Springcare (Hatton) Limited

Hatton Court Care 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
Hatton Court Care Home is a residential care home which provided personal and nursing care to 56 people at the time of our inspection.

The service can support up to 60 older people, younger people and people living with dementia in one building with a large central communal area. One unit at the home provides support for people living with dementia and has its own communal area. Another unit is a rehabilitation unit and provides support to people who have been discharged from hospital to enable them to go back to their own homes. This also has its own communal area with a kitchenette.

People's experience of using this service and what we found
Relatives and staff told us they felt the service was good but also shared there had been some recent challenges and concerns. One staff member told us, "This is a really good home even though it might be having a bit of a rough patch. We [staff] are doing our best."

Systems were in place to assess risks to people but were not always well managed or overseen to ensure people stayed safe. As a result people had been placed at risk of poor skin care and not having enough fluids.

Systems and processes had not been used effectively to learn from incidents, however improvement had recently been made to address this shortfall.

Staffing was stretched and their focus was on completing tasks. The shortfalls in staffing were covered by the use of agency staff. The provider was actively recruiting for staff and told us they had restricted admissions to the home until they were more stable.

The leadership and management of the home had not ensured the delivery of high quality care for all people. Although the provider had a governance framework in place this had not been used to focus on continuous learning and improvement. The oversight of agency staff and poor record keeping had not been considered as risks to people's health, safety and wellbeing.

A new management team was in place at the home which had started the process for improvement.

Overall, safe infection prevention and control procedures were followed and the management addressed issues with staff's use of personal protective equipment (PPE) during our inspection. People and staff had access to COVID-19 testing and vaccination. All visitors were tested in line with government guidance.

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 20 July 2018).

Why we inspected
We received concerns in relation to people receiving poor and unsafe care, poor fluid management and poor management of their skin. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

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.

We reviewed the information we held about the service. No areas of concern were identified in the other key questions. We therefore did not inspect them. Ratings from previous comprehensive inspections for those key questions were used in calculating the overall rating at this inspection.

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

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 Hatton Court Care Home 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 governance and the management of risk 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.

Hatton Court Care 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 three inspectors on the first day and two inspectors on our second day.

Service and service type
Hatton Court Care 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.

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.

The registered manager was not present for this inspection.

Notice of inspection
This inspection was unannounced. We gave short notice from outside the home due to the risks associated with Covid-19. We needed to know of the Covid-19 status in the home and discuss the infection, prevention and control measures in place on our arrival.

What we did before the inspection
The provider was not asked to complete a provider information return prior to this inspection. This is

information we ask providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

We reviewed information we had received about the service since the last inspection. We sought feedback from Healthwatch, the local authority and other professionals who work with the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used all of this information to plan our inspection.

During the inspection
We spoke with eight people who used the service and nine visitors about their experience of the care provided. We spoke with two visiting health professionals. We spoke with 17 members of staff including care staff, nursing staff, housekeeping and maintenance staff, the operations manager, admissions manager, administrator and quality monitoring officer.

We 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 reviewed a range of records. This included 13 people's care records and multiple medication records. We looked at two staff files in relation to recruitment. A variety of records relating to the management of the service, including policies and procedures were also reviewed.

After the inspection
We contacted all relatives after our inspection and communicated with ten of them to obtain their feedback. We continued to seek clarification about our findings from inspection with the operations manager to validate evidence found.

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 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

- Although risks associated with people's care and support had been identified, there was not always a plan in place to help reduce these risks. One person had been assessed as being at a high risk of falls, but no plan was in place to instruct staff on how to keep them safe. Another person had been assessed as a high risk of falls but there was no information in their care plan to say why this was the case.
- On one unit, we observed people going into other people's bedrooms. No staff were observing those people and so they could not intervene to divert them into alternative activities to occupy their time. Some relatives raised concerns about the safety of their family members due to this. This did not demonstrate staff were delegated effectively to ensure people in their own rooms had their privacy and their safety protected as far as possible.
- Risks to people, such as falls and choking were identified, but the action needed to reduce these risks did not always happen. One person's care plan stated they needed to be "watched closely" because they were at risk of choking, but we saw this did not always happen. This increased the risk to the person's safety.
- Some people needed to be repositioned throughout the day to help their skin stay healthy and help prevent pressure sores. A visiting health professional had recommended for one person, who had pressure sores, to be repositioned more frequently from four hourly to two hourly. This recommendation had not been updated in the person's records and care staff continued to reposition them every four hours. This placed the person at increased risk of further skin deterioration.
- Some people needed their fluid intake recorded and monitored because they were at risk of not drinking enough. The recording of this was not consistently completed and no targets had been set for how much they should drink each day. When people's fluid intake was low it was not clear what actions were or had been taken. This placed people at risk of dehydration.
- Some people had portable recliner chairs which were able to be wheeled by staff. On two occasions we saw a person with their feet banging off the floor whilst they were moved in the chair. This placed the person at risk of injury.
- Although the provider had systems in place to prevent the risk of infection, we saw some staff did not wear their masks in line with current COVID-19 national guidance. Some staff repeatedly touched their masks whilst others pulled them down to talk to others or wore them below their chins. This placed people at risk of cross infection.

This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

All our concerns were shared with the operations manager who took immediate action to deal with these.

● The provider completed regular checks on the home environment to ensure it was safe for people who lived there. Risks associated with the premises and equipment were managed through a programme of safety checks and maintenance at the home. This included areas such as fire safety, ensuring equipment was in good working order and ensuring all utilities were serviced and safe.
● Each person had a personal emergency evacuation plan (PEEP) which reflected the support they would need to evacuate the premises safely, in the event of an emergency.

Staffing and recruitment
● The staffing levels at the home fluctuated and there was a necessary reliance on agency staff due to staff leaving and the provider not being able to recruit new staff quick enough. Whilst the problems with current recruitment were outside of the provider's control, it did mean there was a potential for people's safety to be compromised because staff were stretched.
● People, relatives and staff all told us the staffing levels were currently lower than usual for permanent staff and therefore agency staff were used. One person told us, "It was recently short staffed but has improved. Staff generally know what they're doing, including most agency."
● Staff were mostly focussed on completing tasks and responding to people's immediate needs, rather than being able to spend quality time with people. One staff member said, "We try our best. It is a good home and we do right by people, but it is busy and that's why a lot of staff don't stay."
● On the second day of our inspection, the operations manager told us they had taken the decision to suspend new admissions to the home whilst they recruited to increase their staff numbers. They had also introduced new recruitment and retention activities to attract staff to the home.
● The provider followed safe recruitment practices to ensure staff were suitable to work with people at the home. Staff recruitment records were up to date and the required employment and identity checks had been completed prior to new staff starting work at the home.

Systems and processes to safeguard people from the risk of abuse; Learning lessons when things go wrong
● Prior to our inspection, we received concerns about people's skincare being neglected and pressure sores not being managed correctly. The provider had completed an investigation into these allegations and found improvement was needed in the reporting of and wound management plans.
● Pressure wounds need to be monitored carefully and must be notified to the Commission and the local authority safeguarding team if they deteriorate to a certain stage. The provider identified staff had not reported the condition of a person with a pressure wound as they should have. This did not demonstrate staff understood their role in escalating and reporting to ensure the person received the right treatment and oversight so that further deterioration was minimised.
● Following the identification of these concerns the provider had taken appropriate actions to ensure people were safe from poor skin care. This included referrals to specialist health professionals, informing people and their next of kin and additional training of staff in the identification, reporting of and management of pressure sores.
● The provider had systems in place to review any reported incidents, accidents or near misses. However, these systems had not always been followed to ensure lessons were able to be learnt in the past. Improvements had been put in place to ensure the provider's policies were followed and systems strengthened to help ensure staff understood their role in escalating and reporting concerns.

Using medicines safely
● We found two instances of people running out of medicine. There was no documented evidence to state why this had happened or what staff had done about it. Staff provided a verbal explanation to us and there was no indication people had been put at risk, however we were concerned that systems were not effective to ensure information about medicines was clearly recorded.

● People's out of date prescribed creams were not always disposed of in accordance with their instructions. We saw one person's prescribed cream was left in a communal bathroom. The instructions for this cream stated it was to be disposed of three months after opening. The date the cream was opened was listed as August 2020 which made it 12 months out of date at the time of our inspection.
● People received their medicines safely and on time and told us they were happy with the support they received. We saw staff assisted people to safely take their medicine and completed the administration records accurately.
● Some people had medicines only when they needed them, such as pain relief. Staff had the guidance they needed to know when people may require these medicines and to ensure they were given as prescribed. Staff recorded the effectiveness of these medicines to make sure they benefited the person.

Preventing and controlling infection
● We were somewhat assured the provider was promoting safety through the layout and hygiene practices of the premises. Staff did not always clean moving and handling equipment after use to help minimise the risk of cross infection. Equipment which is used with different people must be cleaned in accordance with current COVID-19 national guidance.
● We were somewhat assured the provider was using personal protective equipment (PPE) effectively and safely.
● The housekeeping staff kept the home's environment clean and followed current Government guidance for enhanced cleaning.
● We were assured the provider was preventing visitors from catching and spreading infections. Arrangements were in place for visitors to be tested for COVID-19 prior to entering the home, this included health professionals.
● We were assured the provider was meeting shielding and social distancing rules.
● We were assured the provider was admitting people safely to the service.
● We were assured the provider was accessing testing for people using the service and staff.
● We were somewhat assured the provider could make sure infection outbreaks could be effectively prevented or managed. The provider had not ensured staff wore their PPE correctly and equipment was cleaned between uses. This could increase the risk of cross infection.
● We were assured the provider's infection prevention and control policy was up to date.
● We were assured the provider was facilitating visits for people living in the home in accordance with the current guidance.

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 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.

Continuous learning and improving care

● The leadership, management and governance of the home had not ensured people received high quality and person-centred care at all times. Although the provider had quality assurance systems in place, they had not been used effectively. Therefore, issues had not been identified early enough and improvement actions had not always been monitored for their effectiveness.

● The registered persons had failed to ensure staff, including agency staff, maintained accurate and up to date care records for each person. People's care plans were not always up to date, catheter care plans were not always in place and daily charts did not always reflect the repositioning frequencies identified in some people's care plans. Because of people's existing health needs this placed them at an increased risk of harm.

● The provider's own audits showed a history of daily charts, such as fluid intake and repositioning charts, not always being completed by staff. Despite the registered manager taking actions to address this, it continued to happen and it was evident at our inspection this was a trend which had continued month on month. This placed people's health, safety and wellbeing at an increased risk.

● The registered persons had not ensured potential risk to people's health, safety and wellbeing had been mitigated in respect of the staffing issues at the home. Staff shortages had been filled by agency staff, but these staff were not always supervised to ensure they completed their responsibilities fully and they were deployed in the areas of the home they were needed the most.

This is a breach of regulation 17 (Good governance) of the Health and social Care Act (Regulated Activities) Regulations 2014.

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

● The registered persons had not made sure the external environment was safe for people to use unsupervised. On one unit, staff told us people could not access the outside area because, "It was hard for them to watch people as they may escape." For one person whose care plan stated, "[Person's name] enjoys spending time in the garden", this meant they had no access to an environment they enjoyed.

● The registered manager had not always maintained an open culture. Not all relatives we spoke with considered the home had been well led. They spoke about not being involved, poor communication and some difficulties with maintaining contact with their family members during the COVID-19 pandemic. Some relatives told us they were not kept up to date with their family member's health and treatment. This

included not being told about injuries, changes to treatment and weight loss.
● Support for staff was inconsistent. Staff told us they felt they were not always treated fairly by the company. They told us they had not felt appreciated by previous managers, but this had improved recently. One staff member said, "We are a good home, we [staff] just feel a bit underappreciated."
● It was evident staff tried their utmost to provide good quality care to people. However, they were limited by the current staffing issues which had an impact on them being able to spend quality time with people.
● One relative summed up what most relatives had told us. They said, "Staff are lovely, but there isn't enough of them to ensure all the person-centred care happens. Staff have to be task focussed to ensure everything gets done, but don't seem to have time for all the little things."

This is a breach of regulation 17 (Good governance) of the Health and social Care Act (Regulated Activities) Regulations 2014.

Following our inspection, the operations manager sent us their action plan for making the required improvements within the home. They told us "Please be assured of Hatton Court's commitment to improve the service for all that live, visit and work here."

● Staff were attentive to people's needs and we saw positive, caring interactions between them. It was obvious staff knew people well and had respect and affection for them. This was seen on our first day when staff showed respect, dignity and compassion following an incident at the home.
● Some relatives we spoke with were positive and praised staff for their communication and support with video calls given to their family members. One relative said, "They made a significant effort to set up a [video calling] session during the lockdown period and this has been extremely beneficial to those of us who live a considerable distance away."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
● The registered manager was not present for our inspection. The provider has confirmed they have resigned their post as the registered manager. The operations manager had provided cover for the day to day management of the home and will continue to do so.
● The registered persons are required by law to submit statutory notifications to us. These ensure that we are aware of important events and play a key role in our ongoing monitoring of services. The registered manager had failed to inform the local safeguarding authority or us about two people's pressure ulcers. The operations manager had taken action and reported these retrospectively.
● Prior to our inspection, the operations manager had already identified issues with people's care plans not being up to date and accurate. They had requested the provider's quality monitoring officer to complete a high-level audit. This focused care plan work was ongoing.
● As required, the provider had displayed their previous inspection rating conspicuously within the reception area of the home. Also displayed was information about whistleblowing, safeguarding and health and safety.

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 operations manager was aware of their duty of candour including the need to admit when things went wrong, to attempt to put things right and to offer apologies.
● The operations manager also responded to concerns we raised during our visit. They had already completed an action plan which identified most of the issues we found. They told us, "We need time to stabilise and address the shortfalls we know about." This helped to show that they were able to recognise

where improvement was needed and take the required action to drive these improvements.

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

● People told us they were happy at the home but were aware there were staffing issues at present. One person told us, "I have been in lots of homes and this is the best."

● Relatives told us although they felt managers had been receptive to their views, action was not always taken to address their concerns or complaints.

● The provider had mechanisms in place to gather feedback from people, their relatives and members of staff. However, these had not been used effectively. The operations manager told us they had just circulated satisfaction surveys for people and relatives to complete. At the time of our inspection, the outcome from the survey was not known.

● Following our inspection the operations manager told us they had met with as many people and relatives as possible to give them the opportunity to express their views. They also had held a meeting to give staff feedback on the inspection and involve them in making improvements.

Working in partnership with others

● The provider worked with external agencies to deliver personal and nursing care to permanent residents and people needing enablement support.

● The feedback we received from these external agencies was mixed. The main issue raised with us was of poor communication and information not always being shared effectively from staff to them. This was something the provider was aware of and was taking steps to improve.

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 The provider had not ensured adequate risk management to ensure people were protected from the 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 Although governance systems were in place, the registered persons had failed to use these effectively to improve the safety and quality of care where needed. The registered persons had not ensured potential risk to people was mitigated by the systems they had in place. Accurate, complete and contemporaneous records were not maintained in relation to decisions made about people's care and treatment.