London and Manchester Healthcare (Fulwood) Limited

Hulton House Care Residence

Inspection report

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14 November 2022

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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
Hulton House Care Residence is a nursing home providing nursing and residential care to up to 74 people. The home supports people with advanced dementia and other physical and mental health needs. At the time of our inspection there were 69 people living in the home. The home has two floors and four distinct units. The kitchen and laundry facilities are on the first floor which houses two units and offices are on the ground floor with the remaining two units.

People's experience of using this service and what we found
Risks to people living in the home were not effectively assessed or mitigated. People were not supported to have maximum choice and control of their lives. Staff did not support them in the least restrictive way possible and in their best interests; the policies and systems in the service did not support this practice. Medicines were not always safely managed or administered by staff with an appropriate competency assessment. There were enough staff, but they were not always suitably trained or deployed to best meet people's needs. Staff were not routinely supported to ensure any reasonable adjustments were made in response to their health needs.

Suitable systems had not been developed to ensure effective oversight of the service. Records used to keep people safe required attention to assure the service delivered met their specific needs. Audits did not identify action which was required to improve delivery and safety.
Care and support were not always delivered in a person-centred way. The lack of activities to engage people had a detrimental effect on people's wellbeing. Most people received care and treatment which met their needs and the home sought support from professionals to meet people's physical health needs. People we could speak with spoke highly of the staff and felt supported.

Equipment and the building were checked to ensure their safety
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 21 May 2021). 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 by notification of an incident following which a person using the service died. This incident is subject to further investigation by CQC as to whether any regulatory action should be taken. As a result, this inspection did not examine the circumstances of the incident. However, the information shared with CQC about the incident indicated potential concerns about the management of risk to people living in the home. This focused inspection examined those risks, checked the provider had followed their action plan and to confirm they now met legal requirements. This report only covers our

findings in relation to the Key Questions Safe and Well-led which contain those requirements

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. The overall rating for the service has changed from requires improvement to inadequate based on the findings of this inspection. We have found evidence that the provider needs to make improvements. Please see the safe and well-led key question sections of this full report.
You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Hulton House Care Residence on our website at www.cqc.org.uk.

Enforcement and recommendations
We have identified breaches in relation to safe management of risks including medicines and safeguarding people from abuse, staff competence and the recruitment of staff. We have also found breaches in relation to support being provided to meet people's individual and specific needs and the overall governance and oversight of the service delivered to people at this inspection.

We took urgent action to ensure the provider took steps to keep the most vulnerable people at the home same. The provider did not appeal this action and has been adhering to the the requirements of the conditions added to their registration.

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.

Special Measures
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 of 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.

Hulton House Care Residence

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
This inspection was completed by three inspectors and one pharmacist inspector

Service and service type
Hulton House Care Residence is a 'care home' with nursing care. 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. 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. Inspection activity started on 9 November 2022 and ended on 15 November 2022. We visited the service on 9, 10 and 14 November 2022.

What we did before the inspection
Following receiving information of concern around risk management, a full review was completed of all information held by the Care Quality Commission. Feedback was requested from professionals and we reviewed information available in the public domain. The provider returned their annual Provider Information Return (PIR) as requested and this was reviewed 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. We used all this information to plan our inspection.

During the inspection
The inspection team spoke with 23 staff over the course of the inspection, some in detail and others in passing but giving the opportunity to engage with the inspection team, if staff wanted to or had the time. We spoke with 6 people who lived in the home and used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We spoke with 9 professionals during the inspection to seek feedback or share information to keep people safe.

Management information and records to support people were reviewed including 36 care records, either in detail or for specific information. We looked at 5 staff recruitment folders and 4 additional folders to review support provided to staff. We looked at minutes for meetings, audits and other records to support how the service was managed. We gave feedback to the management team including the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider.

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.

Using medicines safely

At our last inspection the provider had failed to manage medicines safely. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Medicines were not always administered safely and records for administration were not always kept in line with best practice.
- A prescription for insulin was not recorded on the Medicines Administration Record (MAR) and dose directions were only recorded on the insulin pen. This left a risk of the right dose not being administered as the label deteriorated on the pen.
- We found the administration of topical medicines including creams and patches was not done so in line with best practice. Some creams were missing from MARs, were not administered as directed and procedures in place to follow safe administration were not followed including the rotation of transdermal patches.
- Most people on one unit had their medicines administered covertly. We were not assured procedures for the safe and lawful administration of covert medicines were always in place. We noted one person had been administered a medicine covertly prior to any agreements or assessments being in place.

When procedures for the safe management and administration of medicines is not followed this is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Assessing risk, safety monitoring and management; Learning lessons when things go wrong

- Risks to people's health and wellbeing were not suitably assessed, reviewed or mitigated to ensure people were kept safe.
- We looked at risk assessment information for 7 people who received increased observations from staff. We found assessments did not clearly define how best to support the individual, including a lack of detail around presenting risks and risk management options.
- Some people who lived in the home were supported with 'safe holds' when they became particularly anxious and were communicating their anxieties or frustrations physically. This allowed staff to ensure the person did not injure either themselves or others. We found the records to support this type of physical intervention were not detailed enough to allow appropriate review. This was required to ensure actions

were proportionate and, where required, improvements could be made.
● We found contradictions in people's records which would lead to confusion as to the correct care and support to provide. This included contradictions in people's dietary needs, their skin integrity and risk of falls. This put people at risk of receiving inappropriate care.

Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service This placed people at risk of harm. This was a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Equipment had been safely tested and risk assessments for the environment were in place. However, the fire evacuation point had recently been repositioned following a recent risk assessment. Signage was yet to be put in place to show the new evacuation point and other procedures had not been updated to account for the change.

We recommend you ensure when risk assessments identify a change is required to keep people safe, immediate steps are taken to implement that change.

Systems and processes to safeguard people from the risk of abuse
● Systems were not effectively developed to ensure all potential risks of abuse were reported and investigated. Procedures were not in place to ensure risks of abuse were reviewed and mitigated.
● The provider had failed to ensure staff understood their responsibilities to keep people safe from abuse or improper treatment. Staff had not received appropriate training to ensure allegations of abuse were appropriately recorded and escalated to the appropriate person for investigation.
● We saw information which if appropriately escalated would have led to changes in behaviours and practice. This included the use of physical restraint designed to keep people safe from harm. There was no available information to assure us that when people were supported with 'safe holds' the decision to do so had been made in the person's best interest and was the least restrictive option to keep them safe.

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 working within the principles of the MCA and if needed, appropriate legal authorisations were not in place to deprive a person of their liberty.

When people are deprived of their liberty through restrictive practice and appropriate assessment and authorisations are not in place, this is abuse and a breach of regulation 13 (Safeguarding service users from abuse and improper treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staffing and recruitment
● Staff were safely recruited including completion of a comprehensive health questionnaire. However, we

saw two questionnaires which identified key health needs which, under employment regulations required assessment, these had not been completed.

Staff are supported by legislation to ensure when they present with key health needs, these are assessed to determine if any reasonable adjustments are required to their workplace. When this is not done it is a breach of regulation 19 (Fit and proper persons employed) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Staff told us they were well supported and well trained to undertake the responsibilities of their role. However, we had concerns around the deployment of staff.
● There were 10 people living in the home who were supported by increased staff observations. Where this was the case, there was a risk for those people to show their emotions physically if they could not be understood. There were daily occasions when people were supported by 'safe holds' to keep them and others safe. We were not assured that all staff completing increased observations were appropriately trained to do so.
● When we looked at rotas and observation records, we found a high proportion of the time staff completing increased observations were not suitably trained. We were told that there were other staff in the building who were, but they had not been allocated to provide the support.

When staff are allocated a role to complete, for which they are not competent as they have not received the required training or do not have the required skills, this is a breach of regulation 12 (Safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Appropriate checks had been made to ensure staff were suitable including 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.
● There were enough staff present at the time of the inspection to meet people's needs.

Preventing and controlling infection
● We were somewhat assured that the provider was using PPE effectively and safely.
● 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 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.

We have also signposted the provider to areas of concern to develop their approach.

Visiting in care homes
● The home was open to visitors and we did not note any issues with visiting arrangements.

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 for this key question 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.

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

- Whilst we saw staff who were passionate about the support they provided to people, they were not supported with the information and activities staff to enable them to deliver an inclusive and person-centred service to people in the home.
- Key information about people's needs on admission and changing needs once in the home were not routinely captured in risk assessments and care plans. This meant staff did not always have all the information they needed to support individuals in a person-centred way.
- Where information was available on people's preferences, choices and interests this was not routinely used in developing care plans to meet needs and reduce risks to people.
- Staff told us working at Hulton House Care Residence was a rewarding job but also a very challenging one, made worse by the lack of activities staff to engage with people to develop and sustain their emotional, social and mental wellbeing.
- The views of staff, people living in the home and/or their families had not been captured for some time. This did not give the management team assurance they were delivering a service which met people's needs and preferences.
- The last providers information return identified the importance of 'a good understanding of the individual' to allow staff to 'understand potential triggers and anticipate people's needs'. This is particularly important when people communicate frustration and anxiety physically. There was no evidence that this understanding of the person had been used effectively to 'understand potential triggers and anticipate people's needs'.

When services provided do not meet people's needs or reflect their preferences this is a breach of regulation 9 (Person-centred care) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- There was a suite of audits to be completed at different intervals. These were mostly completed but did not identify concerns. Senior managers' audits identified concerns and issues month after month but action to improve was not taken in a timely or effective way.
- Records used to report incidents and accidents were not reviewed appropriately. The information was not actioned in a timely way to ensure any changes in how support was delivered were captured and

implemented.
● Systems used to capture key information were not correctly used to allow effective oversight of the service delivered. Reports were not contemporaneous of events and action taken so effective review, monitoring and audit was not possible.
● Governance procedures were not embedded; information of concern was not effectively shared with staff and staff views on conflicting systems was not acknowledged. Staff were clear about the importance of good information but the rationale for the processes they used to capture that information was confusing and diluted as information was often recorded in different places by different people.

The provider had failed to establish and operate effectively systems and procedures to assess, monitor and improve service provision. Records held were not contemporaneous of events that took place. This was a breach of regulation 17 (Good governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Working in partnership with others
● The registered manager told us how the pre-admission process was implemented to ensure safe admissions. Upon reviewing the pre-assessment information supplied by health care professionals for 5 people with complex physical and mental health needs, we found the information was not effectively used to build appropriate risk assessments and care plans.

We recommend the provider reviews their processes around effective oversight of preadmission information to ensure people's needs can be met upon admission to the home.

● Referrals were made as required to professional teams for additional support in meeting people's needs.
● The management team were responsive to feedback and worked well with professionals to identify and reduce risks.

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
● The home supports people with very complex needs. Some people have both dual diagnosis and both physical and mental health needs. On each providers registration there are details of different service user needs called 'service user bands'. Hulton House Care Residence does not have mental health as a service user band.

We recommend the provider ensures that for each service user type supported there is the associated service user band on their registration with the Care Quality Commission.

● The last inspection report was available both in the foyer of the home and on the provider website.
● Notifications were received by the Care Quality Commission as required, when the home identified notifiable events and situations.

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 Treatment of disease, disorder or injury	Regulation 9 HSCA RA Regulations 2014 Person-centred care Regulation 9 (1) (2) b, c, d, f, (5) People or if appropriate their families or relevant professionals were not routinely involved with ensuring care and treatment was delivered to meet people's needs and preferences. Person-centred care was not always delivered and steps had not routinely been taken to ensure decisions were in the person's best interest.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Regulation 19 (1) c Assessments had not been completed to support staff and understand if any reasonable adjustments were required due to health needs.

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 Treatment of disease, disorder or injury	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12, section (1)(2)(a)(b)(c)(g) Safe care and treatment, of the Health and Social Care Act 2008 Systems had not been established to assess, monitor and mitigate risks to the health, safety and welfare of people using the service Staff were not always competent to complete the role for which they were allocated and procedures for the safe management of medicines were not routinely followed.

The enforcement action we took:

urgent NOD with conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Regulation 13, (1) (2) (3) b (5) (7) a, b, Safeguarding service users from abuse and improper treatment, of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. System were not in place to safeguard people from the risk of abuse. Where people were deprived of their liberty steps had not always been taken to ensure the legal authority was in place to do so.

The enforcement action we took:

warning notice and urgent NOD with conditions

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17, section Regulation 17 (1) (2) a, b, c,

Treatment of disease, disorder or injury

f, of the Health and Social Care Act 2008

Systems and procedures were not effective to assess, monitor and improve service provision. Records held were not contemporaneous of events that took place.

The enforcement action we took:

urgent NOD with conditions and warning notice