Healthcare Homes Group Limited

Haughgate House 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
Haughgate House Nursing Home is a care home providing personal and nursing care for up to 42 older people in one adapted building. At the time of our inspection there were 29 people living in the service

People's experience of using this service and what we found
The service had experienced a high turnover of staff and challenges recruiting both care staff and nurses. As a result, there was a high level use of agency staff which people told us impacted on the quality of care they received. A number of incentives had been introduced to improve the ability to recruit and retain staff.

The provider's governance systems in monitoring the quality and safety of the service were ineffective and did not identify the shortfalls we found at this inspection. Where we found people at risk from scalding hot radiators, this had not been identified in management audits.

Infection control processes were not robust. People were not sufficiently protected from the risks associated with the spread of infection, including from COVID-19 due to ineffective cleaning regimes. There were systems to support people to have visitors and a programme to test staff and people using the service.

The lack of management oversight meant some previously evidenced standards and regulatory compliance had not been maintained. We were not assured incidents were analysed effectively, and lessons were learned and applied to reduce the risks to people and ensure their safety.

People told us staff were kind.

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 Good (published 15 April 2019).

Why we inspected
Prior to our inspection we received concerns about shortages of staff including a lack of permanently employed nurses and ineffective leadership. 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.

This report only covers our findings in relation to the Key Questions safe and well-led only.

We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

The overall rating for the service has changed from good to requires improvement. This is based on the findings at this inspection.

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

Enforcement
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 discharge our regulatory enforcement functions required to keep people safe and to hold providers to account where it is necessary for us to do so.

We have identified breaches in relation to risk management, infection control, health and safety and governance.

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 request an action plan for 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 return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Haughgate House 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 Care Act 2014.

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 carried out by two Inspectors and one 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.

Service and service type
Haughgate House is a 'care home'. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection.

During the inspection-
We spoke with nine people who used the service and five relatives about their experience of the care provided. We spoke with 10 members of staff including the regional director, senior care staff, care staff, the cook, head housekeeper, trainer, clinical consultant and peripatetic nurse.

We reviewed a range of records. This included four people's care records and multiple medication records. We looked at three staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at training data and quality assurance records. We also spoke with health and social care professionals.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to 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.

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

- Risks to people's safety associated with improper operation of the premises had not always been identified and action taken to reduce these risks.
- We found people were at risk of burns and scalding from hot surface radiators in people's rooms. Burns and scalds are damage to the skin caused by heat. We immediately informed the regional director who took action to turn down the thermostats and told us they had alerted the provider's health and safety department to rectify and make safe.
- Where people had a diagnosis of epilepsy there was no risk management plan which would provide staff with the information needed to identify the specific triggers and signs for monitoring seizures. This meant care staff were not provided with adequate information to enable them to identify and reduce risks.
- There was a high number of people cared for in bed, but it was not always evident in care plans as to the reasons for this.
- A high number of people cared for in bed had bed rails in place. We observed one person trying to climb out, over their bed rails with the bed raised at waist height. We noted from their care plan they were fully mobile, prone to falls and had experienced hip fractures. Daily notes had identified other incidents of this person attempting to climb out of bed over bed rails. The use of bed rails had not been reviewed given the serious risk of harm. In response to our feedback the regional director told us the bed rails had been removed and a low profile bed provided.
- People's care records showed not everyone identified at risk received a welfare check at the regularity as described in their care plans to monitor their safety and wellbeing. This put people at risk of harm.

Using medicines safely

- Not everyone where staff administered creams and lotions had a medicines administration record [MAR] in place to evidence medicines had been applied as prescribed.
- Where MAR records were in place for prescribed creams and lotions, we found multiple gaps in staff signatures to evidence these medicines had been administered. This meant we were not assured people had received their medicines as prescribed.
- The regional clinical support nurse had identified in a recent audit the unsafe practice of internal, oral and external medicines being stored together. We found this unsafe practice had continued. This presented a risk to people of medicines meant for external use only being administered orally.
- Checks we carried out of oral medicines stocks tallied with MAR records.

Preventing and controlling infection

● We were not assured that the provider was promoting safety through the hygiene practices of the premises. We found a lack of oversight in monitoring and minimising the risk of infection to staff and people who used the service.
● Cleaning schedules stated all rooms had been regularly cleaned when this was not the case.
● There had been a recent outbreak of COVID-19 at the service.
● We found rooms of people who had died unlocked and had not been deep cleaned with beds unchanged. Not all deaths COVID-19 related.
● One of the four rooms found was of a person who had tested positive for COVID-19 and had died 29 days prior to our visit, we found their room un-locked still containing clinical waste, bed not changed, no deep clean of their room and their personal possessions including medicines still present. These shortfalls had not been identified in any management audits.
● In response to our feedback a deep clean of all rooms we had identified took place.
● Staff told us there were in the last month occasions when there was insufficient housekeeping staff to ensure touch point cleaning took place regularly to protect people from the risk of cross contamination. Staff told us there was a reliance on care staff to also complete this task. Requested information to evidence this task had been carried out by care staff was not provided.
● There was no appointed infection prevention and control lead within the service as stated within the provider's infection prevention control policy.
● COVID-19 risk assessments had not been completed for people who used the service. Care and risk management plans did not show risks to individuals, including those with complex health conditions had been assessed with guidance provided for staff to keep people safe.

In relation to the above we found no evidence that people had been harmed however, systems were either not in place or robust enough in the management of risk to demonstrate risks to people's safety was effectively managed. 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.

● There were systems in place to ensure screening of visitors to the service.
● We were assured that the provider was accessing testing for people using the service and staff.
● Measures were in place to ensure the provider is meeting COVID-19 vaccination requirements of staff.
● 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 the provider was facilitating visits for people living in the home in accordance with the current guidance.

We have signposted the provider to resources to develop their approach.

Staffing and recruitment
● Prior to our inspection we received a number of concerns regarding the lack of permanently employed staff, including nurses available to meet people's needs.
● We received mixed comments from people regarding the availability of staff to meet their needs. Comments included, "I don't wait very long, unless they are busy like lunchtime, usually I wait only about 5 minutes, they are very good at night." And, "They have a huge number of agency staff, you see lots of changes of faces, couple of occasions I could not understand them, it would be a so different if we had all permanent staff, much nicer place to live." Another person told us, "You can be ringing between 8 and 9 in the morning and evening, most of the time you are left waiting especially if it is handover time and then, I am unlikely to get a response."
● Staff told us, "We have struggled with a lack of staff. Lots of staff have left. The new wing upstairs has only

one member of staff and downstairs two units with two staff on each but one of those staff has to come up to help the one carer up here. You constantly have to go up and downstairs asking for help, that can be annoying when people have to wait for support, the senior is tied up with the nurse doing dressings and medicines, it is very tiring." Another told us, "We are short almost every day, care staff and kitchen staff, it is difficult, service is affected, meals can be late as the carers are still attending to personal care and there is no one to come and get the food."

● We noted from a review of management reports, rotas and talking with staff there was a high number of agency staff employed to fill gaps in staffing shortages, however there were occasions when there was insufficient staff available to meet people's assessed needs.

● We noted the dependency tool in use was not regularly reviewed to reflect people's changing needs and ensure the numbers of staff were adjusted as and when needed.

● The provider had appointed an interim peripatetic and a clinical lead nurse until new staff were recruited. A number of recruitment and retention incentives had also been introduced including, flexible working, a review of pay and bonus schemes in an attempt to attract more staff.

This demonstrated a breach of Regulation 18 (staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Required recruitment safety checks had been carried out to ensure that staff employed were suitable to carry out the work they were employed to perform

Systems and processes to safeguard people from the risk of abuse

● People told us they felt safe and that staff treated them well.

● There was a safeguarding policy and procedure in place. Staff had received training about how to protect people from harm and abuse.

● Information provided to us by the local authority informed us of three current alleged safeguarding incidents under investigation. We had not been informed of these as required. Please see the well-led section of this report for further information.

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 the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to 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.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; 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 provider's quality assurance systems were not robust. There was ineffective governance and a lack of oversight at registered manager and provider level which had failed to fully identify shortfalls in the service putting people at risk of harm.
- Management audits did not identify with actions the risks associated with infection prevention control, the risk of scalds and burns from unprotected radiators and where the use of bed rails posed a risk to individuals.
- Opportunities had been missed to identify ways of preventing future incidents. Safeguarding investigations did not always include findings with lessons learnt to prevent the risk of future harm.

We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate effective oversight of the service. This placed people at risk of harm. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

- Prior to our inspection we received a number of concerns regarding the lack of permanently employed staff and ineffective leadership of the service.
- There had been changes of registered manager in the last 12 months with a third change imminent which had destabilised the service and resulted in inconsistency in approach.
- Staff told us these changes along with other staff leaving the service had impacted on staff morale. One member of staff told us, "It has been a bit up and down here with different managers coming and going, I am sure we will pick up, the loyal main staff have stayed but many have left. We use a lot of agency staff, their standards have varied, a few not great, mainly lack of English language problems." Another said, "Generally we are now starting to tick over, several staff have moved to the new home in the town. Morale has been low, but it is starting to build up. The manager is leaving and the new manager and deputy coming are both nurses which is good. We have been very short of nurses."
- The registered manager was on leave during our inspection. The regional director told us the registered manager would be leaving the service in December 2021. A nurse manager had been appointed and was

due to take up the post of manager in January 2022 as well as a new deputy manager due to start in December 2021.

● The registered manager had not always reported to CQC all incidents as required by law. This included notifications of deaths and safeguarding incidents with investigation outcomes. This meant there was reduced external oversight of risk.

We are looking at potential failures to notify and will report on our findings once completed.

Working in partnership with others

● Following recent safeguarding incidents, the local authority told us the management team was working with them to make improvements needed in the quality and safety of the service.

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 12 HSCA RA Regulations 2014 Safe care and treatment Systems were either not in place or robust enough to demonstrate the management of risks to people's safety including risks of scalds, medicines and infection prevention control was effectively managed. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 17 HSCA RA Regulations 2014 Good governance We found no evidence that people had been harmed however, systems were either not in place or robust enough to demonstrate effective oversight of the service. This placed people at risk of harm.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care Treatment of disease, disorder or injury	Regulation 18 HSCA RA Regulations 2014 Staffing There was insufficient staff available at all times to meet people's assessed needs.