Sentimental Care Limited

Horton Cross Nursing Home

Inspection report

Horton Cross
Ilminster
Somerset
TA19 9PT

Tel: 0146052144

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

About the service
Horton Cross Nursing Home is a care home registered to provide care and accommodation for up to 47 people. The home specialises in the care of older people. At the time of the inspection there were 37 people living at the service.

People's experience of using this service and what we found
During the inspection several concerns were identified and shared with the provider. The provider did not have effective oversight of the care provided and the running of the service. Repeated breaches of the regulation linked to safe care and treatment and good governance indicate lessons were not being learnt by the provider. This meant they also failed to implement improvements at the service in a timely manner.

People did not always receive safe care and treatment. Risks and care needs were not always identified and actions to lessen risks not taken.

People did not always have their clinical needs met effectively. Instructions from health professionals was not always followed leaving people at risk of further health complications.

People did not always receive care that was personalised to their individual needs. The provider had not always ensured staff on duty were sufficiently qualified, competent, skilled, and experienced. This impacted on the quality of care delivered to people.

People were not always supported to have maximum choice and control of their lives and staff did not always support them in the least restrictive way possible and in their best interests. The practice and systems in the service did not support this practice. We have made a recommendation as care plans for people living with dementia did not always contain records of best interest decisions in relation to where and how people spent their time. We observed several people spent all day or long periods in bed or in their room. However, records did not contain information about how these decisions were made.

The provider took the concerns found during the inspection seriously and will work alongside CQC and other agencies to address the issues. The provider developed an action plan following the inspection to address the shortfalls found.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk
Rating at last inspection and update
The last rating for this service was requires improvement (published 20 October 2022).

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.

At our last inspection we recommendations the provider monitor the storage temperatures for all medicines and make improvements were required to the environment, including access to bathing and showering facilities. We found action had been taken to address the recommendations.

Why we inspected
The inspection was prompted in part due to concerns received about how people's needs were being managed. A decision was made for us to inspect and examine those risks.

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.

The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection.

Enforcement and Recommendations
We have identified breaches in relation to safe care and treatment, staffing deployment, person centred care, and governance.

We have taken enforcement action requiring the provider to ensure the robust and effective management and governance of the service.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will meet with the provider following this report being published to discuss how they will make changes to ensure they improve their rating to at least good. We will work with the 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 overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service. This will usually lead to cancellation of their registration or to varying the conditions the registration.

For adult social care services, the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Details are in our safe findings below.

Is the service well-led?

Inadequate

The service was not well-led.

Details are in our well-led findings below.

Horton Cross 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 completed by two inspectors.

Service and service type
Horton Cross 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. Horton Cross 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 not a registered manager in post as they had resigned shortly before the inspection. The provider had appointed a new manager who planned to register with the Care Quality Commission.

Notice of inspection

This inspection was unannounced.

What we did before the inspection
We reviewed information we had received about the service since the last inspection, this included notifications made by the service and concerns raised with the Care Quality Commission. We sought feedback from the local authority quality assurance team and safeguarding team, as well as other health and social care professionals. We used all of this information to plan our inspection.

The provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. A PIR is information providers send us to give some key information about the service, what the service does well and improvements they plan to make.

During the inspection
We met all of the people who lived at the service and spoke with 14 people about their experience of the care provided. We also spoke with 3 family members to get their view of the service. We observed people and staff in the communal areas throughout the day.

We spoke with 18 members of staff including the nominated individual for the service, care and nursing staff, agency staff, the general manager, maintenance person, chef and catering staff, and housekeeping staff. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

We reviewed a range of care records. This included a full review or partial review of 6 people's care records and several medication records. We looked at 2 staff files in relation to recruitment and staff supervision.

A variety of records relating to the management of the service, including policies and procedures, maintenance records, cleaning schedules, staff rota's, monitoring charts, fire documents and external servicing records were reviewed.

We asked the service manager to email a Care Quality Commission inspection poster to all relatives and staff, inviting them to share their experiences either through our website or by phone. We received comments from four staff members and two relatives in response to this.

Inadequate

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 has changed to inadequate. This meant people were not safe and were at risk of avoidable harm.

Assessing risk, safety monitoring and management
At the last inspection systems and processes in place had not protected people from receiving unsafe care and treatment. This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Although some improvements were noted at this inspection, not enough improvement had been made and the provider remained in breach of regulation 12 safe care and treatment.

- The provider had failed to robustly manage the risks relating to the health, safety, and welfare of people living at the service.
- Each person had a detailed care plan along with risk assessments relating to their health and wellbeing. These included instructions for staff on how to mitigate these risks. However, staff practice did not ensure these instructions were consistently followed.
- Several people had recommendations made by the speech and language therapy team (SALT). Guidance included the type of cup or beaker a person should use to ensure they were safe. This guidance was available in care plans and on the handover sheet shared with staff. However, we observed staff assisting people with the wrong equipment. This put people at risk.
- Some people had unexplained bruises and other injuries, such as skin tears. An audit of wounds had been completed by the provider prior to the inspection and shared with the local authority.
- We found not all wounds had been identified on the provider's audit. Staff were unable to confirm how one injury had happened, or the type of injury sustained. There were no records in the person's care plan relating to the injury. The person told us they sustained a skin tear when staff were assisting them with repositioning.
- Pressure relieving equipment was used where people had been assessed as being at risk of developing pressure wounds. However, arrangements in place did not ensure mattress settings were checked. We reported to the management team that one person's mattress setting was too high and could result in harm.
- Several people required support to reposition in bed to prevent pressure damage to their skin. Care plans provided guidance for staff, including position changes 2 to 4 hourly for those most at risk. We observed one person, with existing pressure damage, to be in the same position for 7 hours. We reported this to the management team. They took immediate action to ensure the person was supported to change position.

Effective systems were not in place to minimise potential risks to people. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Fire safety checks and drills were carried out and along with regular testing of fire and electrical equipment. A fire risk assessment was carried out by an external contractor in July 2022. The nominated individual confirmed they were working to address some recommendations, including a review of fire doors and fire compartments. Arrangements were in place to have the fire risk assessment reviewed and updated by an external professional. A visit from the Devon and Somerset Fire and Rescue service in August 2023 found adequate fire safety arrangements in place. The fire service made suggestions to further improve fire safety, which the provider was addressing.
● People had individual personal emergency evacuation plans (PEEPs) with information about their mobility and support needs should they need assistance to evacuate the building in an emergency.
● People were protected from the risk of falls from windows as window were restricted. The risk of burns was reduced as radiators were covered.
● The provider was taking steps to address issues relating to Legionella.
● External contractors undertook regular servicing and testing of moving and handling equipment.

Staffing and recruitment
● On the first day of the inspection the staff on duty were not sufficiently qualified, competent, skilled or experienced. This impacted on the quality of care delivered to people.
● There were 9 care staff on duty, 5 were agency staff. There was little direction or supervision of staff on the floor by senior staff. Agency staff did not know people well although they had access to care records on handheld devices. 2 agency staff were unable to confirm the assistance required by one person with meals. Another agency member of staff was observed assisting a person using equipment which could place them at risk.
● We received mixed feedback about staffing levels. People said they had to wait for attention at times, sometimes for 30 minutes or more. On the first day of the inspection, we observed call bells ringing for over 15 minutes on more than one occasion.
● The skills, experience, and deployment of staff on the first day of the inspection impacted on mealtime and people's experience in dining room and in their private rooms. People sat for nearly an hour in the dining room waiting for lunch to be served. People in their bedrooms who required assistance with meals did not get lunch until after 2pm.

There were not sufficient staff with appropriate skills and experience deployed in the service. This was a breach of regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At the last inspection people were not fully protected by safe recruitment practices. This was a breach of regulation 19 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found improvements had been made and the provider was no longer in breach of regulation 19 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Improvements had been made to staff recruitment since our last inspection. Recruitment folders had a checklist, which demonstrated relevant checks were being undertaken to ensure new staff were recruited safely. This included references from previous employers and Disclosure and Barring Service (DBS) checks. These provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.
● We reminded the provider that they needed to ensure all employment gaps were explored as we found a 5-month deficit in one staff member's file.

Learning lessons when things go wrong
● The provider had systems to learn lessons when things went wrong, however these systems were not always effective in ensuring actions were identified in a timely way. Repeat breaches of the regulation linked to safe care and treatment and governance indicated lessons were not being learnt by the provider.
● Not all incidents and accidents were recorded or analysed. There was little documented oversight to ensure any trends or patterns could be identified and mitigated. For example, in relation to unexplained bruises and injuries.

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)

● We found the service was not always working within the principles of the MCA. Decision specific mental capacity assessments had been carried out for people in relation to their capacity to make decisions about their care and whether they were able to give consent. However, we observed many people spent the day in bed. 3 people were unsure why they were in bed and said they would like to be up more frequently.
● One person who lacked capacity spent all their time in bed. A staff member said this was due to their behaviour, which could place the person and others at risk. The staff member explained this was "in the person's best interest". However, there was no record of the decision within the person's care records. Staff had not ascertained their wishes or whether this was in their best interests if they lacked capacity to make this decision themselves.
● Staff had received training in the MCA and told us they always asked for people's consent before providing them with support. However, some staff had a poor understanding about how best interest decisions should be made.

We recommend people's capacity to make specific decisions in relation to spending time in bed be assessed and recorded. We recommend additional training for staff to ensure their understanding of the mental capacity act.

● DoLS authorisation applications had been made to the relevant authority where it had been identified that people might be deprived of their liberty.

Using medicines safely
● At the last inspection we made a recommendation to ensure regular temperature monitoring in relation to the storage of medicines took place and the information recorded. We found that improvements had been made and medicine fridges and medicine rooms were being monitored daily to ensure medicines were being stored within the appropriate temperature range.
● People were supported to receive their medicines safely.
● Medicines were administered by registered nurses who had completed the relevant training and competency checks.
● Nurses administering medicines wore a red tabard reminding people not to disturb them, to minimize the

risk of making a medicine error. Nurses were observed taking time supporting people appropriately with their medicines.
● People who received medicines 'when required' (PRN) had protocols in place containing information to support staff to administer the medicines correctly.
● Medicines, including medicines which require additional security were stored securely.
● A nurse told us there had been several improvements made to the medicine management at the home which had made medicine management safer. This included, additional checks and a medicines room on each floor, so the nurses had everything they needed in the area of the home they were working.
● People received their prescribed creams in accordance with their needs. The nurse told us care staff supported people to apply prescribed creams and lotions and records were kept of when these had been applied. This enabled their effectiveness to be monitored.
● There was a system in place to ensure emergency equipment, for example a suction and nebuliser machine, was regularly checked and serviced.

Systems and processes to safeguard people from the risk of abuse
● Most people we spoke with told us they felt safe at the service. Comments included, "Yes, I am safe here. Better here than anywhere else".
● One person disclosed concerning information to us about staff practice. This was reported immediately to the management team, who took action to protect the person and others at the service. A safeguarding referral was made to the local authority safeguarding team for further investigation. On the second day of the inspection the person was able to tell us they no longer felt at risk.
● Staff spoken with, including agency staff, understood what to do if they had any safeguarding concerns. This included how to raise a safeguarding concern. Staff were confident if they raised concerns these would be acted upon. Staff were aware of external organisations they could contact about safeguarding concerns.

Preventing and controlling infection
● Improvements had been made to the overall cleanliness of the service. A new team of housekeeping staff completed cleaning schedules and took pride in their role. They said they had the cleaning chemicals they needed. They also said they, "Had seen lots of improvements" and "It was a nice place to work."
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

Visiting in care homes
● The provider was facilitating visits for people living in the home in accordance with the current guidance. There were no restrictions on visiting times in the home.

Inadequate

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 has changed to inadequate. This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

At our last 3 inspections the provider had failed to ensure there was good governance at the service. 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.

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

- The service had not maintained compliance in meeting regulations. We found continued breaches in relation to regulation 12, safe care and treatment and regulation 17, good governance.
- There were not always clear lines of accountability and responsibility. The service lacked leadership, guidance, and direction. There was a failure to ensure there were effective systems and processes to monitor the work and performance of all staff during shifts. A work allocation sheet was used for each shift. However, there were no arrangements to check how each member of staff was managing their work. There was little direction and supervision of staff to ensure the delivery of care was safe and of a good standard. As a result, people were at risk of receiving unsafe care.
- There was poor oversight of the work of senior care staff. For example, seniors did not always oversee the completion of records by care staff, such as food and fluid charts. This meant the risks of malnutrition and dehydration were not effectively monitored and addressed.
- People were at risk because the provider failed to ensure there were always enough suitably qualified, competent, skilled and experienced staff on duty. A high use of agency staff on the first day of the inspection meant people's needs and preference were not met in a timely or safe way. This was because agency staff did not know people well.
- The provider did not have systems in place to ensure all care records were accurate and up to date. For example, there was no information about one wound a person had sustained. The information in some wound care plans was inadequate as it did not provide clear directions about how often the dressing should be renewed or the dressing to be used. There was no information or evaluation about how the wounds were progressing to show if the treatment was effective.
- People were at increased risk of harm as systems for monitoring and learning from incidents and accidents were not robust.

● The provider did not have effective oversight of the care provided which meant they failed to comply with regulations, meaning people were at risk of harm. They failed to implement improvements at the service in a timely manner.

Systems and processes had not effectively assessed, monitored and improved the quality and safety at the service. This was a continued breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● An experienced manager had been appointed shortly after the site visit, along with a deputy manager and clinical lead. The provider also confirmed that additional registered nurses had been appointed and 5 care staff vacancies had been filled. The provider said these appointments would provide stability and continuity to the team and reduce the need for agency staff.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people

● Systems failed to identify people did not always receive person centred care. At the last inspection we recommended that daily routines were reviewed to ensure person-centred care and support was consistently delivered to people living at the service.

● While we observed some improvements, for example, a range of activities were now on offer to people, some routines were not person centred. For example, several people remained in their bedroom or were cared for in bed. It remained unclear from records and speaking with people and staff, how this had been decided. Visiting professionals also commented on the high number of people remaining in their room or in bed.

● Quality assurance processes had failed to address the fact there was a lack of stimulation and meaningful occupation for people being cared for in bed or choosing to stay in their room. There was a considerable risk of people becoming withdrawn due to lack of social stimulation.

The provider did not ensure people's care was personalised and met their emotional and social needs. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Working in partnership with others

● Whilst the staff and management team referred to and worked with other professionals, advice and instruction was not always followed and this meant people were at risk of harm. For example, the advice of the speech and language therapy team was not always followed, and the correct equipment was not always used when supporting people to drink.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

● Processes were not in place to routinely involve people and their relatives in planning their care or improving the service. There was evidence of communication and attempts to gain feedback, but the approach was not consistent.

● Feedback about involvement and engagement at the service was mixed. Some people said they had contact with the previous registered manager and felt they were approachable. However, some people and their relatives were unaware the previous registered manager had left the service. One relative explained they had raised concerns in the past, which had been acted on, but they found the same issues reoccurred.

● The previous registered manager had re-established 'resident's meetings' to provide an opportunity for people to share their feedback and ideas and suggests for improvements. The last meeting was held in April 2023. Areas discussed included food, fluids, activities, and staff. Where people had made some suggestions,

these had been acted on, for example the introduction of more fresh fruit. However, other areas, such as having more access fluids, required further improvement.

● The last resident's annual satisfaction survey was completed in June 2022. Surveys had not been sent to relatives so they could express their views.

● We did not find clear evidence of consistent involvement of people in their care and treatment.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The registered persons did not always ensure that the care and treatment of service users was appropriate, met their needs or reflected their preferences.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered persons did not ensure care and treatment was provided in a consistently safe way. Risks were not always assessed, monitored safely and mitigated. Systems and best practice guidance were not followed relating to safe care and treatment. 12(1)(2)(a)(b)(c)

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered persons did not ensure there were sufficient staff with appropriate skills and experience deployed in the service.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered persons failed to ensure systems and processes were established and operated effectively. Procedures for governance and oversight of quality and safety were not effective, and there was a failure to seek and act on feedback. Accurate, complete and contemporaneous records were not maintained. 17(1)(2)(a)(b)(c)(d)(e)(f)

The enforcement action we took:

WN for repeated reg 17 agreed at MRM