Care Quality Commission

Hunters Lodge Care Homes Limited

Hunters Lodge 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
Hunters Lodge Care Home is a residential care home providing personal care to up to 44 people. The service provides support to older people, most of whom have dementia or a mental health need. At the time of our inspection there were 40 people using the service.

People's experience of using this service and what we found
Risks associated with people's health conditions and support needs had not always been assessed, monitored or mitigated effectively.

The management of medicines was not always safe. This included in relation to 'as required' medicines, topical creams and time sensitive medicines.

The provider lacked effective governance systems to identify concerns in the service and drive the necessary improvement. At times, there was a lack of detailed records regarding people's support needs and any potential risks posed to them.

People were mostly supported to have maximum choice and control of their lives and staff often supported them in the least restrictive way possible and in their best interests. However, not all practices that restrict people's privacy and freedom were carried out within the MCA framework. We have made a recommendation about this.

Records did not always reflect the requirements of the duty of candour had been met to show an open and transparent service. We have made a recommendation about this.

The provider had safeguarding processes in place. Staff understood how to recognise abuse and how to report this. We were assured the service were following safe infection prevention and control procedures to keep people safe. Recruitment practices were safe.

Staff enjoyed their work and spoke warmly about the people they supported. People, relatives and staff told us they were given the opportunity to feed back on the service. They were confident the registered manager would listen and act on any concerns.

The management team were responsive to feedback given and were dedicated to ensure people received a safe, person-centred and compassionate service. They began taking action to make improvements in 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

The last rating for the service was good, published on 31 August 2019.

Why we inspected
The inspection was prompted in part due to concerns that some people were being hurt by others who were experiencing distress and agitation. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

We have found evidence that the provider needs to make improvements. The overall rating for the service has changed from good to requires improvement based on the findings of this inspection. For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating.

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

Enforcement and Recommendations
We have identified 2 breaches in relation to safe care and treatment and good governance.

We served a warning notice for the breach in relation to safe care and treatment.

Follow up
We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect. We will check the requirements of the warning notice have been met 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? The service was not always safe. Details are in our safe findings below.	**Requires Improvement**
Is the service well-led? The service was not always well-led. Details are in our well-led findings below.	**Requires Improvement**

Care Quality Commission

Hunters Lodge 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 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 an 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
Hunters Lodge Care Home is a 'care home'. 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. Hunters Lodge Care Home is a care home without nursing care. 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.

What we did before inspection
We reviewed information we had received about the service since the last inspection. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with 8 people who lived at the home, 9 relatives and 3 external professionals about their experience of the service provided. We also received emailed feedback from a further 2 health professionals. We spoke with 11 members of staff including the registered manager, 2 deputy managers, care workers, a cook, a housekeeper and an activities coordinator. We observed care in communal areas. We reviewed a range of records, including 6 people's care records in depth and sampled additional care records. 4 staff files were reviewed in relation to recruitment. A variety of records relating to the management of the service, including audits, training, staff rota's, policies and procedures were also reviewed.

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 good. 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.

Assessing risk, safety monitoring and management
● Hunters Lodge specialises in supporting people with dementia and a mental health need, some people experienced distress and agitation associated with this. This increased the risk of them harming themselves or others. Risk assessments had been implemented which provided guidance for staff to follow. These were lacking in enough detail which increased the risk of staff not having enough information to effectively support people.
● People were highly dependent on staff knowledge and skill to support their well-being. Staff received dementia training for 3.5 hours every 3 years, and there was no documented evidence of mental health training. Therefore, we were not assured the training was in depth and provided staff with the necessary skills to support people in this area.
● The provider had not fully considered the impact of the environment on people's wellbeing. At times the main communal area was chaotic and loud. This type of environment can contribute to people feeling overstimulated and result in heightened agitation. A staff member acknowledged this and said, "It can be overwhelming." There was also a lack of signage and landmarks to help people to find their way around. We discussed our concerns with the registered manager who told us they would review the environment.
● There were a high number of incidents of physical altercations between people, some of which had resulted in people being harmed. Other people had self-harmed. The issues highlighted above demonstrated risks associated with people's needs had not been safely managed or reduced.
● Not all other risks associated with people's care had been identified, mitigated, and monitored effectively. For example, some people were at risk of constipation and dehydration but there were no risk assessments in place. Records demonstrated some people had not drunk enough according to their daily target amount and others had not had their bowels open for a long time. There was no evidence what action was taken as a result. This increased the risk of harm to people.
● Risks relating to people's health conditions were not always safely managed. For example, one person was at risk due to their immune system being compromised and was also at risk of urosepsis. However, no risk assessments had been implemented.
● Records demonstrated risks were not always being monitored or mitigated in line with guidance. This included supporting people to reposition to prevent pressure sores and observations to support people with their emotional well-being at the time intervals specified.
● Where people required moving and handling equipment, risk assessments did not detail person specific information such as sling size, type or positioning to ensure staff were aware of how to move people safety. This increased the risk of injury to people.

The failure to effectively assess, monitor and mitigate risks was a breach of Regulation 12 of the Health and

Social Care Act 2008 (Regulated Activities) Regulations 2014.

● Following the inspection, the registered manager informed us of improvements they had made and plans to address the remaining issues. However, these improvements needed to be embedded and sustained to ensure risks were consistently managed safely.
● Other risks associated with people's needs were managed in a safer way such as malnutrition and choking.
● The provider took appropriate action to reduce potential environmental risks such as fire and Legionnaire's disease. Equipment, such as hoists and lifts were serviced and checked regularly.

Using medicines safely
● Records demonstrated people did not always receive their medicines as prescribed. On some occasions, no reason was given for the omissions whilst other reasons included the person was asleep or it was too soon. Follow up or actions had not always been taken in response to this. This increased the risk of a person becoming unwell.
● Where people were prescribed time specific medicines to manage health conditions, they frequently did not get these at the right time. This placed people at risk of their medicines not working effectively.
● Some people were prescribed 'as required' (PRN) medicines. PRN protocols were not always in place, and when they were in place, they lacked detail and personalised information. This increased the risk of people not receiving their medicines in the most effective way. When staff had administered PRN medicines, they had not recorded the outcome for the person after receiving the medicine. This meant the efficacy of the medicine could not be reviewed.
● Some people were prescribed creams to alleviate skin conditions. There was no consistent guidance in place related to the application of external/topical medicines. Their application was not always recorded. This meant people were at increased risk of issues with their skin.
● We identified other areas for improvement. These included a lack of information recorded about staff administering homely remedies for people, 2 people still being given a topical cream despite the prescription stating it should have stopped and medicines subject to extra controls were not stored in line with guidance from the National Institute of Clinical Excellence (NICE) when they needed to be disposed of.

The failure to protect people from the risks associated with the unsafe management of medicines was a breach of Regulation 12 of the Health and Social Care Act 2008 (regulated activities) Regulation 2014.

● The registered manager told us of their plans to improve the management of medicines. This included, additional training and reviewing the systems used.
● Staff received medicines training and had been assessed as competent to administer medicines.
● People and their relatives provided positive feedback about the support they received with their medicines.

Systems and processes to safeguard people from the risk of abuse.

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 mostly 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.
● Some practices that restrict people's privacy and freedom were in place to aid safety. Some of these had been taken in line with the MCA and it was clear the use of sensor mats and bed rails had been undertaken in people's best interests if they lacked the capacity to make these decisions. However, there were no records to demonstrate the use of closed-circuit television (CCTV) and frequent checks on people had been carried out in people's best interests. This meant people's human rights could be compromised. Following the inspection, the registered manager told us of their plans to improve practice around adhering to the MCA.

We recommend the provider seeks reputable guidance to ensure all practices that restrict people's privacy and freedom are carried out within the MCA framework.

● The registered manager understood their responsibility to share information with the local authority safeguarding team and to CQC to ensure allegations or suspected abuse were investigated. We noted 1 safeguarding concern which had not been notified to safeguarding or CQC. The registered manager explained this was an oversight and would improve their systems to ensure these organisations were notified for all relevant concerns going forwards.
● The provider had safeguarding and whistleblowing policies and procedures and provided safeguarding training for staff. Staff understood how to identify and report safeguarding concerns and were confident their managers would listen and act if they raised a concern.

Staffing and recruitment
● There were mixed views about staffing levels. For example, 1 person said, "There seems to be plenty [of staff] about." Whilst another said, "I don't think there's enough [staff]. They've got no time to chat, they're very busy. A relative said, "At times, staffing is a bit of a struggle, but I don't think there's any drastic impact on people." A health professional external to the service told us, "There appears to be a good level of staffing, with a mix of management, senior and junior staff on duty to ensure the day-to-day operation runs smoothly."
● We discussed the feedback with the registered manager who assured us they kept staffing arrangements under close review. 2 people's needs had recently increased, and they had arranged for 1 dedicated staff member to support them throughout the day.
● Throughout the inspection, we observed that although staff were very busy, they responded to people's needs in a timely way.
● Safe recruitment practices were followed before new staff were employed to work with people. The relevant checks were made to ensure staff were of good character and suitable for their role.

Learning lessons when things go wrong
● When things went wrong, reviews and investigations took place to prevent similar incidents from occurring again. For example, falls were analysed for individuals and across the service. We saw actions were implemented such as referrals to health professionals and falls prevention equipment.
● Other incidents were not always reviewed sufficiently to identify improvements needed. For example, identifying the impact of the environment, lack of mental health training and reviewing techniques to support people with their mental health. This meant measures in place to reduce risk and prevent further

incidences reoccurring did not always work. You can read more about the providers oversight and governance in the well-led section of the report.

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.

Visiting in care homes
There were no visiting restrictions in place and visitors were able to access the home as required.

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 good. 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.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements: Continuous learning and improving care
● The provider's website described Hunters Lodge as 'Specialising in care for those with behavioural problems, memory loss, dementia and Alzheimer's'. This inspection has evidenced shortfalls in the environment, risk assessment and staff training which did not always effectively support people with these needs. This had not been identified by the provider's quality assurance processes.
● There were a range of audits in place such as medicines management and care plans. Some audits were carried out by staff members and had not been overseen by the registered manager or provider to ensure the effectiveness of them. These systems were not always effective in identifying the concerns we found at this inspection. For example, the concerns we identified with the management of medicines and risk.
● Records were not always detailed enough for people to receive safe care. For example, risk assessments and medicines records.

The failure to have effective systems in place to assess, monitor and improve the quality and safety of the service and to maintain accurate and complete records was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● The management team were receptive to feedback during the inspection and were committed to improving practices across the service.
● An action plan was in place to take forward improvements to the service based on feedback they gained from a variety of sources and the findings from quality audits.
● To aid learning and development the provider had enlisted the support of an external consultant. This was very new, and we were not able to assess the effectiveness of this.
● The provider was aware of their regulatory responsibilities and except for 1 time notified us of incidents they were required to do so by law.

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 had a duty of candour policy that required staff to act in an open and transparent way when accidents occurred.
● Following any incidents people and their relatives were kept informed showing a transparent service. However, records were not kept in line with this regulation. We discussed this with the registered manager who assured us they would maintain records regarding any future incidents.

We recommend the provider seeks reputable guidance to meet the duty of candour when something goes wrong.

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

● Although staff demonstrated a desire to provide good, person-centred care, people did not always achieve good outcomes. This has been detailed in the safe domain of this report.
● Despite this, relatives and most people were positive about Hunters Lodge and said they would recommend it. For example, a relative said, "It's welcoming. There's a culture of it being for the residents. It's not just a job for them [staff].' A person said, "Yes, I think I would [recommend it]. It's very well run. I'm impressed, if I have to be somewhere other than home, it would be here."
● Staff interacted with people in a kind and considerate manner, treating them with dignity and respect.
● Relatives and staff told us the registered manager and both deputy managers were always accessible, approachable and supportive.
● Staff said they enjoyed working at Hunters Lodge. They mostly felt valued for the work they did and demonstrated a commitment to the people who lived there.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics: Working in partnership with others

●The provider had systems in place to gain feedback from people, their relatives, and other stakeholders. Meetings for people and staff were held regularly and were used to share and receive information. Feedback received was used to develop the service.
● Staff were committed to engage and involve people in several ways. For example, a regular newsletter kept people up to date with what was happening in the home. Events were also organised such as a recent garden party to bring people and relatives together.
● The service worked in partnership with external professionals, such as social care professionals, community nurses and GPs to support and maintain people's long-term health and well-being. Professionals provided positive feedback about how staff in the service worked with them.

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	Regulation 17 HSCA RA Regulations 2014 Good governance The failure to ensure effective quality assurance processes were in place to ensure people received safe care.

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	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The failure to effectively assess, manage and risks for service users. The failure to safely manage medicines.

The enforcement action we took:

We served a warning notice.