London and Manchester Healthcare (Fulwood) Limited

Hulton House Care Residence

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
Hulton House Care Residence is a dementia specialist care home providing personal and nursing care to 53 people at the time of the inspection. The service can support up to 74 people across four separate units, each unit has separate adapted facilities. Two of the units specialise in providing care to people living with complex dementia nursing needs.

People's experience of using this service and what we found
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.

We expect health and social care providers to guarantee autistic people and people with a learning disability the choices, dignity, independence and good access to local communities that most people take for granted. Right support, right care, right culture is the statutory guidance which supports CQC to make assessments and judgements about services providing support to people with a learning disability and/or autistic people. We considered this guidance as there were people using the service who have a learning disability and or who are autistic.

Staff were recruited safely and there were sufficient staff to meet people's needs, however some concerns were raised from people, staff, and relatives about staffing levels. The provider increased staffing levels in response to the feedback shared during our inspection. Improvements had been made to the quality and the safety of the service, although the provider's systems needed further oversight to ensure they remained effective. People told us they were safe; systems were in place to protect people from abuse and concerns had been appropriately reported.

People received their medicines safely and the provider was working to reduce the use of 'as and when required' medicines. Staff were suitably trained for their roles and understood risks to people's safety and well-being and worked to lessen these risks. The building was clean, tidy and people could visit family members without restriction.

The manager, provider and management team had been responsive in implementing positive change and worked with health and social care professionals to improve people's quality of life. We received positive feedback about the manager, deputy manager and the culture of the service. People and their relatives had been included in the development of the service.

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 inadequate (published 01June 2023) and there were breaches of

regulation. 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 improvements had been made and the provider was no longer in breach of regulations.

At our last inspection we recommended that when risk assessments identified a change was required to keep people safe, immediate steps were taken to implement that change. We recommended preadmission information ensured people's needs could be met upon admission and for each service user type supported, there is the associated service user band on their registration with us. The provider had made changes to address these concerns.

This service has been in Special Measures since 25 February 2023. During this inspection the provider demonstrated that improvements have been made. The service is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is no longer in Special Measures.

Why we inspected
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 carried out an unannounced inspection of this service on 09 November 2022. Breaches of legal requirements were found. The provider completed an action plan after the last inspection to show what they would do and by when to improve safe care and treatment, safeguarding service users from abuse and improper treatment and good governance.

We undertook this focused inspection to check they 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. 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 inadequate 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 Hulton House Care Residence on our website at www.cqc.org.uk.

Follow up
We will continue to monitor information we receive about the service, which will help inform when we next inspect.

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.

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
Three inspectors and 1 Expert by Experience carried out the inspection. 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
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 not a registered manager in post. The manager had submitted an application to register. We are currently assessing this application.

Notice of inspection
This inspection was unannounced.

Inspection activity started on 19 July 2023 and ended on 26 July 2023. We visited the service on 19 July 2023.

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 require 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 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 this information to plan our inspection.

During the inspection
We spoke with 5 people and 3 relatives about their experience of the care provided. We spoke with 26 members of staff including the manager, regional and deputy managers and the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with members of the management team, nurses, advanced practitioners, senior carers, carers, housekeeping and laundry staff. We also spoke with activities staff, administration maintenance and catering staff. We had a walk around the home to make sure it was homely, suitable, and safe. We observed the administration of medicines and the care and support people received. This helped us understand the experience of people who could not talk with us.

We reviewed a range of records. This included 10 people's care records and a further 5 people's records related to any restrictions they had in place. We reviewed 6 staff files in relation to recruitment and a variety of records relating to the administration of medicines, and the management of the service, including policies and procedures.

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 our last inspection we rated this key question inadequate. At this inspection the rating has changed 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.

Using medicines safely

At our last inspection the provider had failed to manage medicines safely. This was a breach of regulation 12 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

- People received their medicine on time by nurses and staff who were trained in safe administration.
- The management team audited the management of medicine on a regular basis.
- People told us they received their medicines as prescribed. One person said, "If I don't know what they [my medicines] are, I won't take them. The nurses bring them to us."

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

At our last inspection 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 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 12.

At our last inspection, we recommended the provider ensure when risk assessments identified a change is required to keep people safe, immediate steps are taken to implement that change. The provider had made improvements.

- The management team had assessed and recorded risk to keep people safe. They had reviewed care plans to ensure assessments were up to date and identified current risks. Assessments and behaviour plans guided staff on how to offer person centred care and support.
- Each person had a personal emergency evacuation plan [PEEP]. A PEEP is a plan for a person who may need assistance, for instance, to evacuate a building or reach a place of safety in the event of an emergency.
- People who required one to one support were supported by staff who were trained to offer physical and emotional support when required.
- The provider had engaged in quality improvement meetings to drive improvement. They had invested in

new staff and created new staff roles to promote quality outcomes for people.
● The manager had taken timely action to minimise risk when assessments had identified concerns.
● The manager and senior management team reviewed incidents as part of lessons learned, to ensure risks were assessed to prevent reoccurrence where possible. Staff said they were kept updated on any incidents and what changes had been implemented to lessen the risks and keep people safe.

Systems and processes to safeguard people from the risk of abuse

At our last inspection we found restrictive practice and appropriate assessment and authorisations were not in place, this was abuse and a breach of regulation 13 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 13.

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 working within the principles of the MCA and if needed, appropriate legal authorisations were in place to deprive a person of their liberty. Any conditions related to DoLS authorisations were being met.

● Where restrictions had been placed on people's liberty to keep them safe, the manager worked with the local authority to seek authorisation to ensure this was lawful and that any conditions of the authorisation were being met. Best interest discussions had taken place with people, relatives and health and social care professionals.
● We observed staff supporting and empowering people to make daily decisions about their care and treatment.
● The manager followed best practice guidance to reduce the need of staff intervention when supporting people. This included post incident debriefings.
● The manager had systems to record, report and analyse any allegations of abuse. Staff had received training to recognise abuse and knew what action to take to keep people safe,
including reporting any allegations to external agencies.
● People told us they felt safe living at Hulton House Care Residence. One person told us, " I like it here; I'm safe; I'm happy." A second person said, "Normally [I feel safe]. The people I'm with help me to feel safe."

Staffing and recruitment

At our last inspection the provider had not ensured when staff presented with key health needs, these were assessed to determine if any reasonable adjustments were required to their workplace. This was a breach of regulation 19 (1)(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 19.

● The manager had processes to ensure staff members health concerns were reviewed as part of their recruitment process.
● We received some negative feedback on staffing levels. One person told us, "No, not enough staff." One relative commented, "At the moment, there's a shortage of staff. Weekends can be a bit difficult, they [management] can't seem to get that sorted." One staff member said, "The staffing levels are unsafe." The provider told us staff were employed in sufficient numbers to meet people's needs safely and staffing levels were regularly reviewed. Where people had additional one to one support, we saw this was being provided by suitably trained staff.
● The provider after the inspection, reviewed and increased staffing levels within the home.

● Systems were in place to ensure staff were recruited safely and records confirmed a range of checks including references, disclosure, and barring checks (DBS) had been requested and obtained prior to new staff commencing work in the service. Disclosure and Barring Service (DBS) checks provide information including details about convictions and cautions held on the Police National Computer. The information helps employers make safer recruitment decisions.

Preventing and controlling infection
● We were assured that the provider was preventing visitors from catching and spreading infections.
● We were assured that the provider was supporting people living at the service to minimise the spread of infection.
● We were assured that the provider was admitting people safely to the service.
● We were assured that the provider was using PPE effectively and safely.
● We were assured that the provider was responding effectively to risks and signs of infection.
● We were assured that the provider was promoting safety through the layout and hygiene practices of the premises.
● We were assured that the provider was making sure infection outbreaks can be effectively prevented or managed.
● We were assured that the provider's infection prevention and control policy was up to date.

The manager supported visits for people in accordance with government guidance. This meant people could have relatives and friends visit at any time. One relative commented, "Since Covid restrictions ended, there's no limit to visits, within reason."

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 our last inspection we rated this key question inadequate. At this inspection the rating has changed 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; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

At our last inspection, services provided did not consistently meet some people's needs or reflect their preferences this was a breach of regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 9.

● Management changes meant not everyone knew who the manager was, comments included, "I don't know the manager's name, but I know her face," and, "It [the home] looks all right to me; no, I don't know who the manager is."
● People, and relatives felt there had been positive improvements in the culture at Hulton House Care Residence. One person told us, "[The carers] are good with me, gentle, yes. I am looked after well here, I would say." A second person said, "I join in [meetings] as and when. We're allowed to involve ourselves. Before, it didn't feel homely, now it feels more like home, more relaxed." One relative commented, "We have had a meeting with the home because of complaints we've made. Now things are a lot better, and we know they're trying to change things here, to improve."
● Staff were positive about the new leadership team but felt staff levels could be improved; please see the Safe domain for more information. Efforts had been made to improve the culture of the home through regular team meetings, supervisions, and training plans to ensure staff had all the support they needed. One staff member said, "I feel more of a nurse here." A second staff member commented, "There is a lot more management presence. [Manager] listens and acts on what she hears."

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

At our last inspection, 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 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Enough improvement had been made at this inspection and the provider was no longer in breach of regulation 17.

● The provider had systems to assess and monitor the service. However, not all these systems were consistently followed. The provider had introduced new processes to improve compliance.
● Audits and checks were in place and identified issues, and improvements could be seen based on the analysis of information gathered.
● There was a clear management and staffing structure. Each staff member had a clearly defined role and responsibilities. This supported the effective delivery of timely support to people, as all staff knew what was expected of them.
● The management team were aware of their regulatory responsibilities. The manager and senior management liaised with health and social care professionals and used feedback to drive improvement and ensure positive outcomes for people.

Working in partnership with others

At our last inspection, we recommended the provider reviews their processes around effective oversight of preadmission information to ensure people's needs can be met upon admission to the home. The provider had made improvements.

● There had been no new admissions since the last inspection. However, the provider had new guidance to lessen the risks when people were identified to move into Hulton House Care Residence. This included compatibility assessments and limiting the number of new admissions each week.
● Records highlighted advice and guidance was sought from health and social care professionals when required. This helped to ensure people's needs continued to be met and their wellbeing enhanced.

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

At our last inspection, we recommended 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 provider had made improvements.

● The provider had made changes since the last inspection to ensure their paperwork reflected the physical or mental health support needs of the people they supported.
● The manager and provider understood their responsibilities to keep CQC informed of events which may affect people and the care delivery. They were open and honest about what achievements had been accomplished and what improvements needed to take place.
● The manager encouraged candour through openness and frank discussions. All the management team were fully participated in the inspection process.