Ultimate Care Limited

Bilton Hall Nursing Home

Inspection report

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Date of inspection visit:
01 November 2021

Date of publication:
16 December 2021

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
Bilton Hall Nursing Home is a nursing home providing personal and nursing care to 50 people aged 65 and over at the time of the inspection. The service can support up to 60 people. Bilton Hall Nursing Home is a single adapted building with two wings. One of the wings specialises in providing care to people living with dementia.

People's experience of using this service and what we found
People were not safely protected from the risk of infection transmission due to the practices within the home.

Governance oversight and management systems did not identify issues which we found on inspection.

Risk assessments were not always in place to make sure people had support to minimise the risk of harm. Care plans did not always contain up to date or accurate information.

Medication was not always managed safely. Records did not demonstrate people received the correct creams and ointments. One person received covert medication without the correct checks and legal safeguards in place.

People were protected from the risk of abuse or neglect. Staff were safely recruited and there were enough staff to meet people's needs. The registered manager learnt lessons when things went wrong.

People told us they were supported to live empowered lives with choice and control. The service worked in partnership with other agencies and had a duty of candour when things went wrong.

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 good (published 8 June 2018).

Why we inspected
The inspection was prompted in part due to concerns received about safeguarding incidents and unsubmitted notifications. 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.

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

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 infection prevention and control measures and management oversight at this inspection.

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

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.

Bilton Hall 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
The inspection was undertaken by two inspectors. An Expert by Experience spoke with people and their relatives to gather their views on the experience of care. 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
Bilton Hall Nursing Home 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.

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. 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 five people who used the service and four relatives about their experience of the care provided. We spoke with six members of staff including the area manager, registered manager, assistant manager, clinical lead and the chef.

We reviewed a range of records. This included six people's care records and multiple medication records. We looked at three staff files in relation to recruitment and staff supervision.

After the inspection
We continued to seek clarification from the provider to validate evidence found. We looked at a variety of records relating to the management of the service, including engagement with people, relatives and staff records and quality assurance records. We spoke with one professional who regularly visit the service.

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.

Preventing and controlling infection

- Systems did not robustly protect people from the risk of infection transmission.
- We found not all staff wore personal protective equipment (PPE) correctly which increased the risk of infection transmission. PPE was not consistently used in line with best practice. For example, we found staff changed their PPE, including their face mask, in the person's room with the person present.
- We found some PPE stored in the corridors which increased the risk of infection transmission. We observed people touch the PPE which contaminated it.
- Staff did not encourage people to maintain social distancing whilst the service had a COVID-19 outbreak.
- Single use medication pots were not used and assurances were not in place to demonstrate repeat use medication pots had been effectively sanitised.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate infection prevention and control 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.

- We observed most staff correctly wearing PPE during the inspection.
- The premises were clean, tidy and odour free. Domestic staff cleaned appropriately throughout the inspection.

Assessing risk, safety monitoring and management

- People's risk assessments were not always in place. For example, not everyone who had bed rails had this risk assessed.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate the assessment of risk was effectively managed. This placed people at risk of harm. This was a further breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Maintenance checks identified three taps produced very hot water due to a broken part. The taps had been found to produce very hot water over a three month period. There was no evidence to show the taps had been fixed. We informed the registered manager who responded immediately to this. They found two taps produced water at the correct temperature, whilst the third was too hot. The registered manager took immediate remedial action manage the scalds risk.

● Regular safety checks were completed including gas safety, electrical safety and environmental safety to monitor the risk to people living at the service.
● One person told us "I feel safe here, there are lots of people I can contact if I need to. If I was worried about anything, I would speak to someone who was the most senior on the floor at the time"

Using medicines safely
● Medication was not always managed safely.
● Nurses "ticked" to say emollient creams had been applied by care staff however this had not been observed or checked. Care staff did not always record when creams were applied on care records.
● Management audits did not identify the issues the inspection team identified.
● We found one person was being given covert medication without the correct safeguards in place. This meant the person could not refuse the medication, which is their legal right. Professionals had been involved in this decision but the legal safeguards or a review system was not in place to monitor this.
● Medication protocols for 'as and when required' medicines were not always person-centred. They did not highlight to staff when to give the medication to the person or what signs the person may show.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate medication was effectively managed. This placed people at risk of harm. This was a further breach of regulation 12 (Safe Care and Treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems and processes to safeguard people from the risk of abuse
● People were protected from the risk of abuse or neglect.
● There were systems and processes in place to ensure signs of abuse or neglect were detected. The local authority and CQC had been informed of safeguarding incidents in line with legislative requirements.
● People told us they felt safe living at the service. One person told us "I feel very safe here. The staff are kind."

Staffing and recruitment
● Staff were recruited safely. Staff had mandatory recruitment checks in place to ensure they were safe to work with people living at the service. Staff received regular supervision with the registered manager to review competencies and quality of care.
● People had mixed feedback about the staffing levels. One person told us "The staff always seem overworked, I don't know if that's because there is not enough of them, they have got a lot of work to do" while another person told us "For the number of residents that live here, I don't think there are enough staff both during the day and at night. They are very busy." One person told us ""I have the bell on my knee, they come quickly, but it does depend on what they are doing." The provider has a dependency tool to monitor the staffing levels needed and ensured there were enough staff available.

Learning lessons when things go wrong
● The registered manager reviewed adverse incidents to learn lessons when things had gone wrong.
● Information had been shared with staff to improve the quality of care given following a lessons learnt review.

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.

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

- The systems in place were unsuccessful in identifying poor infection prevention and control practices and poor recording.
- Governance oversight checks failed to identify issues highlighted by the inspection team in relation to environmental checks, safe medication practices and the response to COVID-19.

We found no evidence that people had been harmed however, systems were not robust enough to demonstrate effective management oversight to respond to poor practices. 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.

- Staff spoke highly of the registered manager. One staff member told us, "The registered manager is fair and open. I can always go to them. I feel listened to." Another member of staff said, "The registered manager is fine. I can always go to them and they will come onto the floor and engage with staff."

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

- People received person-centred care where they were empowered to achieve good outcomes.
- One person told us, "The home is well managed as far as I am concerned, with everything that is going on in the world they are doing a good job"

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 registered manager acted with a duty of candour.
- The registered manager undertook a lessons learnt review if something went wrong to learn from this and share the learning with staff. This prompted a risk awareness and promoted continuous learning.

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

- People were involved in making decisions about the service. The registered manager engaged with people, their relatives and staff on a regular basis to develop the service.

● Staff reported they were involved and engaged with decisions about the service. Staff reported being able to raise concerns if needed and share ideas to improve people's quality of life.

Working in partnership with others

● The service worked in partnership with others.

● The service had links with the local community organisations such as the GP, district nurses and social care professionals who routinely visited 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 Infection prevention and control systems were ineffective in safely managing the risk of cross contamination. 12(2)(h) Risk assessment were incomplete or missing which placed people at increased risk of harm. 12(2)(a) The storage and administration of medication was ineffective where it placed people at risk of missed ointments being applied and medication not being disposed of correctly. 12(2)(g)

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 Audits completed by the provider and registered manager did not identify the issues identified on inspection by the inspection team. These were in regards to the quality of care planning, infection prevention and control practices, medicines management and management of risk. 17(2)(a)