks left on their bedside tables, which were later cleared away. We could not be confident there was effective monitoring to ensure people were being given the right support to keep hydrated.

The registered manager and the provider carried out regular audits and checks of the quality of people's care. However, we found these audits did not identify the issues were found during our inspection.

The provider carried out a range of checks when recruiting staff. We have made a recommendation about providing better evidence of satisfactory references.

Temporary workers were used to cover the staffing rota when needed. We have made a recommendation about making checks of the training temporary workers have completed.

People spoke positively about the home and the care provided. Comments included "Overall we are very happy with the home. (Family member) is happy and settled and you can tell when staff walk in and he smiles that he is forming relationships," "Overall it is very good. (Family member) has improved while she has been here and is a happy, contented lady. The nursing home has a real family feel to it" and "I think they are awesome, the staff are diligent and so kind…it is all good except the rooms are a little dated."

Relatives felt their family members received safe care. The registered manager referred any safeguarding concerns to the local authority or other agencies, as necessary. People's medicines were managed safely.

People were supported to have maximum choice and control of their lives and staff supported them in the

least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (report published February 2021). The service remains rated requires improvement.

The provider completed an action plan after the last inspection to show what they would do and by when to improve.

At this inspection we found the provider remained in breach of regulations.

Why we inspected
The inspection was prompted, in part, due to concerns received about the provider's approach to visiting, responding to concerns and risk of a closed culture. A decision was made for us to inspect and examine the concerns across a range of Caring Homes Healthcare Group Limited services. We found no evidence during this inspection that people were at risk of harm from this concern.

We looked at infection prevention and control measures under the Safe key question. We look at this in all care home inspections even if no concerns or risks have been identified. This is to provide assurance that the service can respond to COVID-19 and other infection outbreaks effectively.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

We have found evidence that the provider needs to make improvements. Please see the Safe and Well-led sections of the full report.

You can see what action we have asked the provider to take at the end of this full report.

Enforcement and Recommendations
We are mindful of the impact of the COVID-19 pandemic on our regulatory function. This meant we took account of the exceptional circumstances arising as a result of the COVID-19 pandemic when considering what enforcement action was necessary and proportionate to keep people safe as a result of this inspection. We will continue to monitor the service and will take further action if needed.

We have identified breaches in relation to fire safety, infection prevention and control and governance of the service.

Full information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

We will request an action plan from the provider to understand what they will do to improve the standards

of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Details are in our safe findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

Hulcott Nursing Home

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

As part of this inspection we looked at the infection control and prevention measures in place. This was conducted so we can understand the preparedness of the service in preventing or managing an infection outbreak, and to identify good practice we can share with other services.

Inspection team
The inspection was carried out by one inspector and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience spoke with relatives or people's representatives, to seek their views of the service.

Service and service type
Hulcott Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and/or personal care as a single package under one contractual agreement dependent on their registration with us. Hulcott Nursing Home is a care home with nursing care. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations.

At the time of our inspection there was a registered manager in post.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received and held about the service.

We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make.

We used all this information to plan our inspection.

During the inspection
We sought feedback from the local authority and professionals who work with the service. We contacted 39 staff by email, to invite them to provide feedback. Two replies were received.

We spoke with three people who used the service. We had discussions with the registered manager and a range of housekeeping and care staff. We had discussions with 19 relatives by telephone. We looked at a sample of records. These included four people's care plans and associated documents such as risk assessments and daily notes, four staff recruitment files, checks carried out for four agency workers, the staff training matrix and staffing rotas. We checked a sample of quality assurance audits and records related to maintenance and upkeep of the premises. We viewed a range of health and safety records including accident and incident reports and a sample of policies and procedures.

After the inspection
We requested and received additional evidence from the registered manager.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question remains requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Preventing and controlling infection

At our last inspection the provider had failed to ensure there were adequate infection prevention and control measures in place. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 12.

• We were not assured the provider was promoting safety through the layout and hygiene practices of the premises.
• We found contamination risks in the laundry. For example, apples belonging to a member of staff were placed on a shelf alongside linen. We were told they intended to take them out on their break. We saw there were mugs on the draining board of the sink used for handwashing and other purposes. This showed housekeeping staff were not following good infection control practice and placed themselves at risk of harm.
• The laundry floor was carpeted on one side of the room. It would not be possible to keep this type of flooring hygienically clean in a high contamination area. For example, through effective disinfection.
• Laundry bags containing soiled linen were stored on the floor by a washing machine. An item of laundry was placed on top of the bags. It either needed to be in a red bag itself if soiled or stored away from the high risk contaminated washing. These items were in very close proximity to a portable heater and a vacuum cleaner. During a walk around of the home, we found a laundry skip containing a soiled duvet had been placed in a dining area. This showed there were poor practices in preventing the spread of infection from contaminated items. The area was deep cleaned after the incident was brought to the registered manager's attention.
• We were not assured personal protective equipment (PPE) was being used effectively and safely. During the inspection we found some staff did not have their nose and mouth covered by a mask. This had the potential to place people at risk of infection.
• Four automatic hand gel dispensers were not working on the first day of the inspection. This was remedied as soon as it was brought to the registered manager's attention. We noted bottles of hand gel without dispenser pumps were in use. These were indented where they had been repeatedly squeezed in the middle to get gel out. This had the potential to spread infection as a greater area of hand contact was needed with the bottle to squeeze gel out, as opposed to using a pump.
• Staff were not routinely ventilating the premises. Areas such as the conservatory / dining area, small lounge

adjacent to it and the smaller dining room were not being ventilated during walk arounds at various times on both days. We needed to ask for windows to be opened in communal rooms to ensure adequate flow of fresh air.
• We were assured the provider's infection prevention and control policy was up to date. However, our observations showed staff were not adhering to this, to prevent the spread of infection.

This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to adequately assess, prevent, detect and control the spread of infection.

• We were assured the provider was preventing visitors from catching and spreading infections.
• We were assured the provider was admitting people safely to the service.
• The home had been awarded the highest level of food hygiene rating by the Food Standards Agency.

Visiting in care homes
The home was following appropriate guidance at the time of our inspection. Relatives told us there were no restrictions on them being able to see their family members. Comments included "Initially we had to book but things have eased and now we can visit without restriction, although we are still wearing masks and doing LFT (lateral flow) tests," "Visiting is alright, no restrictions just masks and LFT tests" and "They are very flexible with visiting, just masks and LFT now."

Assessing risk, safety monitoring and management
• People were not consistently kept safe and the likelihood of injury or harm had not always been reduced.
• Fire safety measures were not sufficient to protect people from the risk of fire.
• We noticed two fire exit doors were obstructed on the outside by stacks of garden chairs. This obstructed the evacuation route and prevented one door from opening fully. This was remedied after it was brought to the registered manager's attention.
• Personal evacuation plans showed everyone at the home could be evacuated using a sledge and two staff to assist them. Thirteen people required use of a wheelchair, eleven were nursed in bed.
• A fire risk assessment was carried out by an external company in July this year. As well as recommending areas for improvement, it contained information about fire drills and the need to simulate these.
• Records of fire drills were insufficient to show appropriate training and learning had been undertaken in response to a potential fire or other emergency. The drill records did not show which staff had attended the drills. However, the provider was able to show us a spreadsheet of when staff had attended them.
• Information was not recorded about how long drills took or evidence of practicing different scenarios, such as fires in various zones. There was no learning or issues identified for improvement on fire drill records. Given the high level of support people needed, there was nothing to demonstrate how the home would cope, especially at night when staffing levels were at their lowest.
• One drill record included "Everyone came to the assembly point letting (telling?) me why are you having to let off at night time when all are in bed. Said not to worry because if it was a real fire everybody would know about it." Another drill record said "My staff didn't understand what was going on at that time" under a section to describe what discussion took place with staff. There was no learning or recommended action listed under the 'outcome of the drill' sections.
• We could therefore not be confident staff had sufficient training or rehearsal in what to do in the event of an emergency, to keep themselves and other people safe.

This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed assess the risks to the health and safety of service users and done all that is reasonably practicable to mitigate any such risks.

• The provider told us the drill template had since been updated to capture more information about fire practices.
• Regular checks were carried out of fire equipment such as call points and emergency lighting. There was regular servicing of the alarm system by an external company.
• There were certificates to show checks had been made of the electrical installation, portable electrical appliances, hoists and lifts. Water sampling had been undertaken to check for Legionella species and found to be clear.
• Risk assessments were in place in people's care plans and had been kept under review.

Staffing and recruitment
• Checks were carried out to make sure prospective workers had the skills and experience to support people. This included a Disclosure and Barring Service (DBS) check. These provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
• There was evidence checks were made to ensure nurses were registered with the Nursing and Midwifery Council.
• Proof of identification was sought for all workers and the right to work in the UK was checked, where applicable.
• We were unable to view all references which had been obtained for workers. The provider had transcribed some of the information from references on to a template. We were shown the templates as evidence of satisfactory references. However, templates did not include the detail of what the referee had written and in a number of cases did not have part or all of the worker's name on the form. We understood references were returned to the provider's headquarters and could be accessed by relevant staff at the home on the computer. When we asked to view these instead, some copies of references were printed off for us but others could not be located.

We recommend clear evidence of all references is available at the home for monitoring and inspection purposes.

• The training matrix showed staff undertook a range of courses to meet the needs of the people they supported.
• We noticed checks carried out by an agency who provided temporary workers contained information about their training. We saw three examples where the agency had said the workers had each completed 14 training courses in one day. We asked the registered manager if this had been picked up and queried with the agency, to check the quality of training and ability to meet the needs of people at the home. This had not been done.

We recommend there is effective validation of information provided by agencies to ensure the suitability of temporary workers.

• People expressed positive comments about staff. These included "The staff are always kind and helpful, there is a bit of banter too. (Family member) had a birthday recently and they had a party and had cake and sang songs and he absolutely loved being made a fuss of, also they have got him taking part in activities and he is enjoying these too." "When they come into his room they always greet him by name and although he has difficulty communicating they seem to get through to each other and are always kind and gentle." "They are lovely with my (family member), they joke with him and have a laugh and he loves them." "They approach (family member) with cheerfulness and are always very gentle, even though they know we are here they are always popping in and out to see that all is well."

At our last inspection the provider had failed to meet the requirements of the Mental Capacity Act 2005. This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We reported on this under the Well-led section of the previous inspection report.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 11.

• We found the service was working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty.

Systems and processes to safeguard people from the risk of abuse
• People were protected from the risk of abuse.
• Relatives we spoke with said they felt people were safe. Comments included "I sleep at nights now she is at Hulcott," "They are very safety conscious, they have to help my (family member) to the toilet and they stay with them all the time, they have had no accidents" and "Yes, that is what is so good about it. (Family member) is bed bound and taken such good care of, whenever I visit she looks well dressed and cared for."
• There were procedures for responding to and reporting safeguarding concerns.
• Staff had received training on safeguarding people at risk.
• Appropriate referrals were made to the local authority and other agencies, when required.

Using medicines safely
• There were procedures for staff to follow on safe medicines practice.
• Staff competency was checked to ensure they administered medicines safely.
• Storage and recording of medicines was in good order. People's allergies and any special instructions were noted.
• An audit was carried out by the dispensing pharmacy in June this year. It reflected good medicines practice, with minor areas to improve. The registered manager confirmed these had been addressed.
• We pointed out a couple of areas where handwritten medicines records were difficult to read and the instructions could be made clearer, to avoid errors.

Learning lessons when things go wrong
• The registered manager received information about national safety alerts. They told us these and other safety issues were discussed in monthly meetings with the provider.
• Records were kept of accidents and incidents at the service.
• The registered manager provided examples where appropriate action had been taken to improve people's health and well-being after incidents had occurred.

Requires Improvement

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating for this key question remains requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

At our last inspection the provider had failed to ensure records were suitably maintained and that effective governance processes were in place. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Not enough improvement had been made at this inspection and the provider was still in breach of regulation 17.

• During a walk around of the home, we noticed some people in their rooms had several beakers of drinks on their bedside tables. In two cases, four drinks were on the person's table and looked like a cold milky drink, cold tea/coffee and squash or water. This was at 9:35 a.m. The drinks were still in position at 10:20 a.m. and did not appear to have been touched.
• Drinks were out of people's reach in some cases, which may have been for a range of reasons. However, each person relied on assistance from staff to manage or encourage fluids. We later saw untouched or partially consumed drinks had been cleared away, replaced by further drinks which were placed on the bedside tables.
• We asked the registered manager if care notes showed whether people were regularly being encouraged to drink and keep hydrated, as the untouched drinks indicated otherwise. The records were not clear in showing this.
• We later looked at some examples of fluid charts, covering a two week period. In one case, the person was being offered little and often, in accordance with specialist advice for their deteriorating condition. In two other cases, we saw people were being offered varying amounts to drink. For example, one person was offered between 750 to 2350 ml per day. There were six days when records showed the person had drunk less than 1000 ml, sometimes as little as 405 ml.
• In another case, the person's records showed they were offered between 1200 to 2400 ml per day. There were five days when their input was only between 600 and 680 ml. Neither care plan contained an optimal target for fluid intake.
• From our observation and the records, we could not be certain people were being given the support they needed to keep well-hydrated and whether this was effectively monitored at the service.
• We saw a range of audits was carried out on a regular basis at the service by the registered manager and

regional manager. These assessed areas such as medicines practice, people's well-being, housekeeping and infection control practice. There were also daily walk arounds by the registered manager or a delegated person.
• However, we found audits had not identified the issues we noticed during our inspection, such as poor infection control practice and the fire safety concerns.

This was a continued breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the provider had failed to ensure there were effective governance systems in place to assess, monitor and improve the quality and safety of the service.

• The home had a registered manager in place. A new deputy manager had recently been appointed, to complete the senior team, and was undergoing their induction.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• We received positive feedback about the quality of people's care. Comments included "My (family member's) care is excellent," "I think it is brilliant, they are all so caring," "Overall the care is good, (family member) always looks well cared for and she needs a lot of support" and "The care is very good, they are very thoughtful."
• People said there were kept informed of their family member's health and well-being and communication overall was either good or excellent.
• Comments included "The home communicates with me all the time, by phone or email, it is very reassuring," "We have phone calls and emails to discuss vaccinations, unusual happenings, anything" and "Communication is excellent, phone or email when anything changes although we are in several times a week."
• People told us residents' meetings and relatives' meetings were held at the home. People who could not attend relatives' meetings said they were sent information about outcomes of these via email.
• People told us surveys were also sent out for them to comment on the quality of people's care. We looked at the outcomes of the most recent residents' and relatives' surveys, reports dated August 2022. These showed good levels of satisfaction with standards of care and some areas where improvements could be made, such as décor/furnishings and complaints management.
• Around half of the people we spoke with said they had been informed of how to make a complaint, if needed. Only one person we spoke with said they had needed to make a complaint.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong; continuous learning and improving care; working in partnership with others
• Community professionals told us staff were friendly and patient and acted on any advice they provided about people's care.
• The provider had a policy on duty of candour. We could see from records that relatives, for example, were informed when people had accidents.
• We saw examples of where the home had made improvements following people's feedback. These included reviewing and making menus more available, replacing some of the windows and ordering new curtains and blinds.
• There was an overall action plan for the home, which combined actions from various audits. The registered manager advised us these had received attention and most were now completed.